NEW REIMBURSEMENT MODELS EXPLAINED: WHAT NURSES NEED TO KNOW IN A VALUE-BASED WORLD

Betty Rambur, PhD, RN, Routhier Endowed Chair for Practice, Professor of Nursing, University of Rhode Island
First—Why Do Reimbursement Schemes Matter?

- Reimbursement is the fuel/nourishment that drives health care

- What is fed, grows

- What is not fed, withers
Fee-For-Service
Predominant—Fuels

- High technology, interventionist care over interactive care or watchful waiting
- Demands little to no accountability for the overall consequences of clinical decision-making
  - MRI for back pain
  - Prostate cancer surgery
- Creates treatment silos because of payment silos
- Fragments care
  - Person with diabetes example
Fee-for Service Fuels

- The silliness factor--example
  - Nurses won’t be reimbursed for a home visit on a non-homebound patient
  - When the patient falls, ambulance, ED and ICU are reimbursable
- Oregon’s Coordinated Care Organizations
  - Air conditioner
  - Mold reduction in home
  - 33 performance measures
  - Stakes high—penalties if not successful
Revenue Generator vs Labor Cost

- In Fee for Service most of medical care, hospitalization, is a revenue generator
- Neurosurgery better compensated than, for example, mental health, primary care, and far better than watchful waiting
- More is Better Model
- Nursing Care is a Labor Cost
- Payment Reform, depending on where along the continuum of change, shifts this
- Important, because society is paying those costs
Specifically

- Health care organization business case does not align with the overall societal economic case
- Orthopedic surgery vs opioid treatment
- Organizations chase revenue
New Models Begin to Ask, “What Difference Does Our Care Make?”

- What does a particular nursing or medical intervention/activity cost?
- What difference does that activity make in the life of the person? Their family? The population?
- How do you know the cost? The longer term impact?
- What can nurses do to improve the patient experience, population health, and contain cost?
- Why does it matter?
It Matters Because

- US health care is too expensive
- US health care a paradox of overtreatment and under treatment
- US health care outcomes lag far behind other industrialized nations
## Income Vs Health Care Cost

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<tr>
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<th>2015</th>
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<td>Cost/Income</td>
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Slide courtesy of Al Goibelle, Chair, Green Mountain Care Board
For All that Cost, We Aren’t Doing Well

U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking

Estimates that 1/3 of what we do in health care doesn’t matter
High Degree of Waste—21-47% of Total Health Care Spending

Types of Waste

- Failures of coordination
- Failures of care delivery
- Overtreatment
- Administrative complexity
- Pricing failures
- Fraud and abuse

(Berwick & Hackbarth, 2012)

And We Are Putting Our Money in Places it doesn’t Matter

- Growing understanding of the difference between health and health care
- Social determinants of health
Emerging Payment Model
Payment Models Conceptualized Along a Range of Most to Least Like FFS

Legend: FFS=fee for service; P4P= pay for performance; PCMH=patient centered medical homes;
But Wait, Haven’t We Tried Reform Before?

- What is Different Now?
  - Clear data on quality failures
  - Clear data on unsustainability
  - Greater understanding of social determinants of health
  - And, The Affordable Care Act (ACA)

- Note, however, much of what is driving change is OUTSIDE of the ACA
January 2015—Historic Sea Change!

- HHS makes historic announcement
- Clear goals and timeline for shifting Medicare reimbursements from volume to value
  - 30% of current traditional FFS to value-based (like ACOs or bundled payments) by end of 2016; 50% by 2018
  - In addition, 85% of all traditional FFS tied to quality/value by end of 2016; 90% by 2018
    - In traditional FFS system poor quality care often receives the same reimbursement, or even higher reimbursement
Clear Signal From CMS—Bundled Payments for Joint Replacement

- 75 MSAs
- Nearly 800 Hospitals
- BUT, because payment is bundled, creates incentives along the entire continuum of care.
ACOs Voluntary...Bundled Payment for Joint Replacement

Included services
- Physicians’ services
- Inpatient hospitalization (including readmissions)
- Inpatient Psychiatric Facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Independent outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Part B drugs
- Hospice

Excluded services
- Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the LEJR surgery
- Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care

https://innovation.cms.gov/resources/ccjr-overview-webinars.html
Are you on the list?

Yes, Indeed!


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<td>Bond County, Calloway County, Clinton</td>
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Three New Mandatory Bundles Proposed

- Acute Myocardial Infarction
  - 98 randomly selected metro areas

- Coronary Bypass Grafts
  - 98 randomly selected metro areas

- Surgical hip/femur fractures exclusive of joint replacement (hip surgeries without a prosthesis)
  - Those already in joint and knee bundled payment
  - Yes, includes Portland
The PLOT THICKENS: MACRA and MIPS

Bipartisan Support: House 392/37; Senate 92/2
How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments **up to** the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

![Diagram showing maximum adjustments ranging from -9% to 9%](image)

Adjustment to provider’s base rate of Medicare Part B payment

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Reminder: What is Wrong with Fee-for-Service? Well, it Fuels...

- A *more is better* approach
- Payment –and therefore treatment--silos
- Fragmented care
- Disincentives for coordination and integration
- An inability to control costs
Payment Models Conceptualized Along a Range of Most to Least Like FFS

Legend: FFS=fee for service; P4P= pay for performance; PCMH=patient centered medical homes;
Pay for Performance (P4P)

- Complementary health care reimbursement
- Offers financial rewards to providers who achieve or exceed specified quality benchmarks
- Most approaches adjust aggregate payments to physicians and hospitals on the basis of performance on a number of different measures.
- Payments may be made at individual, group, or institutional level
Advanced Primary Care/Patient Centered Medical Homes/Person Centered Health Communities

- Advanced Primary Care Practices (Patient Centered Medical Homes)
- Practice Facilitators (assist with preparation for NCQA scoring and ongoing quality improvement)
- Community Health Teams (core teams and extenders)
- Self-Management Programs (Healthier Living, Tobacco Cessation, Diabetes Prevention, Wellness Recovery)
- Multi-Insurer Payment Reforms
- Health Information Technology Infrastructure
- Evaluation and Reporting Systems
- Learning Health System Activities
EXAMPLE WITHIN A SINGLE HEALTH SERVICE AREA

- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi-insurer payment reform that supports this foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
Continuum of Health Services

Level of Need

Higher Acuity & Complexity

Lower Acuity & Complexity

Advanced Primary Care Practice

- Health Maintenance
- Prevention
- Access
- Communication
- Self Management Support
- Guideline Based Care
- Coordinate Referrals
- Coordinate Assessments
- Panel Management

Community Health Teams

- Support Patients & Families
- Support Practices
- Coordinate Care
- Coordinate Services
- Referrals & Transitions
- Case Management
  - Medicaid Care Coordinators
  - Senior Services Coordinators
  - Addictions Care Coordinators
- Self Management Support
- Counseling
- Population Management

Locus of Service & Support

Specialized & Targeted Services

- Specialty Care
- Advanced Assessments
- Advanced Treatments
- Advanced Case Management
- Social Services
- Economic Services
- Community Programs
- Self Management Support
- Public Health Programs
Examples of CHT Team Members

- Care Coordinators
- CHT Managers
- Registered Nurses
- Social Workers
- Mental Health/Substance Abuse Clinicians
- Pharmacists
- Nutrition Specialists and Registered Dietitians
- Health Educators and Health Coaches
- Certified Diabetes Educators and Asthma Educators
- Tobacco Cessation Counselors
- Community Health Workers
- Panel Managers
- Medical Assistants
- And of course, physicians, nurse practitioners, and PAs
It Take a Village!

Who is coordinating these services?

Source: Maurine Gilbert | Vermont Blueprint for Health, used with permission.
Next Forms Add Financial Risk to the Model

- Accountable for outcomes over time AND cost
- Lets start with Accountable Care Organizations then move to bundled payment models, closing with global budgets with accountability for total cost of care across payers
Accountable Care Organizations (ACOs) are comprised of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population.

These providers work together to manage and coordinate care for their patients and have established mechanisms for shared governance.
If their PCP belongs to an ACO, the ACO accepts responsibility for the cost and quality of care provided to that person.

People see their PCP as they usually do.

In Shared Savings, Providers bill FFS as they usually do.
Calculating Shared Savings

- Projected Expenditures
- Actual Expenditures
- Shared Savings
- Medical
- Matched Federal $ Money
- Risk Adjustment
- Quality Targets
- Accountable Care Organizations

Slide courtesy of Sarah Suter, used with permission
Upside and Downside Risk

- **Downside Risk** -- Cost over projected
  - Offers ENORMOUS pressure to create more efficient models of care
- **Upside**: Many higher performing health systems could not improve outcomes enough to receive savings
  - Dartmouth Pioneer ACA—easier for a 10 minute miler to go to 9 than a 4 minute miler to go to 3
Unanswered Question

- Have nurses, the largest segment of the health care system, informed themselves and actively promoted solutions to create savings?
- IF no, how might outcomes look differently if or when they (we) do?
Three Iterations of ACOs

- **Pioneer**
  - Many dropped out
  - Saved Medicare nearly $400 million over 2 years per independent actuaries (Beck, WSJ, May 4, 2015)

- **Shared Savings Programs (SSP)**
  - Many stayed with upside only

- **“Next Gen”**
  - At least one lay member on governing body
  - Risk sharing inclusive of fully capitated per member per month (PMPM)
  - Addresses significant limitations of SSP
Limitations Next Gen Addresses

- ACO accountability for patients with whom they have had little contact.
- Incentives patients to seek care within the ACO by—potentially—up to $50 per covered lives.
- Modifies existing provisions that lead to unnecessary gaps in care.
  - Claims from home visits for non-homebound beneficiaries
  - Waives 3 day hospitalization before SNF
  - Telehealth outside of rural areas etc. (Finkelberg, Bortniker, Geilfuss, & Rosen, 2015)
Bundled Payments--GOALS

To remove FFS incentives and replace with those which reward collaboration and evidence-based practices across specialties and primary care providers for targeted episodes or types of care which represent opportunities for high return.

Note: Nursing care has always been bundled hospital charges.

Episodes of care
50% of Medicare spending results from 17 conditions, e.g., cardiovascular disease, musculoskeletal impairments (http://bit.ly/1DjX9rd)
Bundled Payment for Care Initiative
- Hospital payments for inpatient*
- Medicare Parts A and B for 48 conditions*
- Payments for post acute claims in*
  - Skill nursing facility, inpatient rehab facility, long term care, home health agency, physician practice group

Hospital-centric**
- Initial hospitalization, health care provider fees during hospitalization, payment for readmission—no other post acute costs

*= retrospective reimbursement
**= prospective reimbursement
Findings to Date

- Greatest spending variability in skilled nursing faculty care, rehabilitation facilities, and home health agencies.
- “Because patterns of variation were condition specific, condition-specific delivery innovations are likely to be needed.”

These settings are nursing sites of practice, where nursing care predominates

- Nurse know these settings and are in a key position to redesign care delivery across the care continuum.
- Yet, are nurses grabbing the rein?
Nurses have game-changing knowledge

- Nurses have essential skills to bring and have skin the in the game, but may not know it or how to enter the change arena.
Nurses with “Skin in the Game”—Managing High Cost Chronicity

- Across payers “Super utilizers” — 1% of pop/22% annual costs
- Medicaid even more dramatic—5%/55% of costs
- Under FFS, no disincentive for hospitals/providers to see and treat, even if it the ED.
Vermont Chronic Care Initiative

- Team of nurses and social workers for individual and population management
- Need data, so local and centralized data analytic staff
- Field based care managers and care coordinators
- CARE BASED, not CURE BASED model
Examples of VCCI Services

RNs and MSWs:
• Encourage and support healthy behaviors
• Help with related issues such as housing, food security, and transportation to medical appointments
• Assist beneficiaries in talking with their health care providers
• Meet with beneficiaries and providers to develop and support a plan of care
Outcomes: Base and FY 13-14 changes

- Saving After Expenses
  - $11.5 FY 12; $30.5 M FY 14

- Reduction in inpatient utilization
  - 8% FY 12; 30% FY 14

- Decrease in ED utilization
  - 4% FY 12; 15% FY 14

- Decrease in 30 day readmission
  - 11% FY 12; 31% FY 14

Source: Eileen Girling, RN
Vermont Dept. of Health Access
Global Budgets: Fixed Revenue
Total Cost of Care

Why?

- Need to move away from fee for service to more comprehensive cost control mechanism
- Way to link payment system to goals of population based health care
- Hospital/health system/disease management/community service alignment/designated agency—service area match
  - Over time represent the total amount community willing to spend on hospital care
  - Give providers flexibility to allocate resources in community responsive way
  - Eliminates the need to create services to chase revenue
- Like a household budget, hospital has strong incentive to reduce unnecessary care and coordinate services
Maryland-State hospital global budget—all payer

- Why?
  - “Providing fixed, predictable revenues allows hospitals to focus on value rather than volume and rewards them for investing in population health improvement” (p. 1899)

- What are outcomes to date? (November 12, 2015)
  - Moved 90% of hospital revenue away from FFS to global budgets more quickly than expected.
  - Agreed to save Medicare $330 M by 2019, have already saved $116M
  - Decreased rate of potentially preventable conditions, exception being two nurse sensitive indicators.

Vermont—All Payer Model for All Part A and B Services

Money In: The Model Agreement and the Federal-State Relationship

Formation, Structure and Regulation of the ‘O’

Money Out: Provider Payments, Services and Consumers Covered

ACO(s)

Medicare

Medicaid

Commercial

Self-Insured

Hospitals

Physicians and NPs

Health Centers

Other Providers

Money In:

Slide courtesy of Ena Backus. Used with permission
How Different is This, Really?

**Fee For Service**
- Hospitalization creates revenue for the provider organization
- Intensive, expensive high tech interventions generates the most revenue

**Global Budget**
- Hospitalization is a revenue drain for the provider organization
- Intensive, expensive, high tech interventions zaps revenue
How Big of A Change is This?

What does it mean to nurses, nursing education, and nurses’ continuing education when we celebrate empty hospital beds?
How Will Success Be Measured?

**Population Health Goal #1**
**Improving Access to Primary Care**

- **Increase % of VT Adults Reporting that they have a Personal Doctor or Health Care Provider**
  - Increase % of VT Medicare Beneficiaries Reporting Getting Timely Care, Appointments and Information
  - Medicaid Patient Caseload for Specialist and Non-Specialist Physicians (monitoring only to start)

- **Process Milestones**
  - Increase % of VT Medicaid Adolescents with Well-Care Visits
    - Increase % of VT Medicaid Beneficiaries Aligned With a VT ACO
Population Health Goal #2
Reducing Deaths from Suicide and Drug Overdose

- Reduce Deaths from Drug Overdose
  - Reduce Deaths from Suicide

- Increase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 measures)
- Improve Follow-Up After Discharge from ED for MH and SA Treatment (2 measures)
  - Reduce Rate of Growth of ED Visits for MH/SA Conditions

- Increase Use of VT’s Rx Monitoring Program
  - Increase # of VT Residents Receiving Medication-Assisted Treatment for Opioid Dependence
  - Increase Screening for Clinical Depression and Follow-Up Plan
Measurement Continued

Population Health Goal #3
Reducing Prevalence and Morbidity of Chronic Disease

Prevalence of Chronic Obstructive Pulmonary Disease, Diabetes and Hypertension Will Not Increase by More Than 1% (3 measures)

For VT Medicare Beneficiaries, Improve Performance on Composite Measure that Includes:
- Diabetes Hemoglobin A1c Poor Control
- Controlling High Blood Pressure
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

- Improve Rate of Tobacco Use Assessment and Cessation Intervention
- Improve Rate of Medication Management for People with Asthma
Potentially This Leads To....

- More incentives for integration of mental health services
- Removes disincentives for addressing social determinants of health
  - Housing as health care
  - Discretionary financial resources to address things like transportation or whatever else is in the way of optimizing health
- Incentivizes CAM when appropriate
Is Behavior Really Changing in ANTICIPITATION?

- Recent hospital budget hearing suggest yes…”The Blue H is shifting from *Hospital* to *Health & Healing*
- Hospital budgets reflect Community Health Assessments
  - Housing as health care
  - Nurse visits to homeless camps
  - EPODE
    - A comprehensive systematic approach to childhood obesity prevention used throughout the world…first US site
      - Creating walkable and bikable paths to schools
What Do You Need to Know To Help Your Organization Be Successful?

- What are the metrics on which cost and quality will be measured? How does payment work?
- How to propose and test delivery models that improve the patient experience and contribute to well-being/quality of life while decreasing costs
- How to mobilize resources to serve patients in the least intensive yet appropriate setting
- How to transition from a fee for service model in which people are turned in to patients to comprehensive, person centered models
EXAMPLE: What About Group “Office Visits?”

- Three general types of shared appointments
  - Access to medical care visits
  - Education
  - Enhancement of self-management skills for lifestyle and behavioral change
- Nurses are ideal for this sort of intervention
Everything Has Changed But Way We Think

- Limited by “physician-centric models with unimaginative use of NPs and PAs” (Nutting, Crabtree & McDaniel, *Health Affairs, 2012*)
& nurses and other providers.
What about new(renewed) roles for nurses?

- Are nurses more effective care managers than other, less expensive individuals?

- Do nurses:
  - Use data for individual and population health management?
  - Use predictive analytics for individual and population health management?
  - Understand the value of prescriptive analytics?
Maine health system, use of clinical data/Bayesian statistics predicted with 70% accuracy which patient would use the ED, be readmitted, have a stroke, be diagnosed with diabetes, as well as the cost of care

- Addition of claims data increased to 90% accuracy
- More rare events, like death, with 30% accuracy
  - Yet were still able to start hospice at more appropriate time

Source, Dev Culver, VILT Annual Summit Presentation, September 20, 2015
Other Dimensions

- What happens when smart watch/app/ smart home data are added?
- Where are nurse developed apps??
- Is our educational system preparing nurse innovators?
- Are we preparing nurses to use big data for care and system redesign toward the Triple Aim? Quadruple Aim?
Essential Nursing Knowledge and Skills

- Redesign care
  - Identify problems, develop potential solutions, create stakeholder buy-in, test the effectiveness of the change

- Understand and effectively manage quality metrics to maximize impact while decreasing cost

- Are nurses demonstrating greater value than less expensive personnel?

- Maker space—where are the nurse entrepreneurs?

- Are nurses taking an active role?
“Medical Assistants…are increasingly taking on administrative roles that nurses and other health professionals once performed exclusively. Case studies of their roles in AHCs, FQHCs, integrated health systems and medical practices reveal that MA’s are acting as health coaches and motivational interviewers, screening for depressions and smoking, perform diabetic foot checks, acting as interpreters, performing home visits and risk assessments, servicing a patient navigators, and coordinating care and providing patient referrals.”

Fraher, E, Ricketts, T., Lefebvre, A., Newton, W. (2013). The role of academic health centers and their partners in reconfiguring and retooling the existing workforce to practice in a transformed health system. *Academic Medicine, 88*(12), 1812-1816)
"Because of sheer numbers—the U.S. health care system employs 2.7 million registered nurses—it is nurses who are arguably in the most pivotal position to drive system change. ...More attention needs to be given, first, to identifying the competencies nurses need in these new roles and, then, to providing continuing professional development opportunities for nurses who wish to undertake the new functions."

(Fraher, Ricketts, Lefebvre, & Newton, 2013)
The baccalaureate program prepares the graduate to:

1. Demonstrate basic knowledge of healthcare policy, finance, and regulatory environments, including local, state, national, and global healthcare trends.
2. Describe how health care is organized and financed, including the implications of business principles, such as patient and system cost factors.
3. Compare the benefits and limitations of the major forms of reimbursement on the delivery of health care services.
4. Examine legislative and regulatory processes relevant to the provision of health care.
AND, nurses are prepared as generalists across settings, and thus foundationally prepared.

Yet, are the faculty of this nation systematically preparing students in these “fundamentals” of nursing in the contemporary era?

What does this mean for associate degree education?
Rethinking our socialization

- Providers/faculty have been socialized in an episodic, fee-for-service milieu—we teach what we know
  - “Sim labs” and high tech practice
  - Little to no practice in “watchful waiting”
  - Little exposure to “real cost accounting”
    - Concept from ecological economics
  - Little skill development in living with the ambiguity a change agenda requires
- Have not been held accountable for the cost of care or quality beyond immediate errors (MD and NP accountable for revenues)
- Accountability horizon narrow and short-term
- No population based or temporal accountability
- Little questioning of underlying assumptions of care/over screening/overtreatment/overutilization
We can’t solve problems by using the same kind of thinking we used when we created them.
Team Based Care

- A strategy toward the Triple Aim, not a goal in and of itself
- Interprofessional care has interaction cost and transaction costs
- SOMETIMES...
  - Need most appropriate individual provider
- Often...
  - Need well configured team
- TEAMINESS.. a concept in evolution
What About the Election?

- Note—much of payment reform is outside the ACA
- Relatively little conversation on health care

- Republican
- Repeal ACA?
  - ACA modified 24 times by Congress

- Democratic?
- Modify?
  - Improve affordability of ACA premium tax credits
  - Address unaffordability of cost share
  - Support Enrollment Assistance
  - Incentivize all states for Medicaid expansion

McDonough, J. How might the Democrats to to improve and expand the ACA in 2017 Millbank Memorial Fund, September 13, 2017
What Do You Think?

- Questions?
- Answers?
- Hopes?
- Fears?
- Your Turn!