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Refocusing Health Care Reform: Implications for Respiratory Care

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Objectives

- **Provide an update on CMS' payment reform initiatives, especially as pertains to acute hospital care;**
- **Describe the three dimensions of IHI's *Triple Aim* and its relevance to clinical practice, and**
- **Discuss the chronic care model and how acute care providers can make a difference in long-term outcomes, and**
- **Review the proposed enhancements to the practice of respiratory care.**

Situational Analysis

Spring 2017

- **Concept of *confirmation bias***
- **Origins of GOP platform**
  - **Herbert Hoover (1929-1933); Great Depression**
  - **Role of Federal vs. State/local government**
    - **Social services, education, regulations - LOCAL RESPONSIBILITY**
    - **Less Federal Government – The Better**
- **The Democrat Approach**
  - **Franklin Roosevelt (1933-1945)** ***1935 Social Security Act***
  - **Lyndon Johnson (1963-1968)** ***1965 Medicare/Medicaid***
  - **Bill Clinton (1993-2001)** ***1995 CHIP***
  - **Barack Obama (2008-2016)** ***2010 Affordable Care Act***

Current Federal Spending

Spring 2017

FEDERAL PROGRAM	BENEFICIARIES	EXPENDITURES
Social Security	59 million	$916 billion
Medicare	56 million	$595 billion
Medicaid	71 million	$591 billion
CHIP	8.1 million	$13.5 billion
⇨ Affordable Care Act	20 million	$70 billion

"The *leftward drift* of American social policy"

"The overreaching hand of big government"

"Big government buries the middle class"

American Health Care Act

March 2017 - - RIP

- Was Going Away
  - Employer and Individual mandates
    - Tax credits vs. subsidies
    - Penalties for delayed/lapsed enrollment
  - 10 Essential health benefits
    - Elements of health plans left to States; Private insurers
  - All taxes funding ACA subsidies/Medicaid expansion
    - Defund Planned Parenthood
  - Shift Medicaid to capped block grants (vs. *open-ended funding*)
    - State legislatures control
    - Scrap 2020 expansion

American Health Care Act

March 2017 - - RIP

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Payment Reforms

Top *FIVE* Concerns Hospital CEOs

2016 ACHE Survey - 383 CEOs

- Financial
- Government mandates
- Patient safety & quality
- Personnel
- Patient satisfaction

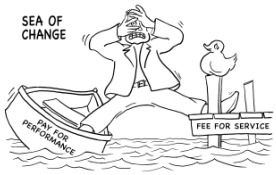
"In 2016, about 52% of acute hospitals didn't make any money"

Toby Cosgrove, MD, President/CEO, Cleveland Clinic

Top *TWO* Concerns Hospital CEOs

2016 ACHE Survey - 383 CEOs

- Financial
  - Medicaid reimbursement (63%)
  - Increasing costs of care (60%)
  - Reducing operating costs (55%)
- Government mandates
  - CMS regulations (67%)
  - CMS audits (57%)
  - Cost of compliance (51%)



The Triple Aim

Institute for Healthcare Improvement; Cambridge, MA

- The simultaneous pursuit of:
  - Improving patient experience of care
  - Improving health of populations
  - Reducing per capita cost of health care

BETTER CARE = BETTER HEALTH = LOWER PER CAPITA COSTS !

CMS' Payment Reforms

- Slowing Medicare growth
  - Transitioning fee-for-service to fee-for-value health care
    - Lack of accountability with current system
  - Measurable outcomes meeting quality/safety standards
    - 2/3 nation's hospitals affected
  - *"Carrot and Stick"* approach
    - Reward the best; Penalize poor performers

For ALL healthcare providers . . It's not so much about
ObamaCare or TrumpCare . . as it is about . .

Payment Reform!

Government Changes in Health Care

Moving Away from Fee-for-Service

- Hospital Readmission Reduction Program (PENALTY)
  - 30 day now; 90 later?
- Hospital Acquired Conditions Reduction Program (PENALTY)
  - Culture of Safety
- Value-based Payment (BONUS or PENALTY)
  - More penalty than bonus; Accelerated transition by 2020
- Bundled Payments (EPISODIC CARE)
  - 90-day timeframe
- Accountable Care Organizations (RISK-SHARING)

Government Changes in Health Care

Newly Emerging Environment of Care

TRADITIONAL EMPHASIS	NEWER EMPHASIS
Acute care	Chronic care
In-patient	Out-patient
Treat symptoms	Manage disease
Individual patient	At-risk populations
Billable procedures	Outcomes of care
Fee-for-service	Pay-for-performance

Fee-for-service = volume driven
Pay-for-performance = value driven

Impact of of Chronic Conditions

- Life-long condition
  - Account for 70% of all deaths in the US (1.7mm/yr.)
  - Not curable BUT controllable
  - Many patients have multiple conditions
- Chronic conditions overly expensive
  - ≥ ⅔ of $3.1 trillion annual expenditures
  - Many suffer frequent exacerbations
- Baby-Boomer generation
  - 2011- 2023 ≈ 2.5 million/year turn 65
  - High prevalence of chronic disease

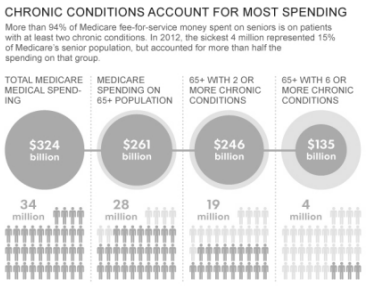
Chronic Disease Management

A New Priority – A Great New Opportunity

- Coordinated approach to chronic medical care
  - Slow disease progression, minimize complications
  - Improve health outcomes, quality of life
  - Manage health care utilization
- Best chronic care:
  - *Patient-centric*
  - *Evidence-based*
  - *Multi-disciplinary*
  - *Utilizes "care-teams"*
  - *Follows the patient regardless of care setting*

Impact of of Chronic Conditions

Medicare's Disproportionate Share



The AARC and Health Care Reform

Strategic Plan 2015-2020

- Linked to *2015 and Beyond* initiative
- Formally approved October 2014
- Eight (8) major objectives
- State affiliates working with State regulatory agencies

The AARC Response

Moving The Profession Forward

- Traditional *scope of practice* is expanding
  - Requires advanced knowledge, skills & attributes
    - Continued development in new technology, clinical innovation
  - Concept of patient-centric care
  - Multi-disciplinary care-teams
- 2015 Taskforce on Competencies Need for Entry into RT Professional Practice
  - AARC, CoARC, NBRC collaboration
  - Exhaustive list of domains & required competencies
    - 153 Developed *prior* to entry; 49 attained *after*

The AARC Response

Demonstrating Our True Value

Competent, Safe & Professional RT Practice
(9 Domains; 202 Competencies)

- Collect Diagnostic Information
- Disease Management
- Evidence-based Medicine and RC Protocols
- Patient Assessment
- Leadership
- Emergency, Critical Care
- Assessment of Therapies
- Application of Therapeutics
- Post-acute Care

"Practicing RTs must continue their development post-graduation in order to attain and maintain their required competencies"

The AARC Response

Summary

- **Newer educational & licensing requirements**
  - **Entry level education, licensing being elevated**
  - **Existing workforce expected to adapt**
    - **State licensing vs. institutional requirements**
    - **Advance Practice Respiratory Therapist (APRT)**

AARC Goal:

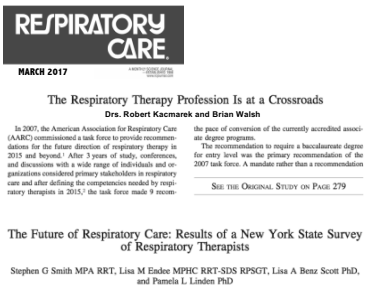
By 2020, ≥ 80% of RT workforce either have (or) be actively pursuing a higher degree

CoARC Standard:

Effective January 1, 2018, all new RT programs must offer a baccalaureate degree or higher

The Future

Thriving or Just Surviving ? ?



RESPIRATORY CARE

MARCH 2017

The Respiratory Therapy Profession Is at a Crossroads

Drs. Robert Kacmarek and Brian Walsh

In 2007, the American Association for Respiratory Care (AARC) commissioned a task force to provide recommendations for the future direction of respiratory therapy in 2015 and beyond.[1] After 3 years of study, conferences, and discussions with a wide range of individuals and organizations considered primary stakeholders in respiratory care and after defining the competencies needed by respiratory therapists in 2015,[2] the task force made 9 recommendations. The recommendation to require a baccalaureate degree for entry level was the primary recommendation of the 2007 task force. A mandate rather than a recommendation

See the Original Study on Page 279

The Future of Respiratory Care: Results of a New York State Survey of Respiratory Therapists

Stephen G Smith MPA RRT, Lisa M Endee MPHC RRT-SDS RPSGT, Lisa A Benz Scott PhD, and Pamela L Linden PhD

Changing The Way Health Care is Delivered

Transforming The Way We Practice

- **Hospital's role in community being *reimagined***
- **RT's role in hospital & community being *reimagined***
- **US health care system notoriously *change adverse***
- **Profound change is *disruptive; transformative***
- **Transformative change is *stressful* (anxiety, uncertainty, fear)**
- **Disruptive change best in small *baby-steps***

Maintaining *status quo* during disruptive change can come at a steep price

Replacing Common Practices with *Best Practices*

AREA	COMMON PRACTICE	BEST PRACTICE
ENTRY EDUCATION	Associate degree	Bachelor degree
STATE LICENSURE	CRT	RRT
CARE HIERARCHY	Physician-directed	Patient-centric
CARE DELIVERY	Individual providers	Care teams
AEROSOL THERAPY	Q2, Q4 Neb Rx's (Stacking)	Medication regimen
VENTILATOR MANAGEMENT	Sedate; Keep them calm	Awake; Ambulate
POST-OP PULM COMPLICATIONS	IS; Mucomyst	Out of bed; OPEP
PATIENT SAFETY	*No Harm – No Foul*	Culture of Safety

If you hold on to something too tightly
You run the risk of getting left behind !

Reimagining Respiratory Care

For Your Consideration

- **Believe in Yourself - - We can & do make a difference!**
- **Make patients/caregivers our best allies**
- **Embed ourselves into "fabric" of hospital operations**
- **Embrace/promote a *Culture of Safety***
- **Avoid complacency**
- **Proactively seek new care responsibilities**
- **Control your professional future** (Educational degree, Credentials)

Summary

The Dawning of a New Era

- **Re-design traditional role to compete in *new environment of care* realities:**
  - **Align practice with newer expectations; Become *strategic***
    - **Hospital's responsibility no longer ends at discharge**
    - **Embrace expanding scope of practice**
    - **Develop innovative approaches to improve care delivery**
      - **Resist being *PENNY WISE AND POUND FOOLISH***
- **Proactive versus reactive approach**
  - **Historically RT tasks/responsibilities *delegated***
  - **It's now a *BRAVE NEW WORLD***
    - **Take responsibility for our future**
    - **Strong, clinical, and visionary leadership essential**

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