Taking the Lead in Transformation of Care Delivery

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Co Founder/Co-Program Director ACCCNN
Association of Chronic and Complex Care Nurse Navigators
Southwestern Vermont HEALTH CARE

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Share my Story…..

- Staff Nurse in Med Surg, ICU, Maternal Newborn Care, ED
- Nurse Manager of Cardio-Pulmonary Unit
- Director of Emergency Department Case Management, Oncology
- Chief Nursing Officer for eight years….until a new CEO came

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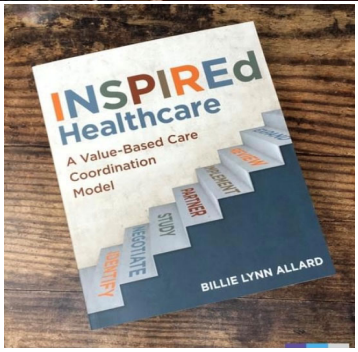

- CEO hired with different values, tried to find strategies to work with him. I was unsuccessful and left, believing my career was over and my life's work was in vain
- ONL nursing colleague reached out to offer me a job as an educator at MAGNET community hospital 13 miles away
- Spent the next 11 years transforming healthcare delivery to meet the triple aim (Institute of Healthcare, 2011)
- ANCC Magnet Prize for Innovation 2017
  Designated as an Edge Runner by Academy of Nursing in 2018
- Inducted as a Fellow in the American Academy of Nursing in 2019
  Sigma Publishing requested I write a book, *Inspired Healthcare2020*
- American Hospital Association Rural Health Leadership Award 2021

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Peter Buerhaus, PhD, RN, FAANP(h)

#1 Challenge Facing the Nursing Profession (2020-2030)

Unprepared for healthcare delivery and payment reform

AONL
American Organization for Nursing Leadership

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W.H.O. Year of the Nurse 2020-2021

Advance nurses' vital role in transforming health care around the world

NOW IS THE TIME

WE ARE THE PROFESSION to LEAD THE WAY

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WE ARE THE PROFESSION

2020 World Health Organization announced "Year of the Nurse and Mid Wife" to celebrate Florence Nightingale's 200th birthday

Florence transformed care delivery in the midst of a war and set the stage for nursing to play a lead role

NURSES are most trusted members of the healthcare team… solidified during the past 2 years with COVID pandemic

You witness daily what is not working….and what needs to be changed… NOW IS THE TIME

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RWJ Future of Nursing Report 2020-2030

- Nurses taking lead role in population health, health equity, SDOH
- All functioning at height of licensure
- Full practice authority for nurse practitioners
- Strengthening nursing capacity and expertise
- Funding for school and public health nurses
- Billing codes for care management, addiction, behavioral health
- Transform nursing curriculum focused on care across community
- Use the lever of community assessment

The FUTURE of NURSING 2020-2030

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Advance Practice Nurses – Key to Success

- Emerging trend on NP owned practices focused on value- based payment
- Results of NP vs MD care= fewer unnecessary hospitalizations, higher patient satisfaction, fewer unnecessary ED visits, decreased health care resource utilization
- Plan= joining together, reducing barriers and regulations, capitalize on achieving success with VBP model
- NPs =added emphasis on disease prevention, health management and patient education

Comprehensive Perspective in Health Care

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Roadblocks and Potential Strategies

- Federal Trace Commission (based on IOM report) physician supervision of NPs "sometimes restricts competition unnecessarily which can be detrimental to healthcare consumer and public health consequence…resulting in decreased access, higher costs, reduced quality of care and decreased innovation."
- Strategy – prove value of NP services , use of quality/cost scores that demonstrate patient-centered care, quality improvement and sustainable business case operations
- Research studies MD/NP care = NP outcomes equal to or better
- NPs focus on engagement not transaction, focus on family and patient, function before cure

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Healthcare in the US is at a crossroads..

- Out of tragedy, heartbreak and pandemic…an opportunity exists

Irrefutable facts…

Healthcare delivery is shifting away from the hospital to outpatient/ambulatory/community settings

The United States health care system costs double the cost of other developed nations, last in most quality outcomes, recent data=decreasing life expectancy

If meaningful and effective healthcare transformation is going to happen, we need to play a LEAD ROLE

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Quality and Cost

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Last in quality out of 11 developed nations

Highest Cost

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US Quality Ranking compared with other Developed Countries

- Access to Care (affordability and timeliness) LAST
- Administrative Efficiency (reduce bureaucracy/documentation) LAST
- Equity (income- related disparities) LAST

1. Highest maternal mortality
2. Highest infant mortality
3. Lowest Life expectancy
4. Highest chronic disease burden
5. Obesity rate (two times higher)
6. Suicide rates

US Highest Rate of Avoidable Deaths

Conditions considered to be preventable with timely access to effective and quality healthcare

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US Healthcare Costs vs Developed Countries

Percent(%)of Gross Domestic Product

- **United States - 16.9**
- Switzerland -12.2
- Germany -11.2
- France -11.2
- Sweden -11
- Canada -10.7
- Norway -10.2
- Netherlands -9.8%
- United Kingdom- 9.8%
- Australia- 9.3%
- New Zealand- 9.3%

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Southwestern Vermont Health Care One Care ACO

SVMC FAST FACTS	(FIVE TIME Magnet Hospital)
• Vermont	**3rd "oldest" state**
• 75,000	**Total Service Area**
• 3	**States Served** (VT, NY, MA)
• Dependent	**Medicare** ⬆
• High	**Medicaid Population**

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Healthcare Reform Efforts in Vermont

- Partnership with UVMC, Dartmouth Hitchcock, Vermont health systems, Green Mountain Care Board
- Vermont legislators and hospital executives discussing possible healthcare reform programs
- One Care Accountable Care Organization ACO (partnerships between hospitals, providers and payers to provide coordinated care , avoiding unnecessary duplication of services and avoiding medical errors CMS.gov.)
- Exploring possible options to shift toward value- based care model to decrease cost and improve quality and population health

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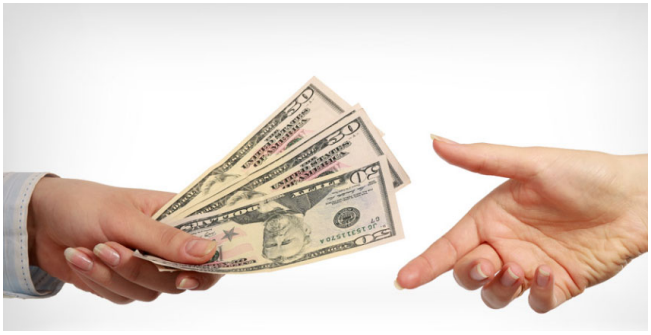
Fee for Service 100 + YEARS

Provider Incentives

- Paid for services rendered
- Rewarded for Volume
- Quantity of Services

Regardless of the outcome

Result = waste, duplication, inefficiency, unnecessary healthcare costs



Consequences = decreased access and equity of healthcare impacting population health

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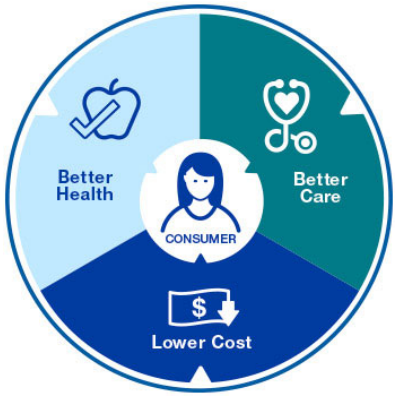
Value-Based Care

Quality Driven,
Aligned financial incentives

Incentivized to keep people healthy

Improved access to equitable care

- Improve patient experience
- Improve health of population
- Decrease spending on healthcare and cost of care



Right care, right place, right time, by right person

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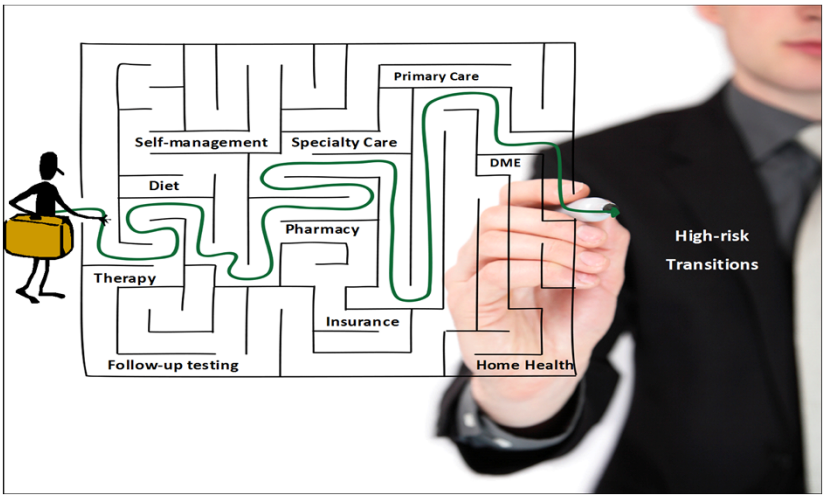
Experience of Care for your Family



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Shift of Patient Care from Hospital to Ambulatory Settings

- SVMC 2000 - 80% Inpatient 20% Outpatient
- SVMC 2015 21% Inpatient 79% Outpatient
- Hospital revenue down
- Hospital census decreasing
- Length of stay decreasing
- Critical nursing positions in jeopardy

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Partnership is Powerful

Nursing Homes

Homecare Agencies

Mental health/substances abuse partners

Primary care/ Specialists

Medical Home

Community Partners

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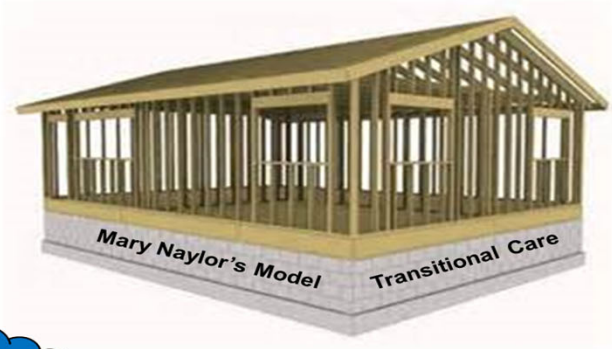
Naylor Model –Transitions of Care



Communication Gap

Care Gap

System Gap

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Hospital-Based Nurses

? What are we doing

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AHA …. Moments

- Nurses partnered with non-medical home primary care provider practices to be resource for PCP, improve care coordination across all settings
- Nurses/Provider identified high risk, chronic disease patients
- Nurses= ambassador for PCP, building relationships with patients/family
- Observing care delivered across all settings from patient perspective
- Identifying gaps, opportunities, safety issues

A Whole New Reality WAS Revealed

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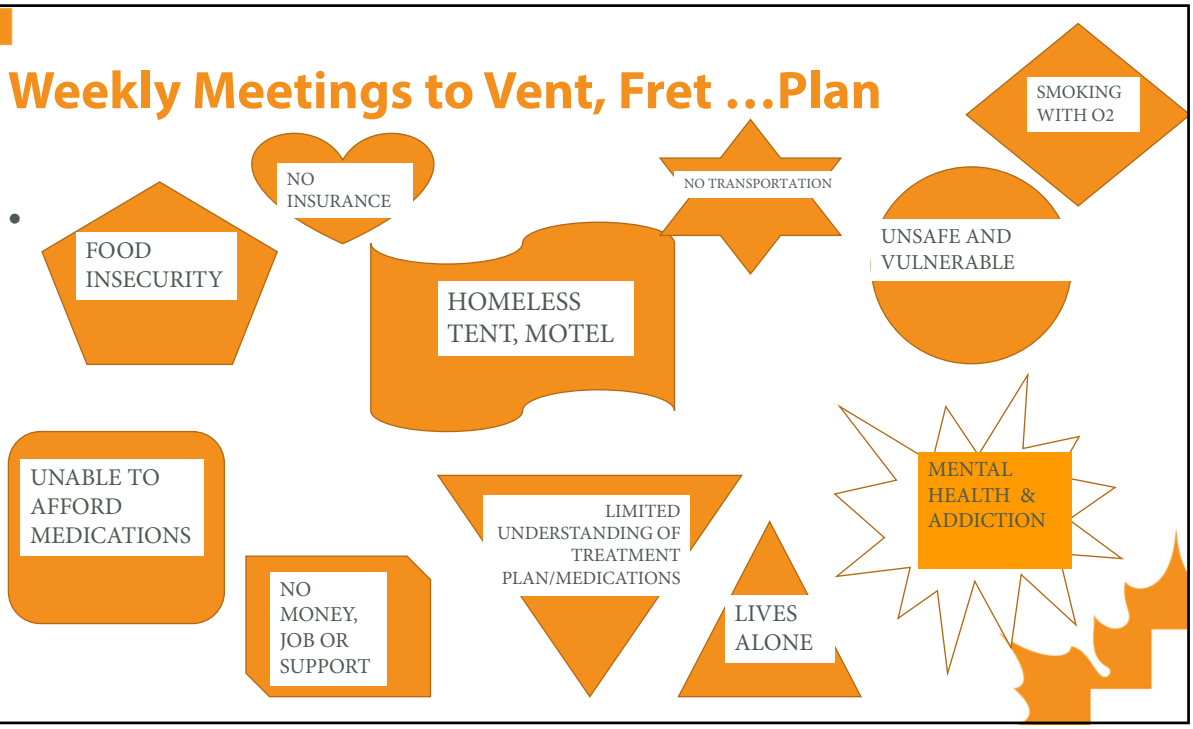
Weekly Meetings to Vent, Fret …Plan



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Support for Primary Care Providers and Specialists

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Transitional Care Nursing

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Integrated Social Work

- Lack of insurance/coverage
- Inability to pay for basic necessities (ex. medications)
- Homeless/safe housing
- Psychosocial support (connect with community resources)
- Substance abuse or mental illness
- Advance Directives

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Goal of Longitudinal Care Delivery

Define and standardize	Define and standardize processes before an inpatient admission and up to 90 days after discharge
Encourage	Encourage shared ownership of desired patient outcomes by all care partners across the care continuum
Promote	Promote overall cost reductions across all episodes of care
Support	Support focused care coordination activities and resources to facilitate patient and family-centered handovers
Drive	Drive appropriate use of post-acute resource connections to optimize patient recovery and quality outcomes

www.premierinc.com (12/18/2018)

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Standardized Education

- Interdisciplinary team
- Refrigerator magnets for easy access
  - COPD & CHF Action Plans
  - Providers sign off
- Shared with:
  - Primary Care Providers
  - Home Care Agencies
  - SNF's
  - Hospital
- Pill boxes, scales, journals

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Motivational Interviewing

R	**RESIST telling them what to do:** *Avoid telling, directing, or convincing your friend about the right path to good health.*
U	**UNDERSTAND their motivation:** *Seek to understand their values, needs, abilities, motivations and potential barriers to changing behaviors.*
L	**LISTEN with empathy:** *Seek to understand their values, needs, abilities, motivations and potential barriers to changing behaviors.*
E	**EMPOWER them:** *Work with your friends to set achievable goals and to identify techniques to overcome barriers.*

Source: https://www.evidenceinmotion.com/blog/2016/05/25/please-dont-lecture/motivational-interviewing/

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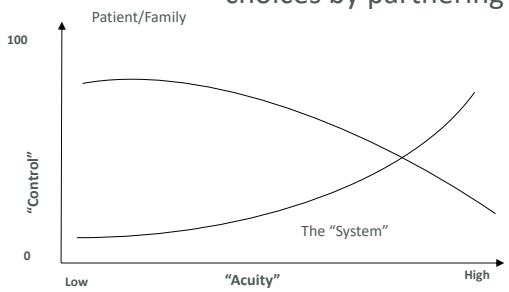
Patients Control Outcomes

The majority of health care occurs at the **low-acuity** end of the scale, where **outcomes are controlled not by physicians** or "the system" but by the **everyday choices of individuals** and families. The largest opportunity clinical staff have to influence health outcomes is to influence choices by partnering over time.



Source: Gottlieb, Sylvester and Eby. Transforming Your Practice: What Matters Most. Family Practice Management. www.aafp.org/fpm. January 2008.

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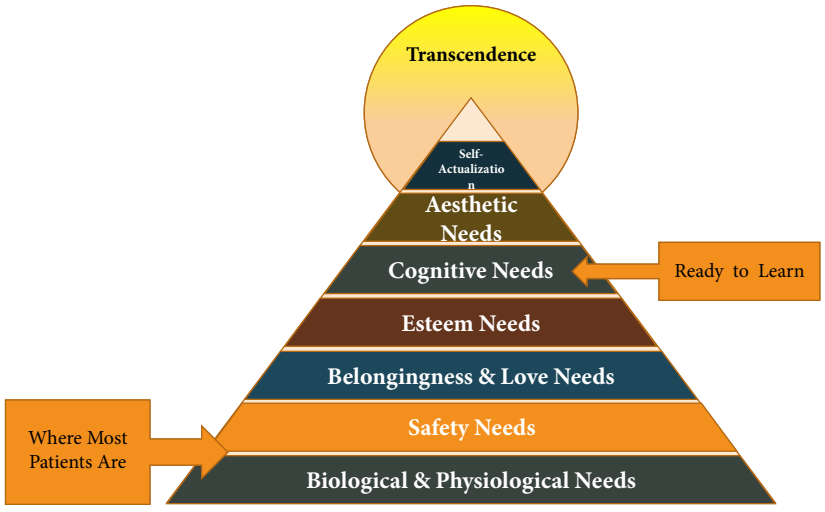
Maslow's Hierarchy



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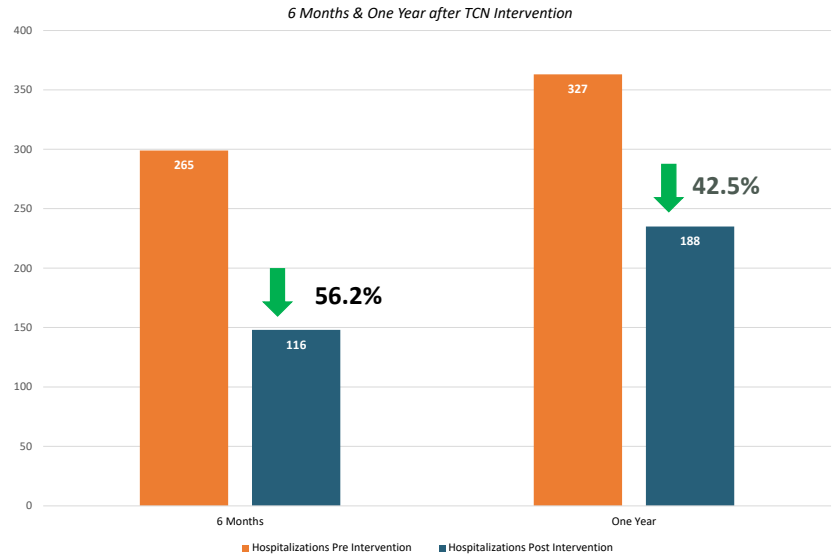
Hospital Visit Reduction



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Nurse Navigator Delivery of Integrated Care

- Improve equity, efficiency, and effectiveness of healthcare services
- Most linked with specific hospital service lines in 2015 (obstetric, pediatric, disease specific)
- Bridge gap between primary and secondary healthcare services
- Created due to lack of coordination between hospital and general practice providers/specialists
- Providing person-centered care, continuity of care and patient empowerment
- Decrease costly service duplication for chronic disease patients

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Population Health is a Paradigm Shift

Patient

Person

Medical Services

Population Health

Hierarchy

Partnerships

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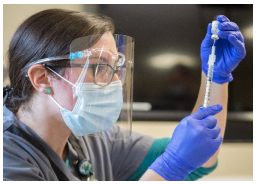
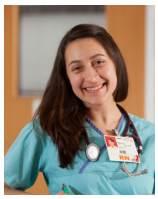
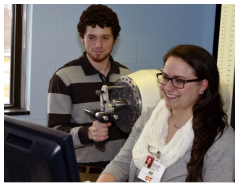
Team Functioning at Height of Licensure



Clinical Pharmacist

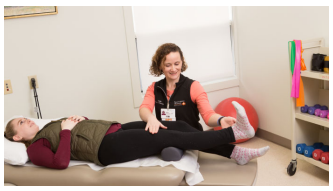


Nurse Practitioner



Occupational Therapist

Social Worker



Physical Therapist

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Daily Interdisciplinary Rounds
Discharge planning for all hospitalized patients

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Community Care Team for Frequent Users of the ED

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Community Collaboration

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Community Partnerships

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Community Care Team

Reduction in Visits at 6 Months

55.4% Reduction in ED Visits

71.4% Reduction in hospitalizations

Reduction in Visits at 1 Year

42.9% Reduction in ED Visits

56.1% Reduction in hospitalizations

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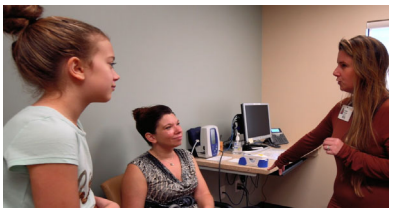
Pediatric Community Care Team

- Medicaid at risk population –50% high risk children
- Increase access to appropriate referrals
- Embraced by community partners joining forces
- Advocate for resources with one voice
- Key strategy for COVID-19 pandemic
- Partnership with school counselors, nurses to connect with high- risk youth
- 22% reduction in ED visits
- 84.6% reduction in inpatient/observation



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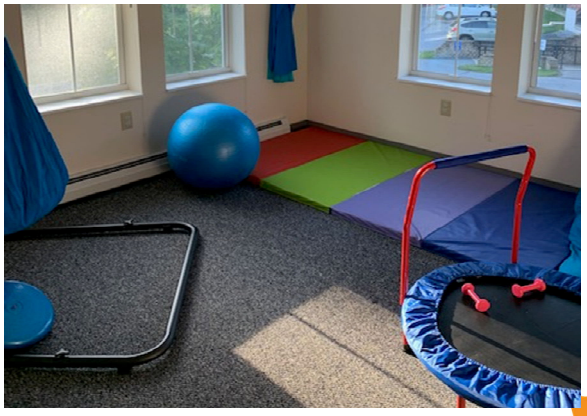
Psychiatric Urgent Care for Kids (PUCK)

- Family Emergency Services (FES) transition child to PUCK
- Youth use sensory room/tools with FES
- Masters-level clinician provides screening and observation
- Parent/family meeting provided
- Consultation on site to child's school
- Psychiatric Medication Consultant is provided
- Consultation with PCP with care plan development



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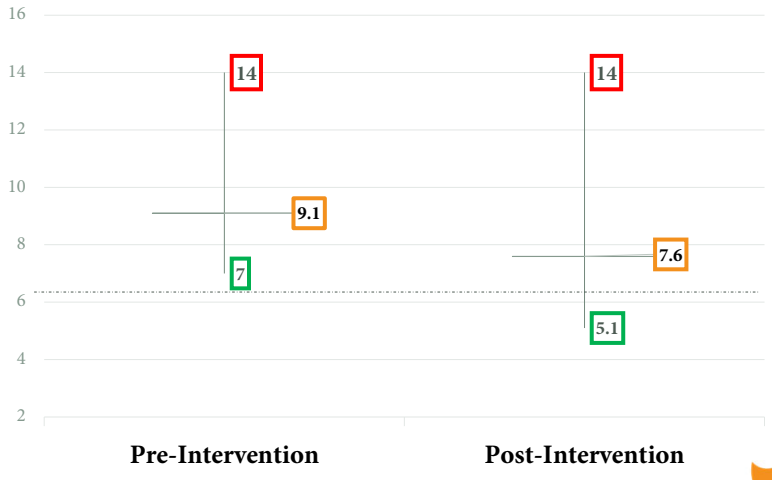
Integrated Diabetes Education



16.5% Reduction in average A1C post Integrated Diabetes Education intervention;
18.4% reduction in ED/inpatient utilization within 12 months of intervention.

N=544

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Cardiac Rehabilitation Referrals

A monitored individualized and personal treatment plan, including evaluation and instruction on physical activity, nutrition, stress management , and other cardiac risk factor education.

Cardiac Rehabilitation Eligibility:

- Heart Attack
- Stable Angina
- Coronary Artery Bypass Surgery
- Valve replacement/ repair
- Angioplasty/ Stents
- Heart Failure EF< 35%
- Heart transplantation
- Peripheral Artery Disease

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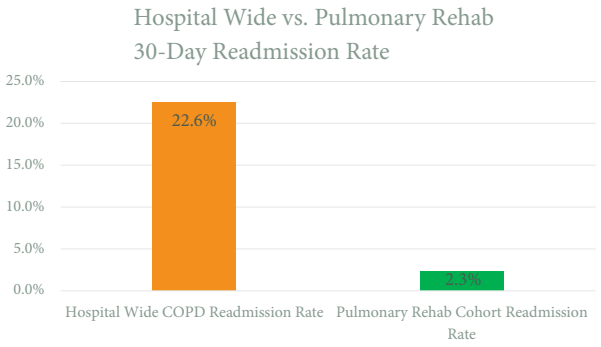
Pulmonary Rehabilitation

- Goal: Improve quality of life, ability to manage illness & health status, and restore patient to highest functional ability
- 71% of participants completed the program
- Individuals who stayed in the Maintenance Program had a 0% readmission rate for the 3 months after graduation.



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Measuring Improvements

- 63.6% • Improvement with dyspnea
- 67.3% • Improved quality of life
- 65.5% • Improvement in functional ability to walk 10 meters
- 67.3% • Improvement in functional ability to walk for 6 minutes

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Food Insecurity

- Grateful Heart Project
- Healthcare Shares
- Medically Tailored Meals
- Leftovers to Food Pantry
- Summer Meal Program
- VT Food Bank drop site
- Food Pharmacy

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Palliative Care Transitional Care Nurse

- 30% of readmissions identified as end stage chronic disease
- "Crucial Conversations" with providers not happening
- Lack of knowledge re: Benefits of Palliative Care
- Lack of timely referrals to Palliative Care/Hospice
- 2020 data = 47% reduction in inpt/obs hospitalizations

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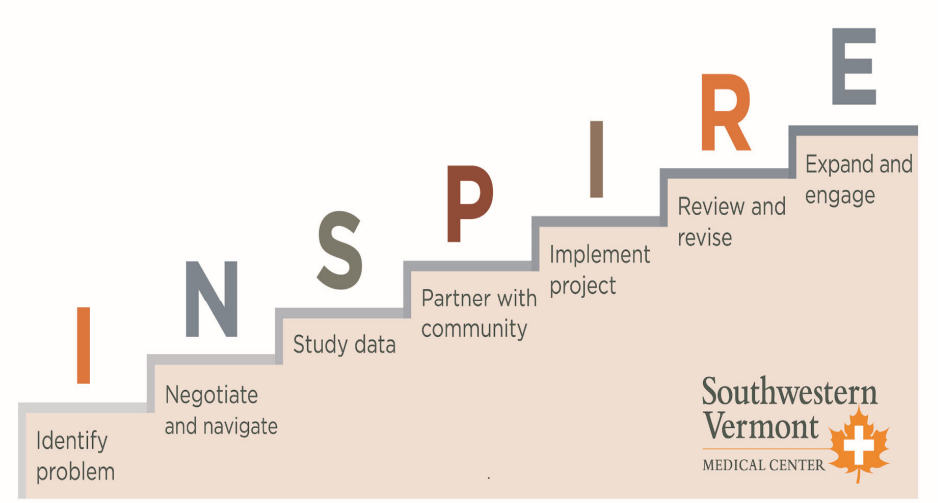

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LESSONS LEARNED

- Meet individuals where they are without judgment
- Decision making resides with each individual
- Assist individuals to make informed choices about care
- Must screen for and address social determinants of health
- Refer to and embrace value of community partners
- All disciplines practice at height of licensure
- All providers deliver longitudinal care (what happened before, what happens after)
- Home visits by someone provides critical information to inform care
- Motivational interviewing to engage people in setting goals that matter to them
- Use community care teams to create integrated care plans shared across settings

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Professional Opportunities

American Organization for Nurse Leadership

Organization of Nurse Leaders Ma. R.I. N.H Conn. VT. (ONL)

AONL | American Organization for Nursing Leadership™

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American Academy of Nursing :

AMERICAN ACADEMY OF NURSING

EDGE RUNNERS

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ACNN Association of Chronic & Complex Care Nurse Navigators™

- Sister Organization of AONN+ (Academy of Oncology Nurse and Patient Navigators) founded by Lillie Shockney (John Hopkins)
- Co-Founder and Co-Program Director
- Kick off Summit in San Antonio Nov. 2023
- Outreach to Nurse Navigators and interested future navigators across the country

SPREAD THE WORD Come Join the Movement

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Opportunity Costs

1 Emergency Department visit	1 months rent
2 hospitalizations	1 year of childcare
20 MRIs	1 social worker for a year
60 echocardiograms	1 public school teacher for a year

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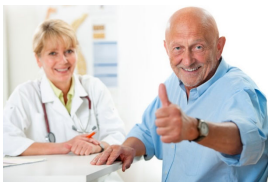
Meeting the Quadruple Aim



Source: http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Moving-Upstream-to-Address-the-Quadruple-Aim.aspx

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Thank You

Billie Lynn Allard, MS, RN, FAAN
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THE FUTURE IS IN OUR HANDS

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