



ANA ISSUE BRIEF

*Information and analysis on topics affecting nurses,
the profession and health care.*

New Care Delivery Models in Health System Reform: Opportunities for Nurses & their Patients

Key Points

Nurses' education, skills and professional scope make them indispensable contributors to successful implementation of evolving patient-centered care delivery models.

Accountable Care Organizations (ACOs), Medical/health homes, and Nurse-managed Health Clinics are three of the varied approaches to coordinated care.

Health reform opens the door to a more central role for APRNs in the creation, leadership and management of new and innovative patient-

Evolving Models of Care Delivery

The Patient Protection and Affordable Care Act of 2010 (PPACA) contains many provisions that seek to intertwine the quality of care with the cost of care. This is a response, in part, to research demonstrating that a single focus on reducing cost is not enough. Rather one must ask *what* we are purchasing with each health care dollar, and how that investment contributes to improved health for individuals and populations.

The current system is fragmented, without any single entity responsible for the overall quality and coordination of the patient's care. "You get what you pay for," and, in health care, the fee-for-service system has directed the larger share of resources to procedures, tests, and acute care. By creating incentives for integrated care delivery models and paying for coordination and quality of care, the law seeks to rebalance the system's resource allocation and reward the value of care over volume of care.

Answering a need: Nurses' leadership and contributions

Registered nurses are fundamental to the success of emerging patient-centered care delivery models. PPACA directs renewed attention and substantially more resources and incentives to promote those elements of care which are also the backbone of nursing practice. These essentials of nursing practice include patient-centered or "holistic" care, including family and community; care continuity; coordination and integration across settings and providers; chronic disease management; patient education; prevention and wellness care; and information management.

In addition, PPACA recognizes the advance practice registered nurse (APRN) as a valuable provider of primary care services, as well as a potential leader in new integrated care systems. The Institute of Medicine defines primary care as "the



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provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”ⁱ The nursing community’s robust advocacy assured that this definition was adopted in PPACA, opening the door to a more central role for APRNs in the creation, leadership and management of new and innovative patient-centered care systems.

Three emerging care delivery models, in particular, are addressed in PPACA. These are the accountable care organization, the medical or health home, and the nurse-managed health center. Each is discussed in greater detail below.

Accountable Care Organizations (ACOs)

What is an ACO? The ACO, in its most basic form, is a collaboration among primary care clinicians, a hospital, specialists and other health professionals who accept joint responsibility for the quality and cost of care provided to its patients. If the ACO meets certain quality and savings targets, its members receive a financial bonus.

Under PPACA, the ACO is a creature of Medicare, and the cost targets are termed “shared savings” allocated between the ACO and the Medicare program. The ACO is a group of providers of services and suppliers that

promotes accountability for a patient population and coordinates items and services under [Medicare] parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. (PPACA, Section 3022).ⁱⁱ

If the ACOs meets quality performance standards (established by the HHS Secretary), they are eligible to receive payments for shared savings. The law also establishes a demonstration project for Medicaid pediatric ACOs.

How are ACOs organized? Some important existing models of ACOs influenced the provision that appears in PPACA; those early versions tend to be hospital- or physician-centered. PPACA provides more leeway in terms of who can lead an ACO, permitting greater nursing leadership, as well as participation.

A key term in the law with special significance for advance practice nursing is “**ACO professional**,” because these are the individuals who can organize and provide leadership within the ACO. They also share in the financial risk or reward. They may be ACO professionals in group practice arrangements,



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networks of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, and/or hospitals employing ACO professionals.ⁱⁱⁱ

The law defines "ACO professional" as a physician "and" a practitioner [further defined as Nurse Practitioners, Clinical Nurse Specialists or Physician Assistants].^{iv} The "and" is vague, and it could arguably be read either that both can independently be ACO professionals, or that one must have a physician and any of the other practitioners to form an ACO. The definition of "practitioners" does not include CNMs or CRNAs; however, the HHS Secretary may designate other groups of providers of services and suppliers as deemed appropriate.

There are also some private projects underway that would expand the ACO beyond Medicare. The Dartmouth Institute for Health Policy and Clinical Practice, and the Engelberg Center for Health Care Reform at the Brookings Institution, are two leaders advocating for a physician-centered ACO.^v They have a pilot project testing the model with private payers, and possibly Medicaid, in several geographic settings and among health care entities with different levels of integration, set to begin in 2010. One of the hurdles they have to clear is figuring out how to coordinate the quality targets and cost-sharing among the number of private insurers that would be implicated.

What are Nursing's opportunities? The law's focus on seeking value in care delivery points to a heavy reliance on nursing services and care. As noted earlier, nursing's scope of practice embraces the means and goals of new delivery models, such as ACOs. The statutory requirements that ACOs must meet suggest that the services and care provided by registered nurses, in general, will be essential to the success of ACOs.^{vi} These include the following:

- An ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned it.

- It must include primary care ACO professionals sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO, of which there must be a minimum of 5,000 to be eligible.

- It must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, including the use of telehealth, remote patient monitoring, and other enabling technologies.

- Lastly, it must meet patient-centeredness criteria specified by HHS, such as the use of patient and caregiver assessments or the use of individualized care plans.



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In addition, registered nurses would have the opportunity to collaborate with primary care nurse providers on coordinated care plans for patients.

Nurse Practitioners and Clinical Nurse Specialists have chance to provide significant organizational leadership within the ACO model, particularly in providing care in underserved areas. If nursing can present a patient-centered, nurse-led model to HHS early in the process, and – importantly – can demonstrate savings, nursing may have much to benefit from the ACO model. It would create a situation where more data could be collected regarding the quality and efficacy of nurse-led care and, in the best scenario, would create a continuous feedback loop supporting such nurse-led models.

Medical/health homes

What is a medical or health home? In general, the “medical home” (or “health home” — both terms are used) can be understood as a mechanism to provide patients with a central primary care practice or provider who coordinates the patients’ care across settings and providers. This might be promoted through a capitated payment or other financial incentive to providers to encourage preventive care and chronic care management, as well as reduce reliance on specialist and emergency care.

PPACA authorizes HHS to provide grants to or contract directly with states or state-designated entities to establish community-based interdisciplinary, interprofessional teams (“health teams”) to support primary care practices, including obstetrics and gynecology practices. The teams also must agree to provide services to eligible individuals with chronic conditions.^{vii}

The interdisciplinary, inter-professional providers comprising a health team may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants.

How are medical/ health homes organized? Medical/health homes are similar to ACOs in that they must meet statutory requirements that emphasize care and services squarely within nursing’s scope of practice; nurses will be acknowledged, indispensable leaders and members of the health team.

A health team must, among other obligations, support patient-centered medical homes. This is defined in PPACA as a mode of care that includes



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personal physicians; a patient-centered, whole person orientation; expanded access to coordinated and integrated care; safe and high-quality care through evidence-informed medicine; continuous quality improvements; and payment that recognizes added value from the additional components of patient-centered care.^{viii} The law views “patient-centered care” as incorporating patients, health care providers, caregivers, and authorized representatives in care design and oversight.

Under the terms of PPACA, the health team is required to collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitions between health care providers and settings and case management for patients. Within these collaborations, the health team is also required to develop and implement interdisciplinary, inter-professional care plans that integrate clinical and community preventive and health promotion services. Such care planning is a basic element of skilled nursing practice and nurses can guide such development and implementation with the voice of authority and experience.

A broad scope of coordination of care services typically provided by nurses is required by the law. The health team must provide or facilitate primary care services that coordinate and provide access to preventive and health promotion services; provide access to appropriate specialty care and inpatient services; provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care; provide access to medication management and reconciliation services. By rewarding these activities through financial and other incentives, PPACA’s goal is to encourage and facilitate those healthcare delivery elements that have been demonstrated to improved outcomes (and reduced costs).

What are Nursing’s opportunities? PPACA creates a delivery model that relies on a robust nursing contribution for success. The ability of primary care advance practice nurses to lead a medical/health home may be hampered, to some extent, by the multitude of requirements set by law. As a way of comparison, a 2008 study by the Congressional Budget Office estimated that only one percent or so of medical practices could meet criteria set out by the Centers for Medicare and Medicaid Services for medical home demonstration projects at that time.^{ix} In a 2010 study comparing elements of existing medical home demonstrations, success appeared to depend in part on providing dedicated “nonphysician” care coordinators and also on expanding access to various providers.^x

Most of the experts interviewed for the 2010 study identified care coordination as vital to the success of the medical home, and encouraged dedicated financing and personnel to achieve this. In addition, interviewees



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reported that 24/7 access to a care provider is also an essential element of the medical home equation. Such access, even if only through telephonic or electronic means, helps reduce reliance on emergency rooms and resultant preventable hospitalizations. Nurses are vital to providing such services, as they are consistent with the profession’s core scope of practice that includes patient evaluation and education, assuring continuity and coordination of care across settings and providers, and communicating effectively within the health care team and the patient and patient’s family and representatives.^{xi}

In another study^{xii}, concentration on improved chronic care for the elderly within the medical home reaped improved efficiency and effectiveness. Looking at the “commonality of patients’ needs” permitted standardization of care processes, which enabled nurse practitioners and registered nurses to take on added evaluation and management responsibilities.

“Patient-centered” or “family-centered care” is not new to nurses, although other parts of the health care team may not have been educated to understand that whole person, or holistic, care requires an understanding of the patient’s life situation within family and community. In this area of expertise, especially, nurses can serve as leaders and teachers to their inter-professional colleagues.

Nurse-managed Health Clinics (NMHCs)

What is a NMHC? PPACA establishes a new grant program to fund nurse-managed health clinics for the purpose of providing comprehensive primary care and wellness services to underserved or vulnerable populations.^{xiii}

How are NMHCs organized? NMHCs are nurse-practice arrangements that are required to be led by advance practice nurses. By the terms of PPACA, they must be associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency. The law authorizes the appropriation of \$50 million for FY 2010 and whatever sums are deemed necessary for each of the fiscal years 2011 through 2014.

What are Nursing’s opportunities? Nurses, especially nurse practitioners, have the skills and opportunity to reframe how primary care is delivered, a goal shared by the recently enacted PPACA. Primary care, wellness education, management of chronic diseases and conditions, coordination and integration of care are all building blocks to a “reinvented” health care system that attempts to contain costs, while optimizing patient outcomes.



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Some studies have demonstrated that primary care delivered by nurse practitioners is cost-effective.^{xiv} In an environment intent on slowing the growth of health care costs (often referred to as “bending the cost curve”), data from nurse-managed primary care settings may continue to build the case for the quality and cost imperatives of removing remaining barriers to primary care practice by nurse practitioners. It is anticipated that, in particular, data gleaned from the reporting requirements of HHS grants (such as for NMHCs) will demonstrate that permitting nurses to practice to the full extent of their professional scope results in improved outcomes and value-driven health care. The expansion and reallocation of existing healthcare workforce resources to meet new needs under PPACA demand that barriers to this goal be removed.

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- i. Patient Protections and Affordable Care Act (PPACA) (2010) P. L. 111-148. Sec. 3502.
 - ii. PPACA. Section 3022
 - iii. Ibid.
 - iv. Social Security Act. 42 USC 901 et seq. Sec. 1842(b)(18)(C)(i).
 - v. McClellan, M., McKethan, A., Lewis, J., Roski, J. & Fisher, E. (May, 2010). A national strategy to put accountable care into practice. *Health Affairs*. Project HOPE: Bethesda, MD. 29(5): 982-990. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w219>
 - vi. PPACA. Op cit.
 - vii. PPACA. Sec. 3502.
 - viii. Ibid.
 - ix. Fields, D., Leshen, E. & Patel, K. (May, 2010). Driving quality gains and cost savings through adoption of medical homes. *Health Affairs*. Project HOPE: Bethesda, MD. 29 (5): 819-826
 - x. Ibid.
 - xi. Nursing: Scope and Standards of Practice. (2010). American Nurses Association: Silver Spring, MD. p. 4.
 - xii. Milstein, A. & Gilbertson, E. (September/October, 2009). American medical home runs. *Health Affairs*. Project HOPE: Bethesda, MD. 28(5):1317-1326.
 - xiii. PPACA. Section 5208.
 - xiv. Naylor, M. & Kurtzman, E. The role of nurse practitioners in reinventing primary care. Project HOPE: Bethesda, MD. 29(5): 893-899. *Health Affairs*. Project HOPE: Bethesda, MD. 29(5): 893-899

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