



ACO Development: What's in it for Nurses?

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The Patient Protection and Affordable Care Act (PPACA) will challenge hospitals, health systems, payers, and physicians to assume increased accountability for patient outcomes, quality care, and decreased cost. Sg2, a health care analytics company headquartered outside of Chicago, has been helping organizations interpret the legislation and plan for the new health care landscape. In discussing what accountability will look like -- its structure and its associated care delivery models and payments -- we have just begun to address the largest providers of health care: nurses.

The PPACA provides a unique opportunity for nurses to enhance care delivery and encourage care redesign with the goals of increasing clinical efficiency and taking cost out of the system. New and developing care models, including group visits, e-visits, and telemedicine, will enable clinicians to interact with patients more regularly to encourage proper medical management of common ailments. There is a growing emphasis on the ability to provide high-quality, lower-cost, patient-centered care through palliative services. Growth in this area will increase nurses' opportunities to offer symptom management and discuss advance directives. Moreover, the importance of patient self management during the next decade will increase patient education requirements of nurses.

These changes are expected as the industry prepares for another sweep of nursing shortages. The aging workforce combined with the projected increase in newly insured patients will strain the health system to continue to provide high-quality care. Care redesign and the accompanying clinical efficiency encouraged in an accountable care organization (ACO) framework will decrease the strain on nurses and have the potential to postpone the nurse shortage. So what exactly does an ACO mean for nurses? How will it change care delivery?

The answer is threefold. First, nurses can expect increased responsibility for coordination across the care continuum. Next, nurses should anticipate greater accountability for hospital-acquired conditions (HACs). Lastly, nurses with advanced degrees can look forward to becoming "accountable care providers" within the ACO framework. Together, these components will help nurses lead care redesign in our health system's move toward accountable care delivery.

Care Coordination

With a move away from volume-driven care toward outcomes-driven care, as well as new financial and quality incentives to keep patients out of the acute care setting, nurses will be required to take on more responsibility to coordinate care throughout the care continuum. This will start in primary care settings and will be emphasized through the growing use of the medical home model for patients with chronic diseases. Coordination must continue in the hospital and throughout the discharge process. Growing relationships with post-acute care providers and the threat of readmission penalties will require enhanced discharge planning. This may require the development of new care coordination by patient type (elective, occasional, perpetual, or complex critical) and disease to both manage acute care utilization and improve patient engagement. Remote monitoring technology will support the care team to ensure a safety net for care based on a patient's risk profile for readmission or relapse. Health plans and nurse case managers at the plan level have already begun preparing for the post-2014 marketplace. They have created models varying in size and scope that encourage clinical accountability through care coordination. Regardless of a patient's position along the care continuum, nurses will be accountable for improved quality of care through successful care coordination.

ACO Development: What's in It for Nurses?...*continued***Hospital-Acquired Conditions**

The Centers for Medicare & Medicaid Services no longer pays hospitals additional dollars for 12 HACs if the HACs (which include the subset category of hospital-acquired infections) were not present on patient admission. Prevention of several of these conditions, including pressure ulcers, intravenous catheter sepsis, and catheter-associated urinary tract infections, falls largely on the nursing staff. Not only do these conditions have the potential to impede clinical performance and dramatically increase costs, but they also will be associated with financial penalties. In an effort to link payment to quality outcomes, the PPACA stated that hospitals in the top quartile of HACs will face overall reductions in Medicare payment by 1% starting in fiscal year 2015. The HAC data also will be made public at that time. Nurses in all settings must assume responsibility for their quality metrics to prevent HACs and the financial penalties associated with them.

Advanced Practice Nurses (APNs) as Accountable Care Providers

An APN's ability to act as an accountable care provider depends on the scope of practice as defined by state regulations. In states with broader scopes of practice that allow APNs to function independently, APNs will face similar opportunities and challenges as physicians in terms of ACOs. This means APNs will have the ability to participate in shared savings models, take on increased clinical risk for patients, or exert greater control over care delivery to control costs and improve quality. This effect will be amplified for APNs working in primary care and medical home models; primary care extension is expected as millions more Americans will gain access to the health system via the insurance mandate starting in 2014. In order to participate in an ACO, APNs must be offered a fair share of the cost savings and/or monthly stipends for additional time spent coordinating care for their patients. Extensive ongoing education and data sharing will be required to encourage both physicians and APNs to participate in the new model. The extent to which APNs will participate depends chiefly on the specific scope of practice and ACO model (from virtual to fully integrated) in their care environment.

Key Considerations

Regardless of whether an organization pilots an ACO, gears up for the Medicare Shared Savings Program, or cautiously waits to see how ACOs develop in its local market, the principal underpinnings of ACOs -- assumption of clinical risk, improvements in quality care, and decreases in costs -- will be required of all organizations as we move through Medicare reform. Therefore, all nurses will be required to enhance their overall accountability and become true patient advocates by:

- Enhancing patient and family education
- Identifying patients at risk for 30-day and multiple readmissions
- Increasing use of telemedicine and telemonitoring devices
- Ensuring timely care coordination through targeted communication between hospital and community-based case managers and providers
- Designing new care delivery models that focus on active care coordination and clinical/financial effectiveness
- Creating a patient-centered self-management approach through assessment of patient engagement, access to education/peer groups, and leveraged technology
- Empowering patients and families to engage in their plan of care and manage their expectations

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Sources: Hastings DA. The timeline for accountable care. BNA's Health Law Reporter. www.bna.com. Published March 25, 2010. Accessed December 2010; Sg2 Special Report: Accountable Care Organizations 2010; Sg2 Report: Innovative Care Delivery Models Compendium, 2009.