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Nursing Leadership in ACO Payment Reform

Executive Summary

- Accountable Care Organizations (ACOs) are a promising new model for payment reform in the complex and fragmented health care system in the United States.
- Nursing vision and leadership are essential for the success of an organization participating in an ACO.
- By understanding the political, financial, and cultural facilitators and barriers to change, as well as models for helping organizations transition toward change (e.g., Kotter Model of Change Management), nurses have the potential to be leaders in health care change.

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HEALTH CARE REFORM has heralded testing of new payment models, yet most nurses have been largely socialized within a fee-for-service milieu. Accountable Care Organizations (ACOs) are emerging as a key strategy in payment reform pilots across the country. The professional literature has begun to address the implications of ACOs for nurses (American Academy of Ambulatory Care Nursing [AAACN], 2012; Korda & Eldridge, 2011; Mensik, 2013; Swan & Haas, 2011) and the necessity that nurses come to the table to advocate for their value. Nevertheless, there is scant literature to guide nurses leading payment reform-driven organizational change.

In this article, a broad picture will be presented of how payment reform will affect an organization by outlining the systemic and organizational barriers and facilitators of adopting an ACO model. Implications for nursing leadership will also be addressed, highlighting how nursing leadership must adapt to value-based payment models by developing more effective models of quality assurance and care coordination based on evidence-based practice, showing their value in patient engagement and chronic disease management, and increasing nursing skills in data management (Holmes, 2011). To meet the challenge of creating lasting change, the Kotter Model of Change Management will be provided as a tool for nurses to identify their organization's location in the change process and how to fully participate in enabling successful change.

Background on ACOs

The term *ACO* was coined by Elliot Fisher at Dartmouth-Hitchcock Health in 2007, who proposed ACOs as a solution to the fragmented, variable quality, and high-cost care delivered in the United States (Fisher, Staiger, Bynum, & Gottlieb, 2007). An ACO "is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population" (Rittenhouse, Shortell, & Fisher, 2009, para 4). The Medicare Shared Savings Program for ACOs creates financial incentives to keep costs of care low by allowing participants (providers) to capture shared savings when they keep costs below those projected for their patient population. The amount of savings they capture is determined by how well they meet quality objectives, which is designed to ensure the quality of care remains high. Many gaps in quality are reported to originate

from the way the current fee-for-service system discourages collaboration, leading to fragmented care coordination and transitions (Institute of Medicine, 2001). Accordingly, ACOs are also designed to improve communication between primary care, specialists, and hospitals serving the same patient population through financial incentives for technology improvements and care coordination. ACOs build upon pay-for-performance models by improving data analysis, aggregating data not only from individual practices, but from the entire ACO patient population.

Currently the most prevalent ACO program is the Medicare Shared Savings Program (MSSP), created by the Patient Protection and Affordable Care Act in 2011. The program has been growing steadily since its inception; as of January 2016 there are 477 ACOs nationwide serving nearly 8.9 million Medicare beneficiaries (Centers for Medicare & Medicaid Services [CMS], 2016). Under the MSSP ACO, the percentage of shared savings an ACO captures is determined by how well 33 quality measures are met in the four domains of patient experience, care coordination, preventive health, and at-risk population care. Costs must also remain under those projected for the patient population, calculated from the costs for the Medicare beneficiaries enrolled in the ACO during the previous 3 years. ACOs under the MSSP have two options for risk sharing to enable a smooth transition for practices that may not be accustomed to taking on financial risk. With one-sided risk there is no financial risk to ACOs, and only savings are shared. This is termed *upside risk.* Under two-sided risk, ACOs share both savings and losses – the latter also known as *downside risk* if they exceed projected costs – but also have a greater potential for shared savings: up to 60% versus 50% for those not accepting downside risk (CMS, 2012).

Under the Next Generation ACO Model, launched in January 2016, providers assume higher levels of risks and rewards, with shared savings and losses of 80%-100%. This model uses the same quality measures outlined under the MSSP, but eliminates the electronic health record (EHR) measure; Next Generation ACOs are expected to have already met this requirement. The new model also expands payment mechanisms beyond fee-for-service to a variety of population-based payment options, including capitation, beginning in 2017. ACOs may choose to participate in benefit enhancements such as a waiver of Medicare's skilled nursing facility 3-day rule (also available under the MSSP), expansion of telehealth services, and post-discharge home visits (CMS, 2015).

An aspect of health care reform that is occurring in tandem with the development of ACOs is the Patient-Centered Medical Home (PCMH) and it is important to draw the distinction between them. Both have an emphasis on improving quality and coordination of care, but they take differing yet complementary approaches to meet this goal. While ACOs impact the full spectrum of health care delivery systems, PCMHs are specifically aimed at strengthening primary care, which is currently undervalued in the fee-for-service model. Benefits of meeting standards to become a PCMH for a primary care practice are enhanced reimbursement rates and access to a Community Health Team, in which practices customize additional staff members for the needs of their practice. Additionally, PCMHs have an emphasis on integrating mental health access with primary care and a population focus on treating chronic disease. Together, ACOs and PCMHs have the potential for a synergistic effect on strengthening primary care and enacting payment reform that increases quality while decreasing cost (Rittenhouse et al., 2009).

Incentives and Barriers to Change

To lead change, nurses need a broad understanding of the factors influencing the decision to adopt new payment models. Following are some of the facilitators and barriers to change arising from regulatory and political, financial, and social spheres.

Regulatory and political. Support for ACO development comes from the federal government primarily through the creation of the MSSP described previously. A growing number of states also are turning to ACOs for their Medicaid programs, with several states currently testing pilot ACO programs. The Affordable Care Act also provides financial incentives for improving EHRs and for creating Health Information Exchanges (HIEs) to improve the ability to share patient information among health care providers. Financial incentives are dependent upon EHRs meeting objectives for meaningful use. Examples of meaningful use criteria include recording an updated list of active medications and problems and built-in drug-drug interaction checks. A criterion that is a potential target for ambulatory care nurses is the ability to generate lists of patients with chronic conditions for use in quality improvement. A proven area of the HIE's ability to assist in improving care is in identifying patients who are frequent users of emergency rooms (Shapiro et al., 2013) so that interventions can be targeted to this population.

While there are many political facilitators to ACO development in the current atmosphere of payment reform, one notable exception is antitrust laws. There is concern that a particular ACO may dominate a health care market and increase the cost of care for that region. Accordingly, the Federal Trade Commission (FTC) and Department of Justice created guidelines for ACOs that they must not exceed 30% of the market share. There is, however, a "rural excep-

tion" in which an ACO may have one physician or practice from each specialty even if it exceeds the 30% rule (Sheffler, Shortell, & Wilensky, 2012). The Stark Law also has ramifications for ACOs, as it states physicians cannot refer patients to services in which they have a financial interest. An exception to the Stark Law exists for ACO participants for activities "reasonably related" to the MSSP (Gamble & Walker, 2012). These antitrust laws are intended to protect consumers and keep costs down, but they also may undermine the collaboration needed for an ACO to provide continuous care coordination. While this is often more an issue for the broader ACO organization (Tallia & Howard, 2012), an individual organization may also have hesitation about the legal ramifications of joining an ACO. Conversely, the FTC issued a statement in March 2014 calling for the lifting of restrictions on advanced practice registered nurse (APRN) practice and supervision requirements, citing the anticompetitive nature of state laws limiting full practice authority for APRNs (Gilman & Koslov, 2014).

Financial. The shared savings component is a financial incentive inherent in the design of ACOs meant to attract practices and incentivize keeping health care costs low. Some ACOs also have the added financial incentive of group purchasing rates. However, ACOs' financial incentive to decrease costs may not be enough to offset losses and there may be increased cost shifting to private payers (Sheffler et al., 2012). The up-front investment of capital and time to initiate the change may also be a major barrier, especially for small practices. Additional staff members may be needed and expensive EHR upgrades will be necessary for interfacing with the HIE, though there is federal financial support available. There is also uncertainty surrounding reimbursement for collaborative practice, as the current payment system encourages competing for patients' business, discouraging the collaboration necessary to ensure seamless care transitions (Tallia & Howard, 2012).

Social and cultural. Attitudes about health care reform among providers may be an impediment to change. In writing about their implementation of an ACO in a major medical center in New Jersey, Tallia and Howard (2012) reported a major barrier in gaining provider support was skepticism and cynicism about whether the change would improve patient care. There were misconceptions about ACOs being another version of Health Maintenance Organizations, with the perception of the PCMH being akin to gatekeeping. The prevalent idea that initiation of case management should begin in the hospital rather than in primary care also impedes change towards practices taking on responsibility of case management (Swan & Haas, 2011). Another barrier is a lack of understanding about nursing knowledge and role in primary care from other team members, who may not understand the unique set of skills nursing brings to the health care team. Additionally, nurses may not yet have the skills needed for nursing in the emerging model of ambulatory care, such as data management.

Nursing Leadership within an ACO

By using this higher-level understanding of the factors affecting payment reform, nurse leaders can contribute to the vision for how to enact change within an organization adopting an ACO payment model. This transition is an opportunity for nurses to demonstrate their expertise in care coordination, prevention and wellness for chronic conditions, and quality improvement through developing protocols to improve care delivery. These skills can be directly applied to the measurable outcomes for care built into the ACO and provide increased value and cost savings to the organization (Swan & Haas, 2011). Many quality metrics within the MSSP can be targeted by nurses by developing protocols, including the prevention of ambulatory-sensitive conditions admissions for chronic obstructive pulmonary disease, asthma, and heart failure. Nursing can also prevent hospital readmission, another MSSP metric, by enhancing post-hospitalization follow-up. Nurses are also well versed in the team-based care and information exchange necessary to improve communication among providers in the emerging team model in ambulatory care (Korda & Eldridge, 2011).

Nursing leadership is needed to advocate for nursing's skill in these areas and to develop the new skills and foci necessary to meet the challenges of the new payment models. "Big data" is the buzzword in payment reform, and learning how to manage data related to quality metrics will be key for many nursing interventions under value-based care, including generating lists of patients who can be targeted for enhanced management of chronic diseases. Participating in the development of the EHR so nursing interventions are represented in documentation will be essential to reflect nursing value to the organization (AAACN, 2012). Nurses must also begin to take on responsibility for care coordination at all levels of care (acute and ambulatory) (Swan & Haas, 2011). Increased adoption of evidence-based practice targeting MSSP quality metrics will facilitate the development of successful quality improvement projects (Holmes, 2011).

Organizational Readiness for Change

Clearly many changes will be necessary within an organization to achieve the CMS Triple Aim of increased quality, improved health, and decreased costs (Mensik, 2013). These changes will require

significant cooperation and buy-in from all members of the health care team. Creating and sustaining organizational change is often a difficult process that can be stalled by complacency and fear, and easily revert to more comfortable modes of operation. Many change management models have been developed to identify strategies to avoid these roadblocks. The Kotter Model has been celebrated as an effective tool for managing change in health care (Campbell, 2008). The process of organizational change within the Kotter Model and how it can be applied by nurse leaders to an institution transitioning to an ACO payment model will be described.

Kotter Model of Change Management

The Kotter Model of Change Management (Kotter, 1995; Kotter & Cohen, 2002) identifies common reasons why organizations fail when attempting broad changes and outlines a multi-step process to approach these changes. The model recognizes employees have emotional reactions to change which can undermine the change process if not addressed, but can be transformed into positive, change-promoting emotions. This approach requires a change in thinking from an analytic mindset which speaks to the intellect to one that speaks to the heart, as "emotionally charged" change behavior is more likely to result in sustained action (Kotter & Cohen, 2002). The model outlines eight steps to change in which each step is necessary for laying the foundation for the rest of the change process (Kotter, 1995). These eight steps are organized into three phases: creating a climate for change, engaging and enabling the whole organization, and implementing and sustaining change.

Organizational Change within the Kotter Model

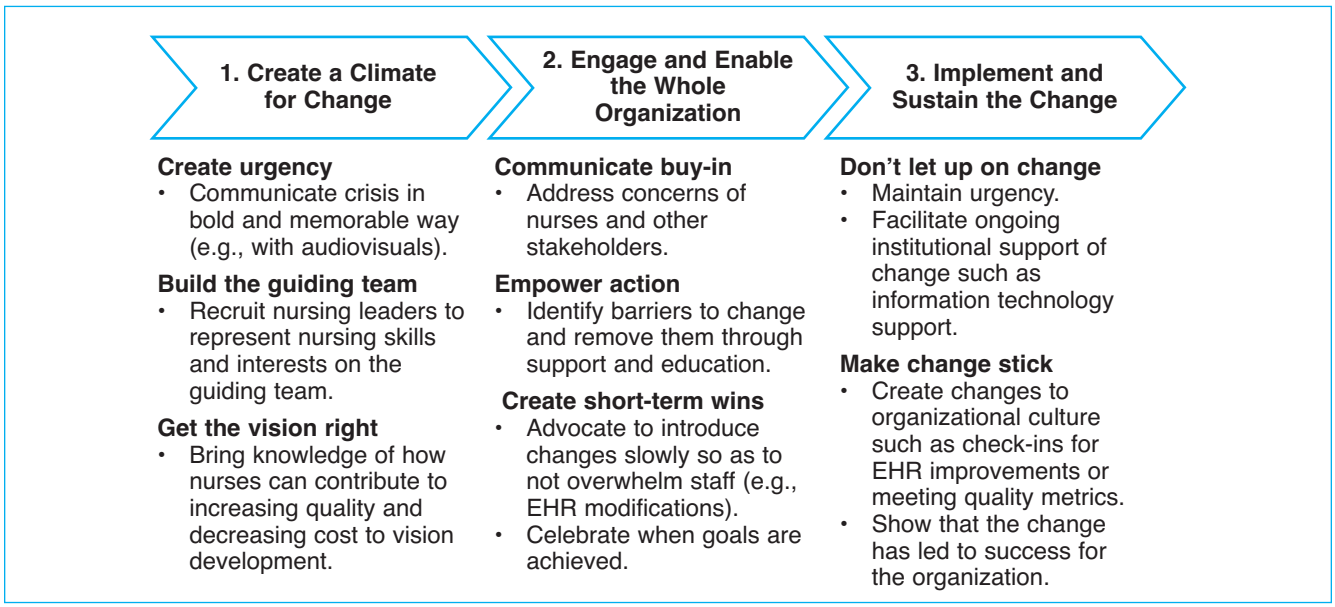
The first step in creating a climate for change is to create urgency, an emotional drive towards change. This step is essential, as some members of an organization are likely to feel complacent about the status quo or feel anxiety about what changes will bring to their schedule and responsibilities. Building a cohesive sense of urgency requires an action provoking a strong emotional response. This can often be achieved by creating a dramatic audio-visual presentation about the change one wants to target. For instance, if the desired change is to develop an EHR with an HIE component, increased urgency could be generated by showing a short video about a family affected by a medical error that could have been prevented with more comprehensive access to medical records (Campbell, 2008). Kotter also stresses the drive for change can come from any member of the organization (Kotter & Cohen, 2002).

The second step in creating a climate for change is building a guiding team. Members of the guiding team are selected to create a combination of capabilities that include relevant knowledge to create a vision for change, credibility with peers to communicate the vision, valid information about the inner-workings of the organization, formal authority, and leadership to communicate and motivate change (Kotter & Cohen, 2002). Nurse leaders must be at the table as part of the guiding team to demonstrate their knowledge and credibility within their institution.

In the third step, "getting the vision right," members of the guiding team create a concise vision statement that considers the options available for change and sample dimensions of each option, such as how each option will affect support staffing, providers, patients, delivery of care, and revenue. Nursing scholars stress the importance of registered nurses and APRNs to "be a part of the vision development, in addition to playing roles in communicating to others the need for change, gathering support from colleagues, and supporting the change process" (Mensik, 2013, p. 252). By getting involved early, nurses can advocate for their knowledge and role within the organization. Coming to the table with an understanding of the organization's current gaps in meeting MSSP quality metrics and demonstrating how nursing actions have the potential for cost savings and quality improvement can have a key role in creating a vision that keeps nursing at the forefront of improving patient care.

The strengthening of vision and leadership in the first phase sets the groundwork for the second phase: engaging and enabling the whole organization. The first step of this phase is to "communicate buy-in," in which leaders identify who will be affected by the change and how, address negative feelings about the change, and guide employees to bring thoughts and actions in line with the change. Thus the guiding team identifies how the changes will influence the "information needs, concerns, roles, levels of effort, and degrees of communication" for each group of employees (Campbell, 2008). Nurses information needs will increase about the MSSP quality guidelines and they may have concerns about an increased level of effort in documentation. Some ways for nurse leaders to address these concerns and "enable action" (step two) are with continuous communication, allowing nurses to access educational opportunities, and connecting them with nurses in similar organizations who have been through the same change and survived. When change is moving forward, step three is to "create short-term wins" so that momentum is built forward and change feels achievable. For example, for nurse leaders it may mean advocating to introduce aspects of the new EHR slowly or focusing

Figure 1
ACO Transitions in the Kotter Model of Change Management



on improving a few quality metrics at a time. Broadcasting and celebrating small wins, such as meeting quality improvement goals, throughout the organization can increase morale and support for the change.

The final phase for change under the Kotter Model is "implementing and sustaining the change." The first step is not to let up on change. This involves maintaining the sense of urgency by letting short-term wins create ambition for bigger changes. Maintaining support for the change, such as information technology assistance for EHR issues, is also essential. Finally, "making change stick" is essential for making lasting changes to organizational culture. This may include creating new elements of organizational culture, such as check-ins with staff about how they are adapting to the changes and working to meet quality objectives. Employees must also see that the change has succeeded, so sharing data about the success of the ACO's cost savings when it has been further vetted is also important to maintain buy-in. The phases of the Kotter Model and nursing actions during each phase of the change process are summarized in Figure 1.

Conclusion

ACOs are a promising new model for payment reform in the complex and fragmented health care system in the United States. Nursing vision and leadership are essential for the success of an organization participating in an ACO. By understanding the political, financial, and cultural facilitators and barriers to change, as well as models for helping organizations transition toward change, nurses have the potential to be leaders in health care change. In particular, nurse leaders should:

- Ask questions about changes occurring in their organization and find out how to join or give input to the guiding team.
- Review the ACO's quality metrics and answer the question, "How can you improve patient outcomes?"
- Understand the underlying financial incentives and disincentives, and be prepared to demonstrate how your work can decrease overall costs.
- Demonstrate and advocate for nursing knowledge in care coordination and quality improvement.
- Ask how EHR upgrades reflect documentation sensitive to nursing care.
- Seek out additional training in data management and leadership skills and increase your awareness of community services.

Finally, nursing must also look ahead to developing the future of nursing leadership. Nursing faculty can guide the upcoming generation of nurse leaders by incorporating modules about payment reform and organizational change models into courses in health care policy and role development. **$**

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