Rural Health Clinic (RHC) Participation in Accountable Care Organizations (ACOs): What Nurses Need to Know

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Objectives

- Define accountable care organizations (ACOs)
- Characterize Rural Health Clinics (RHCs)
- Examine driving and restraining factors for RHC participation in ACOs
- Discuss why nurses need to know about RHCs and ACOs
- Summary & Conclusions
- Questions
What is an RHC?

- Clinic located in a rural, medically under-served area with a separate reimbursement structure from standard CMS programs. RHCs established by Rural Health Clinics Act (P.L. 95-210), (Section 1905 of the SSA)
- Federal initiative to address inadequate supply of physicians serving rural Medicare & Medicaid recipients & increase utilization of non-physician practitioners
- ‘Physician Extenders’ i.e., Advanced Practice Nurse and Physician's Assistants often are the primary care providers in an RHC
- Medicare - cost-based reimbursement
- Types: Independent & Provider RHCs
Rural Health Clinics (RHCs)
What is an ACO?

- **Accountable Care Act (new) model for health care delivery incentives to establish ACOs**
- **ACOs** - Group of physicians, hospitals, & other health care providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve (CMS, 2012).
- **ACO’s** are a “new” model for healthcare delivery. Albeit some believe, ‘we simply are revisiting a 1980’s HMO models’.
ACOs in the US (January 2015)
Background

• Little information available on ACOs in general; and, of RHCs participation in ACOs in particular.
• Important to explore the experiences of ‘early adopter’ RHCs that choose to participate in ACOs; i.e., baseline information
• Nursing currently has very limited involvement in ACOs; but major role in RHCs
• Nurses need to be knowledgeable and be at the table!!
Purpose of Study

Interview RHC managers to better understand:

- Motivations for an RHC to join, or not join, an ACO
- Organizational structure of RHCs participating in an ACO
- Experiences of by RHC leadership associated with ACO participation
- Opinions about benefits (driving forces) risks (deterrents) to ACO participation
Region 4 is comprised of: Alabama, the Carolinas (North & South), Florida, Georgia, Kentucky, Mississippi, and Tennessee (8 southeastern states in total). This Rural Area classification system was devised by the WWAMI Rural Health Research Center, at the University of Washington (2006); and is based on commuting distances from residential zip codes, which was used to define patient place of residence (or rural area variation, as a geographic environmental factor).
Narrative Inquiry Methodology

- University IRB approved
- Personal telephone interviews with management of RHCs currently participating in an ACO.
- Phone interview (audiotaped) ranged from 20-30 minutes in length
- Creation of written narrative comments by interviewer
Semi-structured Interview Guide

- Open ended questions focused on demographic characteristics along with items to elicit relevant qualitative data to address study’ goals.
- Instrument items developed based on an extensive review of relevant literature
- Content validity of interview items further established by an panel of rural health experts.
- Instrument reviewed & pilot tested with an RHC manager to validate items & refine data collection procedures.
Recruitment of Participants

- Identification RHCs participating in an ACO.
- Letters sent to managers in RHCs inviting them to participate in an interview
- Subsequently, up to 3 follow-up phone calls were made to ACO management to determine interest in participating in an interview
- Scheduling phone interview with a researcher
- Challenges in scheduling/rescheduling interviews
- Consent form sent via US mail and electronically
- Interview; follow up calls if questions exist
Data Analysis Procedures

- Content analysis of transcribed interviews
- Iterative review of transcribed narratives
- Themes & key concepts extrapolated from narratives
- Inter-rater reliability of themes established
- Themes supported with direct participant quotes
## Participant Characteristics

<table>
<thead>
<tr>
<th>RHC Participants’ Characteristics (N=7)</th>
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<tbody>
<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td>Females = 2</td>
</tr>
<tr>
<td>Males = 5</td>
</tr>
<tr>
<td><strong>Profession:</strong></td>
</tr>
<tr>
<td>Physician (MD) = 4</td>
</tr>
<tr>
<td>Chief Financial Officer = 1</td>
</tr>
<tr>
<td>Research Coordinator = 1</td>
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<tr>
<td>Office Manager = 1</td>
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<tr>
<td><strong>RHC - ACO Affiliation:</strong></td>
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<td>Two RHCs were members of 2 (of 6) Medicare Shared Savings Program ACOs in Region 4 (January 2014)</td>
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<tr>
<td><strong>Geographic Location:</strong></td>
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<tr>
<td>RHCs were located in CMMS Region 4</td>
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<tr>
<td><strong>RHC Type:</strong></td>
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<tr>
<td>Self-described as Independent</td>
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<tr>
<td><strong>RHC Status:</strong></td>
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<tr>
<td>Self-described as for-profit</td>
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<tr>
<td><strong>RHC County Demographic:</strong></td>
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<td>RHCs located in counties with significant population age 65 and older (i.e., of the total population, at least 25% to 31% are 65+ years of age)</td>
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<tr>
<td><strong>RHC County Demographic:</strong></td>
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<td>RHCs located in counties having population poverty rates from 13% to 16%</td>
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Themes

‘ACOs: “This is the future” (?)

• ‘Plenty of risk with potential yet, somewhat nebulous benefits’
• Experiences & insights of early adopters
  • Motivators for participation
  • Factors preventing RHCs from joining ACOs
• Administrative considerations
  • Structure/organization
  • Communication
  • Technology
  • Patient’ perceptions
ACO’s - This is the ‘future’ (?)

ACOs are the wave of the future. . . Providers really don’t have much choice [about joining] in the changing health care environment. . . know there is an increased emphasis on rewarding quality of care reporting [versus volume].

Little [if any] risk in participating during the 1st year. Our group used a conservative business approach . . . also received a federal incentive grant to start up our ACO. Utilized local financial and legal consultants. We do not have a cost/benefit analysis for our first year in the ACO.
Plenty of risks with potential (yet nebulous) benefits [driving forces] of participation

- Aware of projected/purported cost-quality benefits of ACO participation; uncertain to what degree this will become reality.
- “Time will tell.” Acknowledge achieving long term benefits will take time.
- However, there are experiential advantages by getting on the train early in the game
Driving Forces

- Physician has more decision-making power (than he/she does with other models)
- ACOs integrate primary care & emphasis on prevention
- A community/population health focus.
- Patients have a choice (in where they go for their care).
- (Ultimately, with an ACO model) patient care should be of higher quality & provided at a lower cost
- Improved communication among providers with EHR
Driving Forces

- **Financial benefits** [of prevention; collaboration] described as a by-product (outcome) associated with cost savings. . .

- **Early entry benefits** .... Not yet sure what financial benefits will materialize from our clinic’s participating in the ACO . . . I believe eventually ACO participation will be mandated by CMMS . . . Early entry allowed for some regulatory ‘flexibility’ as we learn and adapt to this new care delivery model. But, we now know . . . as the system evolves we should be ahead of the learning curve and ironed out some of the financial and administrative challenges. As the federal regulations become more restrictive we will have that experience to build on.”
Deterrents to RHCs in joining an ACO

- **Fear** of the unknown . . . uncertainty . . . change. The unknown benefits/risks along with the uncertainty of future government mandates and reimbursement policies . . . These seem to be a moving target . . . So how can one plan without anything definite?”
- **Lack of Knowledge** deters joining. Do not know or understand how an ACO can or will function . . . specific impact on an RHC’s.
- **Ambiguous policies and regulations** (in general) are changing; and, for RHC participation in an ACO (in particular)
Deterrents

Start-up Costs . . . establishing, maintaining and sustaining the ACO infrastructure (e.g., administration, EHR, extra staff to address new regulations, etc.) .

Lack of (rural) infrastructure . . . associated with very low patient volume (i.e., critical mass). Some, probably the majority of RHCs, do not have the essential infrastructure to meet quality & cost containment expectations
Deterrents

Impact on Day-to-day Operations of participation in an ACO
- Initial added (upfront) workload
- Time consuming for staff to obtain patient’s consent to collect data, then to actually collect the data
- Day-to-day business/system operation (e.g., legal, financial, care coordination, record maintenance, storage, analysis

CMS’s Regulations
- Extensive amount of data that needs to be collected, compiled, analyzed and submitted to regulatory and 3rd party-payers

Quality & cost savings
- a new paradigm not emphasized & incentivized in the past. Providers not educated about this approach
ACO Administrative Structures

- Varied based on number of organizations in the ACO. All ACOs have the mandated committees in place (finance, quality care, EHR, etc.). All had community representatives on Board. Larger ACOs had other standing committees/task forces to address changing needs.

- Smaller RHC–ACO Boards included all participating primary care physicians (N=11), financial officers/business managers from all participating clinics (N=6). Entire Board met several monthly; standing committees met more often & reported to the board.

- Larger ACO that included RHCs established an Administration (Executive) Board comprised of representative from each practice/specialty. ACO had a dedicated CEO/manager, administrative support staff, financial officer and IT expert(s). Board as a whole met quarterly (or more often as needed); subcommittees meet intermittently between full board meetings.

- No nursing involvement reported in any of these RHCs/ACOs!
ACO Administrative Structures

Board Meetings
- Regular scheduled (monthly, semiannually; separate committee meetings)
- Strategic Planning meetings

Communication
- Phone & email
- Face-to-face
- “Good - not too many problems . . . so far.”
- Communication quality depended on the “degree of perceived/real access” among ACO participants
Implementation Insights

- Majority of respondents indicated too early to comment about cost/benefit/quality of participation; data analysis in process.
- [for a smaller more localized ACO] . . . some actual and potential challenges of participating in a new health care model were avoided because our ACO’s members already knew each other (professional and personal acquaintances).
- All participating RHCs had compatible EMR systems in place with similar software and hardware. . . Providers and staff were ‘somewhat’ familiar with the technology and data entry.
Insights

. . . Joining [an ACO] is good preparation for the future. If CMS decides that all Medicare patients are required to seek care by an ACO provider, it may be too late for a physician provider to get into an ACO & there may not be an ACO that a provider can participate in. . . . by getting in the game early we learned a great deal . . . now, better prepared if and when there is a federal mandate for all Medicare recipients to seek care from providers who are participating in an ACO.
In the long run . . . ultimately . . . ideally [with ACO participation] health care costs will be reduced and the quality of care probably will be better because we are completing health risk assessments & addressing problems early on (along with using prevention interventions) . . . patients will not be as sick when we see them in the clinic...

Participation in ACO forces physicians to address potential health problems they might not otherwise provide care for. . . Until the condition becomes acute and requires more complex care.

Some patients not comfortable/resist answering the initial intake assessment questions; ‘this is not anyone’s business’
Why should nurses be involved?

- Understand driving and restraining forces of ACO participation
- Interpret ACO quality initiatives and how these ‘play out’ in a very small RHC
- Attuned to financial risks and benefits of ACO participation
- Implement and evaluate care coordination for patients in an RHC-ACO
- As (rural) community members, understand & interpret the local culture, i.e., patient satisfaction
Policy Implications

- Need for clear guidelines for ACOs to address administrative infrastructures of RHCs that take into consideration demographics of small rural communities and comorbidities of patients
- Consider evidence, lessons learned from best practice RHCs in ACOs
- *Since APRNs often are primary care providers, reimbursement/practice issues need to be informed by nurses*
Research Needs

- Additional evidence focusing on the implementation of ACOs that include RHCs, and RHC participation in ACOs
- Other studies that focus on the most cost effective and quality effective ACO model
- Numerous areas for study focusing on nursing practice in RHCs, and RHCs participating in an ACO
Education & Practice Considerations

• Educate health care providers and consumers regarding the role/function of an ACO. Along with the importance of health promotion and illness prevention in primary health care.
• Educate health professionals on effective strategies to obtain health data from clients (medical home data base).
• Educate the public on the value and importance of electronic records for a continuum of care.
• Promote awareness of characteristics of patient/family centered care.
• Prepare nurses for care management/care coordinator roles – outside of acute care settings.
Summary

- Plenty of risk with potential yet, somewhat nebulous benefits
- Highlighted experiences/insights of early adopters
  - Motivators for participation
  - Factors preventing RHCs from joining ACOs
- Administrative considerations
  - Structure/organization
  - Internal communication
  - Technology considerations
  - Patient’ perceptions
- ACOs: This is the future’ – participation may even be mandated for Medicare reimbursement
References


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Questions & Comments
Thank You!!