How Does the IOM Future of Nursing Report Affect Nurses in Long-Term Services and Supports

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A Regulatory Perspective and Future Implications
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Focus

- Key issues in LTSS and what the future may bring
- LTSS State Scorecard in relation to LTSS nurses
- How the IOM Report on the Future of Nursing will impact this future
- Your leadership
Key Issues in LTSS and what the future may bring

• Long Term Services and Support rather than Long Term Care

• Overlap with Chronic Care, Transitional Care—Functional Focus

• Movement toward accelerating Home and Community Based Care
LTSS

- Nurses need to change language to be in tune with today
- Consumer focused
- Not about the care they get from others as passive recipients
- It is about services and supports they ideally control
Key Issues in LTSS and what the future may bring

• Focus on Family Caregivers

• Federal innovations that will affect nurses:
  – Integration with Acute, Primary Care
  – Managed care
  – Duals demonstrations
  – CMS Innovation Center

• CLASS Act
Innovations to Improve Care Transitions and Coordination

- Medicare Community-Based Care Transitions Program
- Medicare Independence at Home Demonstration
- Medicare & Medicaid Center for Innovation
- Patient-Centered Medical Home Demonstration
- Community Health Teams for Medical Homes
- Medicaid Health Homes for Chronic Conditions

See Public Policy Institute Fact Sheet: Health Reform Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions
Payment Reforms that Support Care Transitions and Coordination

- **Hospital Readmission Reduce Incentives (§ 3025)**
  - Penalties for avoidable readmissions

- **Accountable Care Organizations (§ 3022)**
  - Medicare Shared Savings Program
  - Provider bonuses for saving money and improving quality

- **National Payment Bundling Pilot (§ 3023)**
  - Bundled payment for episodes of care
  - Physicians, acute hospitals and post-acute care providers
Medicare Payment Reforms that Support Care Transitions and Coordination

Avoidable Readmission Penalty (§ 3025)

- Incentive to improve care transitions and reduce avoidable readmissions
- Reduced Medicare DRG payments by 1%, rising to 3%
- For certain avoidable readmissions exceeding a threshold (TBD)
- 3 Target conditions TBD starting in FY 2012, 7 in 2015
- Readmission window TBD (ie, 30 days post discharge)
- Hospital-specific readmission rates will be published on Medicare Hospital Compare website
- Expand to skilled nursing homes and HH Agencies
Independence at Home Demonstration (§ 3024)

- Starting in 2012 (or sooner), funding of $5 million/5 years
- House Calls to help Medicare beneficiaries remain at home

- Medical Practices (MDs and Nurse practitioners) must have experience delivering home-based primary care, available 24 x 7

- Target Medicare Beneficiaries with Multiple Chronic Illnesses
  - 2 or more chronic conditions; 2 or more functional dependencies (ADLs)
  - Hospitalized in past 12 months (non-elective)
  - Rehab therapy in past 12 months
  - Voluntary enrollment of up to 10,000 beneficiaries

- Bonus for savings exceeding 5%
Innovations to Improve All Care Transitions and Coordination

Community Health Teams (§ 3502)

- Interdisciplinary teams contract with Medical Homes
  - Collaborate with community support services
  - Teams must be designated by states or Indian tribes
  - Chronic care coordination, discharge planning, transitional care, medication therapy management (§ 3503), mental health referrals, 24 x 7 availability
  - HHS grants: ACA does not authorize funding but HHS has indicated funding will be available

- Teams must become self-sustaining in 3 years
- Targets patients with chronic conditions regardless of payer type (Medicare, Medicaid, private)
Medicaid Innovations to Improve Care Transitions and Coordination

Medicaid Health Homes for Chronic Conditions (§ 2703)
  – Also known as Medical Homes
  – State Medicaid Option

• Targets high-risk Medicaid beneficiaries
  – 2 chronic conditions or
  – 1 existing chronic condition plus risk of 1 or more additional or
  – Serious mental illness

• Services
  – Enhanced integration and coordination of primary care, acute care, behavioral care, and long term care
  – Care management, transitional care, community support services
Medicaid Innovations to Improve Care Transitions and Coordination

Medicaid Health Homes for Chronic Conditions (cont)

• **Funding**
  - Planning grants starting in 2011
  - CMS will base approval on Letter to State Medicaid Directors, Nov 16, 2010, and subsequent regulations
  - Matching funds totaling up to $25 million ($500,000 each?)
  - Over 20 states have expressed interest in planning grants

• **Conditions**
  - During first 2 years, 90% federal matching funds for Health Home services
  - States must track avoidable readmissions
  - Estimate savings from care coordination
  - Report lessons learned
Duals

- CMS: $1 million per state for 15 states to support design

- Person-centered models that integrate the full range of acute, behavioral health and long-term supports and services

- Does not prescribe managed care per se---CMS open to innovative models
Acceleration toward more HCBS

- Money Follows the Person
- Balancing grant program
- Community First Option
- CLASS
LTSS State Scorecard

• Concise performance tool to put LTSS policies and programs in context.
• First attempt to use a multidimensional approach to comprehensively measure state LTSS system performance overall and across diverse areas of performance.
• Differs from analyses that examine a single aspect of states’ LTSS systems.
• Developed over two years—to be released September 8th.
Partners & Contributors

• Funded collaboratively by The Commonwealth Fund and The SCAN Foundation.

• Experts from across the country formed a National Advisory Panel and a Technical Advisory Panel, which were consulted regularly throughout the development of the Scorecard.

• NCSBN key contributor
Our Definition of LTSS*

• Inability to perform ADLs or IADLs on one’s own for an extended period (typically 90+ days)

• Includes human assistance, supervision, cueing and standby assistance, assistive technology, health maintenance tasks, information, care coordination

• Includes services used by family caregivers

• In a high-performing system, LTSS are coordinated with housing, transportation, health/medical services

*Those whose LTSS needs arise from intellectual disability or mental illness are excluded for purposes of the scorecard.
Characteristics of a High-Performing LTSS System

- Support for Family Caregivers
- Affordability and Access
- Choice of Setting and Provider
- Quality of Life and Quality of Care
- Effective Transitions and Organization of Care

- The first four characteristics map to dimensions and indicators
Dimension: Support for Family Caregivers

In a high-performing LTSS system, the needs of family caregivers are assessed and addressed so that they can continue in their caregiving role without being overburdened.

**Support for Family Caregivers** includes:

- level of support reported by caregivers;
- legal and system supports provided by the states; and
- the extent to which registered nurses are able to delegate health maintenance tasks to non-family members, which can significantly ease burdens on family caregivers.
Nurse Delegation Tasks

- Medication administration
  i. Oral medication
  ii. PRN medication
  iii. Pre-filled insulin/insulin pen
  iv. Draw up insulin
  v. Other injectable medication
  vi. Glucometer testing
  vii. Medication through tubes
  viii. Insertion of suppositories
  ix. Eye/ear drops
Nurse Delegation Tasks

• Tube feedings (Gastrostomy)
• Administration of enemas
• Bladder regimen (intermittent catheterization)
• Ostomy care (skin care, change appliance)
• Respiratory Care
  i. Nebulizer treatment
  ii. Oxygen therapy
  iii. Ventilator care
State Policies on Delegation of 16 Health Maintenance Tasks

Number of Tasks Allowed to be Delegated

SOURCE: State Long-Term Services and Supports Scorecard, 2011
NOTE: Data not available for Alabama, Delaware, District of Columbia, North Carolina and Ohio
Future of Nursing: Campaign for Action
Health Care System Challenges

- Fragmentation
- High costs
- Primary care shortage
- Health care disparities
- Aging and sicker population
Fragmentation

- Lack of integration among providers
- System rewards volume, not value
- Result: lower-quality care and higher costs
Health Care Disparities

Racial and ethnic minorities

- Get fewer routine procedures
- Receive poorer care
- Die younger
Aging and Sicker Population

- Life expectancy rising
- Baby boomers aging
- Chronic diseases increasing
Primary Care Shortage

- Rural and low-income areas particularly affected
- Fewer physicians entering primary care
- 32 million more people to get health insurance in 2014
High Costs

- Health care costs unsustainable
- Federal budget deficits affected
- Wages stagnating
High-quality, patient-centered health care for all will require transformation of the health care delivery system.
Health Care Reform and the Nursing Workforce: Matching Nursing Practice and Skills to Future Needs, Not Past Demands

Julie Sochalski & Jonathan Weiner

- A reorganized health care delivery system will have a significant effect on the future roles and responsibilities of RNs and APRNs
Problem: Chronic and cyclical nursing workforce shortage.

• Innovative Solutions:
  • Nursing education funding, emphasis on graduate level
  • Medicare GNE Demo
  • Prevention and Public Health Fund
  • Title VIII of the PHSA
  • NHSC

Problem: Unnecessary re-hospitalizations decrease quality of life for the older adult and drive up Medicare costs.

• Innovative Solution: Transitional care pilot program
• **Innovative Solution:** Medicare’s Independence at Home Demo

Problem: Need for nurse practitioners skilled in community-based health centers.

• **Innovative Solution:** Residency Demo

Problem: Uncoordinated care, lack of communication, too many medications lead to poor outcomes.

• **Innovative Solutions:**
  • Accountable Care Organizations
  • Nurse Managed Health Centers
  • Medicare Medical Homes
  • Medicaid Health Homes
All Americans have access to high-quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success.
Campaign for Action

- Education
- Data
- Practice
- Collaboration
- Leadership
**Education**

- Increase to 80 percent the proportion of nurses with BSN by 2020
- Double number of nurses with doctorate by 2020
- Implement nurse residency programs
- Promote lifelong learning
Evidence

• Significant association between educational level and patient outcomes

• 6 percent of AD grads get advanced degree, enabling them to teach and serve as PCPs, compared to 20 percent of BSN grads
Appendix I

Recommendation 2: Convene expert panels to develop a model pre-licensure curriculum which:

- can be used as a framework by faculty in community college-university partnerships for development of their local curriculum;
- is based on emerging health care needs and widely accepted nursing competencies as interpreted for new care delivery models;
- incorporates best practices in teaching and learning.
Practice

• All practitioners should practice to full extent of their education and training

• Optimal care
  – Physicians, nurses and other health professionals work in team-based model of care delivery
  – Models of care maximize time that providers can spend on their respective roles and responsibilities to patients
Practice

• Evidence: More than 10 studies show equivalent patient outcomes when care is provided by APRN or MD for certain services
  – Includes two Cochrane reviews
  – Randomized clinical trial published in JAMA
  – Office of Technology Assessment

• No studies show care is better in states that do not allow APRNs to practice to full extent of education and training
Leadership

- Nurses bring important viewpoint to management and policy discussions
- Prepare more nurses to help lead improvements in health care quality, safety, access and value
Data

Improve health care workforce data collection to better assess and project workforce requirements

- Research on health care workforce is fragmented
- Need data on all health professions
Diversity

- Nurses should reflect patient population in terms of gender, race and ethnicity
- All nurses should provide culturally competent care

Increase workforce diversity
Transforming Health Care

Interprofessional Collaboration

Workforce Data

Access to Care

Leadership

Education

access

quality

cost
Campaign Strategies

- Diverse Stakeholders
- Policy-makers
- Action Coalitions
- Communications
- Grantmaking
- Research, Monitoring, Evaluation

RWJF AARP Advisory Committee
Campaign for Action

RWJF/AARP seeking support from:

- health professions
- payers
- consumers
- business
- policy-makers
- philanthropies
- educators
- hospitals and health systems
- public health agencies

Nursing must be considered societal issue!
Campaign for Action

Action Coalitions

- Long-term alliances
- Field strategy to move key nursing issues forward at local, state and national levels
- Expect to be in all states in 2012
- Capture best practices, networking

To become part of a coalition, go to: www.thefutureofnursing.org
Campaign for Action State Involvement

Map Legend:
- Orange: Action Coalition State
- Blue: State Involvement

Updated: 7.20.2011
Your Leadership

• New models of care require change, including us

• Action Coalitions
  – 80/20 competencies
  – Scope of Practice (including delegation)
  – Leadership on boards and commissions
  – Interprofessional education and collaboration
Campaign Resources

• Visit us on the Web at: www.thefutureofnursing.org
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