

Introduction

In an effort to improve patient access to quality health care and lower health care costs, patient-centered partnerships are being developed between payers and providers, who will assume accountability for the quality, costs, and overall health care of a defined patient population. Known as Accountable Care Organizations (ACOs), these multidisciplinary health partnerships will focus on health prevention and care management coordination for patients across the health care continuum (Case Management Advisor, 2011). These new partnerships are being designed to offset the failures of Health Maintenance Organizations (HMOs) and Managed Care Organizations (MCOs), which have resulted in rising health care costs due to disjointed and uncoordinated care (Harvard Health Letter, 2011). Developed to serve a patient population of at least 5,000 Medicare patients per partnership, the core idea of the ACO stems from a group of providers (hospitals, physicians, nurses and others involved in patient care) that will work together to serve their patient specific health care needs (Summer, 2011). To ensure accountability for providing access to quality care that is cost effective, ACOs would manage the coordination of care for their specific patient population over the course of three years, and share in the risks of health care costs with their reimbursement organizations. Through the positive patient health outcomes anticipated in these partnerships, ACOs would incur minimum risk and reap the benefits of cost sharing. For those anticipated cost savings with government subsidized patients, Medicare will share the cost savings with ACOs in the form of incentive bonuses (Harvard Health Letter, 2011, p.6).

Under the newly adopted health care reform law, the general premise for ACOs came from the Department of Health and Human Services (DHHS), in conjunction with the proposed Medicare Shared Savings Program. The aim of the Obama Administration's push for the health

care reform law, which goes into effect in 2012, was to decrease health care spending that has shown little results for a healthier population, and provides incentive rewards to health care providers who prescribe tests and procedures, which may or may not be necessary or which have resulted due to medical mistakes (Evans, 2010).

Improving Quality of Health Care

The overall premise for improving quality of health care under an ACO is to provide access to multidisciplinary care that coordinates health care treatments and lessens the risk of duplication, potential for harm, and aims to reduce patient acuity. According to the American Nurses Association (ANA), statistics reveal that one in five patients are put at increased health risk and incur additional financial burdens due to frequent readmissions to the hospital within one month of being discharged. The ANA further reveal that due to research conducted by the University of Pennsylvania School of Nursing on existing health care programs, transitional care (such as community services, patient education and patient/family support) provided by nurses was successful in keeping patients from experiencing declining health and frequent hospital readmissions. Overall, their evidence clearly reflects that implementing a multidisciplinary approach in the provision and the coordination of health care, will achieve better patient care, better patient outcomes, and can serve to reduce health care costs (The American Nurse, 2011).

Accountable care proposes a seamless continuum of care for patients that will serve to improve their health, improve their health care experience, and help to reduce the total cost of health care. Ultimately, ACOs will be set up to act as case managers for patients, ensuring their health care needs are being met. In doing so, patients will not be subjected to the added frustration or increased costs associated with the current fee-for-service medical delivery system, which traditionally is more focused on disease care management than on disease prevention

(Case Management Advisor, 2011). From this perspective, the patient seeks medical intervention only when they are ill, and in most cases acutely ill, rather than seeking health prevention services or taking advantage of health promotion opportunities. Thus, a sicker patient will utilize more health care services that will drive up the health care costs.

Potential Success with Accountable Care Organizations

Research has shown that health care costs are escalating due to the increase of chronic diseases and obesity. Individuals with Respiratory Problems (i.e. Chronic Obstructive Pulmonary Disorders), Cardiac Problems (i.e. Hypertension and Congestive Heart Failure), and Obesity related disorders (i.e. Diabetes and High Cholesterol), would benefit from health prevention services that aim at keeping them out of the hospital and decreasing exacerbations of disease symptoms. Under the current fee-for-service health care systems, it is not uncommon for these individuals to seek health care from a variety of health care providers and, in doing so, run the risk of physical harm due to lack of coordination of health care treatments (medications, tests, and procedures). As a result, medical errors and increased patient frustration at the health care system have prompted patient apathy, renewed interest in alternative and complementary therapies, and self-diagnosing/self-treatment of conditions that could become life threatening (Lewis, 2011). Further, those who are under-insured or uninsured do not have the financial means to get coordinated care or health prevention services leading them to utilize the hospital emergency rooms for health care services when they are acutely ill. This would also hinder their ability to seek follow-up care; thus, a continual cycle of declining health perpetuates and continues to drive up health care costs.

The overall goal of patient health care coordination through the use of multidisciplinary providers aimed at producing better patient care outcomes is an admirable one. We have proof

that the current health care system does not benefit the patient, poses financial demise of hospitals, and has even resulted in health care providers restricting patient access to their practices – leaving more and more individuals on subsidized insurance programs, like Medicare, struggling to find health care services. The key issues centered on ACOs are not so much will they be an effective solution to improving patient care; rather, they stem from who will assume the financial risk for the transitioning into this type of payer system, and is it worth their while. Physicians and hospitals that have limited resources or are in rural areas may not be able to participate in these partnerships. Thus, this opens up the problem of accessibility and provides an unfair advantage to larger hospitals, physician groups, and larger insurers. Further, if it is cost effective to streamline care and incentives are designed to reward ACOs that provide cost savings through bonus payments, then there is the potential to limit resources to patients that may be judged as too costly. Because of the potential by providers to manipulate the payer system to minimize their risks, intellectual integrity and ethical issues centered around the withholding of patient care could surface.

Conclusion

The U.S. Government has been instrumental in establishing goals and objectives for promoting health and its delivery through an initiative called Healthy People 2020. Among its goals is the creation of a social and physical environment that is capable of promoting good health for all. The impact of health care reform will change the ways we view the provision of short term and long term care (Lewis, 2011). There is no easy remedy to our nation's health care financial woes or to the increase in health care disparities experienced by the poor, the elderly, the under-insured, and the uninsured. Hospitals have provided care to individuals at less than cost, physicians have had to increase their volume of patients to stay financial solvent, and

insurance carriers have been increasing their premiums, in response to increased health care costs affiliated with rises in chronic illnesses. HMOs and managed care organizations have tried to ration health care and keep health care costs down by directing patient to their sanctioned providers. However, the only aspect of health care that has proven to be both cost effective and promoting positive patient health outcomes has been through transitional care. Per Springgate and Brook, allowing participants the freedom to participate in decisions that will ultimately affect their lives has been linked as important element in improving individual health and in improving economic functioning. It is believed that patients will benefit from active decision-making about their health care choices. Of the perceived benefits through this decision-making process is the potential to become more motivated to achieve improved health (2011, p. 1801).

ACOs have the potential to live up to their mission through improving population health initiatives, improving the health care experience, and being cost effective (Case Management Advisor, 2011). Medicare beneficiaries are slated as reaping the benefits of better access to care, coordination of services, and decreased hospital visits (ED Management, 2011). Congress has allowed Medicare to share the cost savings with healthcare providers who reach quality and cost control targets resulting through the creation of ACOs (Evans, 2010). Patients have the potential to benefit from flexibility afforded by ACOs in choosing their own health care providers and becoming partners in their health care management. Positive outcomes have been experienced by a Medicare Physician Group Practice, seen as a dry run for ACOs, with quality-of-care goals and decreased health care costs. But ultimately, the real test of ACOs to determine their success will be through the evaluation of provider networks that are effective, and from this evaluation, developing practices that are deemed successful. Of the potential pitfalls seen by proponents of ACOs, there may be many more hospital-driven partnerships who have high fixed costs to

recoup; there may be less incentives for participants to participate, as incentives are geared towards the ACO partnerships; and, there is the potential for insurance companies to gain more control over health care access to keep costs down (Harvard Health Letter, 2011).

In conclusion, however we view the development of ACO partnerships, we would be remiss in thinking there will not be growing pains and some failures within the implementation of this new health delivery system. Previous experience with health care reform has produced significant data to learn from and has provided a framework for what does/does not work. But, any effort to include better patient access to health care, increase positive patient outcomes, and aid in the coordination of health care for the betterment of our social structure should be perceived as an effort worth taking. Change can be hard, but looking at the processes involved in change opens up new possibilities and new possibilities are the backbone of innovation.

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