SPN DEPARTMENT

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Accountable Care and Medical Homes: What They Mean for Pediatric Nurses

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For the past several decades, United States (US) healthcare spending has been increasing at a rate much higher than other comparable countries without a correlated increase in quality. The reason for this discrepancy could be the accepted payment model that has that promoted increased healthcare utilization rather than increased quality of care. The historical fee-for-service payment model incentivizes increased healthcare consumption by paying providers a set rate for each intervention or encounter with a patient in the healthcare system (Berenson & Rich, 2010). Many believe that this model has contributed to inflated healthcare use and additional diagnostic tests and procedures, which lead to greater revenue for healthcare providers (Fisher, Staiger, Bynum, & Gottlieb, 2007; Meyer, 2012).

In order to counteract this increased spending and promote increased quality, healthcare reform legislation, the Patient Protection and Affordable Care Act (PPACA), was passed in the US in 2010. In that year, the US spent $2.6 trillion on healthcare, which represented 17.3% of the total US Gross Domestic Product (GDP) (CMS, 2015). In comparison, the United Kingdom spent 9.6%, Canada spent 11.4%, Switzerland spent 10.9% and Germany spent 11.5% of their GDP on healthcare that same year (OECD, 2015). Despite ranking first in healthcare spending per capita, the US ranked 26th compared with similar countries for life expectancy, 46th for infant mortality, 36th for adult male life expectancy and 35th for adult female life expectancy (WHO, 2011). The goal of PPACA legislation is to provide healthcare coverage to all Americans and to develop payment systems that promote population health and improve outcomes by incentivizing wellness and quality over healthcare encounter quantity.

Accountable Care Organizations (ACOs) and medical homes have been promoted as two ways to increase quality while decreasing cost through improved population health management thereby meeting the goals of the PPACA. It is important for pediatric nurses to understand these models as the healthcare system adopts and implements them. They will change the focus of care from a person-focused ill care model to a proactive, wellness-focused population model. These changes will be the result of a change in the way healthcare is reimbursed from a quantity-focused payment to a quality-focused payment.

ACOs are a way that healthcare groups come together and contract to be accountable for the care, quality of care, and health of a defined population for a set reimbursement known as a capitated payment. The groups retain any savings in healthcare dollars and are at risk for any losses beyond their contracted amounts as long as they meet predefined quality and patient satisfaction metrics (Berwick, 2011; Fisher et al., 2007). ACOs can be formed by hospital systems, or a group of providers who contract with a larger group of healthcare providers, to provide all the care a patient needs (Berwick, 2011). They pass on the same quality and satisfaction metric requirements to those groups with which they contract, with the goal of reducing healthcare spending in order for all parties to retain larger profits.

ACOs were originally tested in a large Center for Medicare and Medicaid Services (CMS) demonstration project with Medicare patients and have continued to grow since that time (CMS, 2012). Current market analysis shows that approximately 55% of the US population live in a market with an ACO (Lewis, Colla, Schpero, Shortell, & Fisher, 2014). Of the current ACOs, over half are associated with a CMS program (Peterson, Muhlestein, & Gardner, 2013). In July 2013, CMS reported that over 250 organizations were participating in a form of Medicare ACO covering approximately 4 million beneficiaries (CMS, 2013).

The mission of the Society of Pediatric Nurses is to support its members in their practice. One means of accomplishing this mission is to keep membership informed of innovative initiatives involving the board, committees, and members that promote research, clinical practice, education, and advocacy within the larger pediatric healthcare community. This department serves that purpose.

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Descriptive and evaluation studies of ACOs suggest that the model has had a positive effect on healthcare. Increased patient activation and engagement in health care have resulted in improved quality of health plus decreased cost with the ACO model (Greene, Hibbard, Sacks, Overton, & Parrotta, 2015; Hibbard, Greene, & Overton, 2013). ACOs with private contracts have been found to have more care integration, and a greater number of providers than ACOs with public contracts (Lewis et al., 2014). Patients also report improved access to care and improvement in primary care provider information on specialty services after ACO implementation, but not improvement in physician interactions or overall care (McWilliams, Landon, Chernew, & Zaslavsky, 2014).

While Medicare is a large funding source for adult care, this payment mechanism covers very few children. The Medicaid program that most frequently insures children is called the Child Health Insurance Program (CHIP). CHIP is a state-based government insurance system covering approximately 8.1 million US children (CMS, n.d.). A provision of the PPACA promotes the development and implementation of a pediatric demonstration project associated with state Medicaid programs between 2012 and 2016 (PPACA, 2010).

Application of an ACO framework to pediatrics is challenging because of differences in the focus of care. In pediatrics, healthcare is primarily preventative and developmental rather than the chronic care seen in Medicare (Raphael & Giardino, 2013). Quality measures, an important component of ACOs, have traditionally focused on these chronic conditions and are not well-developed or defined for preventative care and screenings in the predominately healthy pediatric population (Raphael & Giardino, 2013). This ongoing preventative care relationship also leads to delayed realization of cost savings and delayed recognition of the benefits of preventative care which are exhibited through fewer chronically ill adults or adults with better controlled illness (Halfon, DuPlessis, & Inkelas, 2007; Raphael & Giardino, 2013). With Medicaid reimbursing at only about 72% of the Medicare rates, slow cost savings and low reimbursement may cause developed ACOs to shy away from including the pediatric population (Allen, 2010). Finally, unlike Medicare where the population served will remain in the policy for the remainder of their lives, children move in and out of CHIP eligibility, making it difficult for ACOs to demonstrate outcomes and savings (Raphael & Giardino, 2013). Recognizing the differences in pediatric care and the limitations in applying the traditional ACO model to pediatrics is an important factor to consider when developing a sustainable pediatric ACO system. As leaders in pediatric healthcare and quality, pediatric nurses are poised to engage in developing meaningful pediatric ACO quality measurements. The experience and expertise of pediatric nurses are critical in developing models of care focused on disease prevention and pediatric wellness plus their knowledge of the system places them in an ideal position to help identify ways to measure success in an ACO system.

Within ACOs, different provider groups have been focusing on population health and care coordination with the aim of saving on healthcare costs while increasing quality of health in their assigned population through implementation of the medical home model. The concept of medical homes in pediatrics was formed in the 1960s and 1970s when fragmented care in a paper-based system was the norm for children with complex medical needs (AAP, 1967). Different providers followed these children, resulting in uncoordinated care, and duplication of services (Sia, Tonniges, Osterhus, & Taba, 2004). There was also a lack of transparency with every provider keeping a different record on each child without one central hub for information (AAP, 1967). The medical home was developed to pull information together allowing a single physician to direct care (Sia et al., 2004). Over time, the medical home concept expanded to mainstream primary care that included adult care. The system also transformed from a physician direct care model to one that is family centered, thus encouraging healthcare providers to partner with patients and families (Sia et al., 2004). This partnership led to the addition of the phrase *patient-centered* to *medical home*, and many entities refer to the concept as the patient-centered medical home (PCMH) (AHRQ, 2010).

There are five attributes associated with the PCMH: comprehensive care, patient centered focus, coordinated care, accessible services and quality and safety (AHRQ, n.d.). Comprehensive care means that the PCMH utilizes a diverse healthcare team to provide care and education to patients. The team includes physicians, nurse practitioners, nurses, pharmacists, social workers, nutritionists and others (AHRQ, n.d.). Multidiscipline team members provide services either as part of their practice or through partnering with the community (AHRQ, n.d.). Patient-centered care is practiced through partnering with patients and providing care that is in alignment with their beliefs, culture, values and needs thus making the patient and family a part of the healthcare team (AHRQ, n.d.). PCMH care coordination spans the healthcare continuum and includes inpatient and outpatient services through enhanced communication between providers and the patient especially during transitions (AHRQ, n.d.). Accessible PCMHs have short wait times for urgent appointments, alternate forms of communication such as email and telephonic care, and expanded in-person service hours (AHRQ, n.d.). PCMHs also focus on quality and safety using current, evidence-based practice, decision support, and a set of quality metrics and performance improvement goals (AHRQ, n.d.). Quality measurements should include patient satisfaction and population health management outcomes (AHRQ, n.d.). All these elements in unison help define a PCMH and direct their efforts toward improving patient care, experience, quality and engagement.

Though the definition of PCMH is fairly new, outcome and quality research is rapidly emerging and several demonstration projects have occurred nationwide. CMS found that while payment structures were well defined in