

Nurses Role in  
Advancing Value Based  
Healthcare

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# Redefining Value Across the System

- Value that matters to the patient, not just reduction in expenses/costs.
- Reorganizing care around patient conditions into integrated practice units
- Measure outcomes and costs for every patient.
- Move to bundled payments for care cycles.
- Integrate multisite care delivery systems.
- Expand geographic reach to drive excellence.
- Build an enabling technology platform.



# Trends in Healthcare

- Population Health as a system driver
- Discovery to Care Across the Continuum Adapt, Adopt or Abandon non value based practices.
- Balancing Clinical Excellence and Population Health.



Population health management is defined as a health care system or network of providers working in coordinated manner to improve the overall health and well being of patients across all settings under a risk bearing financial arrangement.

## Goal

The CMS target is to have 30% of Medicare payments tied to quality or value through alternative payment models.



# Perspectives on Population Health

- Team based care.
- Focus on wellness and health promotion across settings.
- Outreach between encounters including phone calls, internet, wearable devices , house calls and use of advanced practice nurses to provide education and support for consumer adoption of self care.



# Achieving Hospital Efficiency

- Introduction of Progression of Care Rounds
- Led by nursing
- Multidisciplinary including physician advocates, pharmacy, NP, PA, CNM, therapists, dieticians, social workers, case managers, volunteers and supportive care staff.
- Each unit conducts POCR daily.
- Staff RN presents the patient



# System Efficiency

- Avoidable Admissions through
  - NP House Calls
  - Hospital at Home
  - Post Discharge Check Ins
  - High Risk Case Management
  - Ambulatory Abx Therapy
  - Ambulatory Supportive Care
  - Disease specific management





# Reducing Avoidable Admissions and Readmissions

Use of Advanced Practice Nurses to unnecessary admissions and readmissions.

Program deployed NPs to Skilled Nursing Facilities. NP would see patients in 7SNF within 24 hours of admission and 2-3 times a week.

NP House calls

PharmD Phone Call Post Discharge

## **Outcomes**

Avoidable admissions (acute care) dropped 35%

Readmission rate to (acute care from SNF) dropped 40%

Length of stay dropped from 30%



## Nursing roles in promoting population health

- Proactive health maintenance.
- Leading self help programs aimed at improving overall health.
- Deploying nurses where people live, work or go to school.
- Engaging consumers as equal partners.
- Working with family members as partners.
- Working with teams to address social determinants of health.



## Example: Durham Connects

Program provides free visits by RNs to parents of children 2-12 weeks old.

Nurses:

- Check overall health of mothers and infants.
- Offer assistance with breast feeding and infant care.
- Provide guidance in finding community resources.



Copyright: Tyrone Turner

**Results:** Every dollar spent saves \$3 in avoided hospital emergency costs.

## Example: CAPABLE Program

Program enables frail, elderly people to live in their homes as they age.

- Team of APN s, occupational therapists and home maintenance workers visit participant for 16 weeks.
- Participant chooses functional goals.



Source: Johns Hopkins University

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**Results:** Improves function, health and quality of life. Decreased hospital admissions and readmissions.



## Example: Eleventh Street Health Center

APNs at a health center provides care to 6,000 poor Black residents.

- Offers clinical services, health promotion and disease prevention.
- Superior patient outcomes.



Copyright: Drexel University

**“You apply to nursing school thinking you know what nursing is. Then you come to a place like this and learn what nursing could be” -- Samantha Krugle, 2012 graduate, Drexel University**



# Healthcare is a Team Sport

Nurses work in collaboration with:

- Pharmacists to identify medication literacy and to provide education to improve patient and family safe medication use.
- Social workers to identify safe transitions across the health care system.



A social worker and assistant nurse manager check in at Virginia Mason  
Source: RWJF



# Advanced Practice Nurses

## Nurses:

- Work with engineers, informatics and scientists to remotely monitor patient conditions.
- Deploy technology as part of the early warning system of care for patients with chronic health problems.

## Results:

- Improved self-care management.
- Early detection of changes in health conditions.
- Interventions to prevent hospitalizations.



Source: Melissa King, NP  
director of Telemergency  
program at UMMC.

# Advanced Practice Nurses

## Hospital at Home:

- Nurses provide surveillance and education services for patients.
- Nurses educate and support family caregivers to maintain patients at home.

### Observed reductions in:

- Admissions, readmissions, ED visits
- Adverse events within home settings, including medication errors, falls and other injuries.





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A social worker and assistant  
nurse manager check in at  
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Source: RWJF

# Building a Culture of Health Will Take All of Us!

Imagine a Future Where:

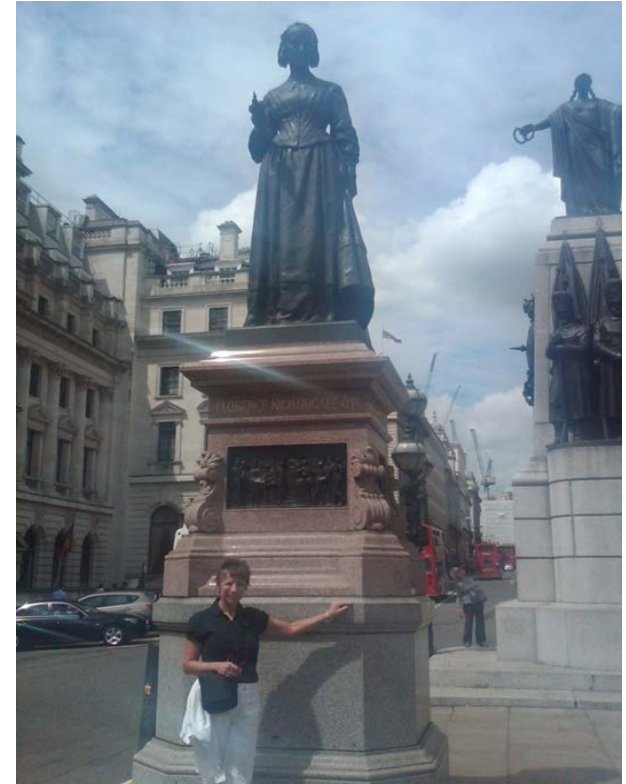
- ✓ Good health flourishes across geographic, demographic and social sectors
- ✓ Being healthy and staying healthy is valued by everyone
- ✓ Individuals have means and opportunities to make choices that lead to healthier lifestyles
- ✓ Business, government, individuals and organizations work together to foster healthy lifestyles



# We Need You!

“May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done”

-- Florence Nightingale





Thank You



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