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Accountable Care Organizations: Elements of Success

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Accountable Care Organizations: Elements of Success

Although much has been written about the Patient Protection and Affordable Care Act's (PPACA) provisions to assist hospitals, physicians, and other caregivers to improve access, safety, and quality while decreasing costs of health care, there is much variability in the acceptance, strategies, and implementation of accountable care organizations (ACOs). On March 31, 2011, more than 2 years ago, the U.S. Department of Health and Human Services (DHHS) proposed new rules to assist with provision of better coordinated care for Medicare patients through ACOs. ACOs provide incentives for teamwork and coordination of care across settings including ambulatory care, acute care and long-term care. "The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary" (DHHS, 2011).

Although ACOs are supposed to decrease costs and increase quality of care, the epicenter of their mission is the goal that the ACO be a patient-centered organization where patients and providers are true partners in care decisions. The ACA specifies that an ACO may include the following types of providers:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint venture arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary (DHHS, 2011).

Shared savings are also a major part of the ACO. Medicare would continue to pay providers and suppliers for specific items and services, but it would also develop benchmarks for each ACO against which its performance will be measured to assess whether it qualifies for shared savings, or should be held accountable for losses.

Ambulatory care nurse leaders need to be aware of the challenges and controversies that surround establishment of ACOs, as well as expected performance parameters and outcomes, so that they can assume leadership in planning and implementing ACOs. In a recent *Wall Street Journal* article, Christiansen (who developed the concept of "Disruptive Innovation") and colleagues from Harvard (2013) argue that ACOs will fail because they are founded on three "untenable assumptions." First of all, ACOs cannot change physician behavior. Physicians need to move to

increased use of evidence-based protocols and to provide care in less expensive settings. Second, ACOs won't automatically change patient behavior. Currently, many ACOs let patients choose their providers, including specialists. This has been done to avoid consumer dissatisfaction with use of "gatekeepers" who authorize access to specialists or procedures. Gatekeepers have been traditionally employed by HMOs to contain costs. Finally, "ACOs will not save money on a grand scale.... No dent in costs is possible until the structure of health care is fundamentally changed," Christiansen and colleagues (2013) conclude.

Christensen's predictions are in line with the Robert Wood Johnson National Commission on Physician Payment Reform Report (2013). They list the following factors that are drivers of the high cost of U.S. health care (p. 2-3):

- *Fee-for-service reimbursement.* Under this model, physicians are reimbursed for each service they provide. Pay is not necessarily linked to outcomes.
- *Reliance on technology and expensive care.* The federal government and private insurers reimburse technology-intensive procedures at higher rates than services focused on evaluating patients or managing the care for chronic (illnesses.)
- *Reliance on a high proportion of specialists.* The U.S. has a high ratio of specialists to primary care physicians. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. The current payment system favors high cost procedures over time spent on evaluation or management of care.
- *Paying more for the same service or procedure when done in a hospital setting as opposed to an outpatient setting.* For example, Medicare pays \$450 for an echocardiogram done in a hospital and only \$180 for the same procedure in a physician's office. While physician salary and related expenses account for 20% of health care spending, the decisions they make influence an additional 60% of spending.
- *Systemic issues.* Specifically, the skewed incentives of fee-for-service payment.

Managed Care magazine did an interview with Clayton Christensen in 2009. According to Christensen, three fundamental investments are needed in health care:

Investment in diagnostics, business model innovation, and the creation of a new system. Diagnostics that precisely diagnose disease pay off very handsomely in affordability down the road. The business model of medicine, such as the hospital and the doctor's office, were put into place 100 years ago in response to conditions that existed 100 years ago. We need to replace them with innovative business models that will do a much better job of focusing the right resources on the right problem. And because health care is a systemic problem, only companies that have the scope to wrap

their arms around the whole system are going to be able to change it. A few institutions, Intermountain Healthcare, Kaiser Permanente, Geisinger Health System, and a few others like these, are integrated fixed-fee sorts of providers that are really building on what HMOs originally were. They have the scope to rethink the creation of new systems that have disruptive business models (Managed Care, 2009).

In a *WSJ* article, Christiansen and colleagues (2013) build on the ideas expressed in the 2009 interview and offer several suggested reform solutions:

- Consider opportunities to shift more care to less-expensive venues, including, for example, “Minute Clinics” where nurse practitioners can deliver excellent care and do limited prescribing. New technology has made sophisticated care possible at various sites other than acute-care, high-overhead hospitals.
- Consider regulatory and payment changes that will enable doctors and all medical providers to do everything that their license allows them to do, rather than passing on patients to more highly trained and expensive specialists.
- Going beyond current licensing, consider changing many anticompetitive regulations and licensure statutes that practitioners have used to protect their guilds. An example can be found in states like California that have revised statutes to enable highly trained nurses to substitute for anesthesiologists to administer anesthesia for some types of procedures.
- Make fuller use of technology to enable more scalable and customized ways to manage patient populations. These include home care with patient self-monitoring of blood pressure and other indexes, and far more widespread use of “telehealth,” where, for example, photos of a skin condition could be uploaded to a physician. Some leading U.S. hospitals have created such outreach tools that let them deliver care to Europe. Yet they can’t offer this same benefit in adjacent states because of U.S. regulation.

Christiansen and colleagues (2013) have apparently read and accepted recommendations made in the Robert Wood Johnson 2010 Report: *The Future of Nursing: Leading Change, Advancing Health*.

References

- Christensen, C., Flier, J., & Vijayaraghavan, V. (2013, February 18). The coming failure of ‘accountable care.’ The Affordable Care Act’s updated versions of HMOs are based on flawed assumptions about doctor and patient behavior. *Wall Street Journal*. Retrieved from <http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html>
- Managed Care. (2009). *A conversation with Clayton Christensen, DBA: Network-model health plans may be tomorrow’s dinosaurs*. Retrieved from http://www.managedcaremag.com/archives/0901/0901.qna_christensen.html
- National Commission on Physician Payment Reform, The (NCPPR). (2013, March). *Report of the National Commission on Physician Payment Reform*. Retrieved from http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf

U.S. Department Health and Health Services (DHHS). (2011). *Accountable care organizations: Improving care coordination for people with Medicare*. Retrieved from <http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html>

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President’s Message

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Interest Group (SIG) networking and the sharing of information. What is a CoP? It is a group of people who share a concern or passion for something and interact regularly to learn how to do it better. The Leadership SIG, their Advisory Group, and past Chair Kathy Mertens agreed to pilot this new concept and the technology that goes with it. A special session at the annual conference was held to educate and demonstrate the capability of the CoPs to leaders and members of the other SIGs, committees, and task forces to promote the use of this interactive tool.

In addition to the CoPs, the AACN Web site (www.aacn.org) has an entire new look and functionality! If you haven’t been there lately, I encourage you to visit and try out some of the enhancements for yourself.

Research and evidence-based practice will be highlighted in a new toolkit soon to be added to the resources available on the Web site. In addition, plans for an ambulatory nurse sensitive indicators task force are in progress.

Strategic Goal #2 – Expand Our Influence

AACN has become a member of the Nursing Alliance for Quality Care (NAQC) – a bold partnership among the nation’s leading nursing organizations, consumers, and other key stakeholders to address the disparities and inefficiencies in health care quality and safety. Thank you to Eileen Esposito, who will serve as our representative to this important group.

Strategic Goal #3 – Strengthen Our Core

Membership and member retention are the highest ever in 2013! We are pleased to have over 2,600 members. Thanks to all our members who are committed to AACN and who are working to invite new members to join us as the organization that encompasses many settings and multiple roles in one unifying specialty of ambulatory care.

Looking Ahead

During the next year, I plan to use this column to keep you informed of the progress of our strategic goals and initiatives. However, we can’t accomplish them without you, our members. Opportunities to volunteer are plentiful – if you find something that “speaks” to you and your practice, join in! You’ll be glad you did.

Thank you for this opportunity to serve as the AACN President this year!

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