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# The changing roles of registered nurses in Pioneer Accountable Care Organizations

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ABSTRACT

*Objectives:* This study focuses on whether and how Pioneer Accountable Care Organization (ACO) leaders believe the deployment of the registered nurse workforce is changing in response to the shared savings incentives.
*Methods:* Semistructured phone interviews with leaders from 18 of the original 32 Pioneer ACOs were conducted.
*Results:* Narrative analysis suggests that all of the organizations are developing new and enhanced roles for registered nurses across the continuum of care. Overall, eight types of changes were reported: enhancement of roles, substitution, delegation, increased numbers of nurses, relocation of services, transfer of nurses from one setting to another, the use of liaison nurses across settings, and partnerships between nurses coordinating care in primary and acute care settings.
*Conclusions:* This exploratory study suggests that Pioneer ACO leaders believe that payment models are affecting the deployment of the health workforce and that these changes are, in turn, driving outcomes.

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## Introduction

Accountable care organizations (ACOs) represent one of the major strategies contained within the Patient Protection and Affordable Care Act (PPACA) that seek to incentivize providers to improve the quality of care and contain costs by moving away from fee-for-service payment. A major component of system change is workforce reconfiguration. In this study, we examine how this is affecting the deployment of registered nurses (RNs). Specifically, we ask whether Pioneer ACOs leaders in the United States believe that the ACO payment program is driving changes in the deployment of nurses.

Under the ACO model, provider groups partner together to voluntarily assume accountability for a group of patients across the full continuum of care regardless of whether or not the partner organizations provide all of that care. If an ACO meets certain quality benchmarks and successfully reduces health care spending below what is projected, the ACO can split the savings with the government (McClellan, McKethan, Lewis, Roski, & Fisher, 2010). Today, there are almost 300 ACOs, including those funded by Medicare and private payers (Colla, Lewis, Shortell, &

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Fisher, 2014). Efforts to evaluate the effectiveness of ACOs have been highly coordinated across funders and the research community and are largely following a framework put forth by Fisher, Shortell, Kreindler, Van Critters, and Larson (2012). To the extent that the shared savings incentives do cause organizations to change the way they deliver care, it seems likely that the reconfiguration of the workforce is an area of important innovation and that understanding those innovations will be essential if ACOs turn out to be successful and the next policy phase is to encourage the spread of such programs.

Indeed, there has been increased attention to the ways in which providers organize their workforce in the context of health reform and ACOs (Adams et al., 2010; DeVore & Wesley Champion, 2011; Haas, Beth, & Haynes, 2013). Some have also suggested that the objectives of ACOs are particularly well aligned with RNs' skills in areas such as improving self-efficacy and moving beyond episodic care (Haas et al., 2013; Howell, 2012; Laughlin & Beisel, 2010; Sochalski & Weiner, 2011). More specifically, the need for care coordination and the adoption of a population-based focus, both key elements of ACOs, may be changing the way RNs are used (American Nurses Association [ANA], 2010; Clinch, 2012; Hart, 2012; King, 2010; Korda & Eldridge, 2011; Laughlin & Beisel, 2010).

Although we know of no other empirical studies that have explored how ACOs are changing the roles of nurses in the United States, a provocative study from England may be relevant. Gemmell, Campbell, Hann, and Sibbald (2009) used a pretest, post-test quasi-experimental design to explore the effects of the 2004 pay-for-performance program in primary care. They found that physician-owned practices increased nurse staffing levels and transferred more clinical work to them during this period, resulting in a decrease in physician visits. They conclude that when practices are rewarded for better health outcomes, they may be more likely to delegate certain functions and certain types of patients to nurses.

Our study explores a similar question in the context of the United States, in this case the Pioneer ACO Shared Savings Program. Are these payment reforms leading to changes in the way RNs are deployed? Although U.S. researchers have anticipated changes in nurses' roles in the context of ACOs (Haas et al., 2013; Howell, 2012; Laughlin & Beisel, 2010; Sochalski & Weiner, 2011), this study is the first to explore whether and how this is occurring. In the absence of baseline data on nurses' roles in these organizations before becoming an ACO, our approach is qualitative and exploratory. We are interested in the perspectives of ACO leaders on whether changes are underway, what those changes are, and why they believe they are occurring.

### *Conceptual Model*

This study builds on the ACO evaluation framework put forth by Fisher et al. (2012) and is consistent with their call for "qualitative research needed to advance understanding of the ACO formation and refine its logic model" (p.). Their logic model includes the following five domains: (a) the environmental context at the national, state, and local levels; (b) local readiness in terms of ACO structures and capacities as well as contract capabilities; (c) implementation activities; (d) intermediate outcomes; and (e) impact. We are interested specifically in the deployment of the workforce, a topic that falls squarely within the domain of implementation activities. The authors suggest that key elements of implementation include health information technology, improvements in the care process, and the degree of integration. They also mention "physician and other clinician engagement and processes" as important. This study seeks to delve more deeply into the "other clinicians," in this case the role of nurses.

To do this, we draw from another conceptual typology that describes health workforce task shifting developed by Sibbald, Shen, and McBride (2004). Although such typologies do not explain interactions among categories of change, they provide heuristic value and are helpful as preliminary categories of analysis. We adapt their framework to include eight types of changes that are relevant to our topic are as follows: (a) the enhancement of roles with new activities, (b) the substitution of one profession for another, (c) the delegation of tasks within a profession with varied levels of areas of specialization, (d) change in numbers of workers, (e) the transfer of services from one setting to another, (f) the relocation of workers from one venue to another, (g) the use of liaison workers across settings, and (h) partnerships across settings. This last category is an addition to Sibbald et al.'s (2004) list, and we have eliminated a category in the framework that refers to the use of new types of workers because our study focuses only on nurses.

## Methods

### *Design and Recruitment*

Our study design is qualitative and exploratory and is based on semistructured interviews with ACO leaders. The objective is to identify a typology of new and expanded RN roles in the context of Pioneer ACOs. Our objective is not to quantify these viewpoints (Bradley, Curry & Devers, 2007).

We focus specifically on Pioneer ACOs because they may be further ahead in exploring the transformation of care delivery. The program was designed for organizations with experience providing coordinated, patient-centered care and operating in ACO-like arrangements that might therefore be willing to assume the greatest level of financial risk among the various ACO programs funded by Medicare (U.S. Department of Health and Human Services, 2012). Although this makes them less representative of the overall ACO