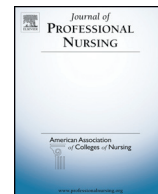




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## Is health care payment reform impacting nurses' work settings, roles, and education preparation?

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### ABSTRACT

This study explores nurses' work settings and educational preparation in the five years before passage of the Affordable Care Act (ACA) and five years after ACA passage, with the aim of identifying areas for nurse educators' attention. The study setting was one small state undergoing rapid transition away from fee-for-service service and thus provided the ideal laboratory to assess the impact of health reform on the nursing workforce. A secondary analysis of data gathered during relicensure compared the nursing workforce at an interval of one decade, with surveys in 2005 ( $n = 4075$ ; 65% response rate) and in 2015 ( $n = 6723$ ; 97% response rate). Findings demonstrated an increase in the proportion of nurses who reported working in ambulatory care and community settings ( $p = 0.001$ ). However, there was no associated decrease in the proportion of nurses who reported working in hospitals. Among respondents who reported employment in the ambulatory care/community settings in 2005, 34.3% had a BSN or higher, a proportion that increased to 41.2% in 2015 ( $p = 0.010$ ); nevertheless, the greatest proportional increase was among AD prepared nurses (34% to 48%). Although new nursing roles emerging as a result of health reform offer baccalaureate nurses the opportunity use the full complement of their knowledge and skills, these data suggest that BS prepared nurses are not fully accessing these opportunities. Implications for nursing education and further research are detailed.

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### Introduction

Health care reform and the growing momentum in the volume-to-value transition creates a new environment for nursing practice. Health reform rooted in "The Triple Aim" of 1) improved patient experiences, 2) improved population health, and 3) cost containment has seeded the development of new payment models and redesigned care delivery. Responsibility for population health and overall cost of care broadens the accountability horizon for organizations. Instead of responsibility for an episodic encounter that is billed and reimbursed, payment reform creates incentives to understand the value of care, the longer term impact of clinical decision making on cost of care and patient overall health and well-being, and population-level costs. Thus, payment reform is an element of health reform that potentially creates particular opportunities for new or renewed roles for nurses. In traditional fee-for-service reimbursement schemas, for example, many nursing skills (such as care management and patient education) equate to a "labor cost," while medical services are perceived as a "revenue generator." Payment reform dramatically shifts this equation, suggesting the potential for

more nursing employment in non-acute care settings. Yet have nurses' work settings and roles evolved as well? This preliminary study explores nurses' work settings in the time of reform, five years pre-Affordable Care Act passage and five years post ACA passage, with the aim of clarifying potentially fruitful areas for curricular reform and empirically-based nurse continuing education.

### Background and Context

One element of health reform, the Affordable Care Act of 2010 (ACA), creates a path toward universal health insurance that builds on the existing U.S. hybrid financing model of governmental payers (Medicare, Medicaid, Children's Health Insurance Program, or CHIPs, and TriCare) and commercial insurance. It requires that all individuals are covered by one of these means, either via one of the governmental insurances or commercial insurance. Commercial insurance may be employer-based or individually purchased. The law also requires each state to either create a "Health Insurance Exchange" or to participate in the federal exchange. The purpose of the exchanges are to enable individuals and small businesses to compare different health insurance plans in an "apples to apples" manner because all plans must include the "essential benefit package", i.e., services that must be covered. What differs among the plans is the "actuarial value" of the plans, the amount of

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cost sharing in the form of copayment, deductible, and coinsurance. These are also standardized by what is termed metal levels. For example, in a plan with a 60% actuarial value (AV)—a bronze plan—the insured would pay roughly 40% of health costs but have a lower monthly premium than, for example, a platinum plan, which has an actuarial value of roughly 90%. The law subsidizes those who meet eligibility requirements, provided they select a silver plan (AV value of 70%).

In addition to providing such onramps to health insurance, the ACA creates incentives for testing alternative payment models (APMs) to address the limitations created by traditional fee-for-service (FFS) reimbursement, a payment model that fragments care by creating payment silos rather than seamless care across the care continuum. Fee-for-service also fuels accelerating health care cost, overtreatment and overutilization while simultaneously leaving others underserved and undertreated. For ease of understanding, APMs can be bracketed in two broad categories that create differing provider incentives for care and thus different delivery models. The first category is a variant of FFS in which providers are held accountable for the outcomes of care. In the second category, providers bear responsibility for not only the outcomes care but also the cost of that care. Examples of the former include patient centered medical homes, person centered health neighborhoods, and other pay-for-performance models in which providers receive additional compensation if quality targets are met. Examples of the latter include most Accountable Care Organizations (ACOs),<sup>1</sup> bundled payments, and fixed revenue total cost of care “global budgets”. Accountability for the cost of clinical decision making, termed “risk bearing,” is new to many providers. In such models, for example, a diagnosis, prescription, education and follow-up to treat a new diabetic is not adequate. Instead, with payment reform there is a *financial* incentive to assure that the person is managing their diabetes, avoiding hospitalization and emergency room visits, and receiving the most effective, least expensive care possible. Conversely, fee-for-service tends to incentivize the most expensive care if the person is well-insured. Thus, payment reform away from fee-for-service creates enormous opportunities for the management of chronic conditions in a manner that is well aligned with nursing expertise. Medicare's historic 2015 announcement (see Table 1 for details) has greatly accelerated the movement from a fee-for service, volume based system to a value based system; substantial transition was planned for 2016, with a target of 90% of provider reimbursement linked to quality or outcomes by the end of 2018. Moreover, while participation in ACOs is voluntary, Medicare is requiring bundled payments (one payment for the full episode of care across the care continuum) for joint replacement in over 600 hospitals within randomly selected health services areas. In August 2016, two cardiac bundled payments in 98 randomly selected metropolitan areas were added, and the initial orthopedic bundle settings expanded to include lower-extremity joint replacement. Thus, although the pace at which the payers and providers in various states adopt such alternative payment models differs, Medicare's adoption is precedent setting. Notably, in traditional FFS, poor quality care receives the same

<sup>1</sup> There are three iterations of ACOs, Pioneer, Shared Savings, and Next Generation. Both Pioneer and Next Generation incorporate provider risk bearing. There are four versions of Next Generation ACOs, one of which maximizes provider risk-sharing in a fixed revenue model, meaning more services do not equate to more revenue and thereby is the largest contrast to traditional fee-for-service. Shared Savings ACOs have a risk sharing model in which providers assume the cost of care beyond what was projected for a given population. This is termed “down side risk,” nevertheless, there are “upside only” ACOs in which providers share in any savings above what was projected for the cost of care for a population provided designated quality metrics are met, but none of the cost. The reader is advised to carefully explore the exact APMs that have been developed and are being developed and tested in their area, as there is dramatic variability throughout the states and even within states. The largest provider groups in the study setting have embraced the Next Generation fixed revenue model and therefore provide a dynamic policy laboratory. Since the initial draft of this manuscript the study setting has negotiated an agreement with Medicare that creates the opportunity for an All-Payer statewide ACO (see <http://healthaffairs.org/blog/2016/11/22/the-all-payer-accountable-care-organization-model-an-opportunity-for-vermont-and-an-exemplar-for-the-nation/>).

**Table 1**

Key provisions of U.S. Department of Health and Human Services January 26, 2015 announcement

Timeline of Medicare Value Based Initiative	Date
30% of traditional fee-for-service to value based payments	By end of 2016
50% of traditional fee-for-service to value based payments	By end of 2018
85% of all traditional Medicare payment to quality or value	By end of 2016
90% of all traditional Medicare payment linked to quality or value	By end of 2018

compensation or even better compensation than high quality care. Medicare had begun to address such perverse incentives with reimbursement policies that preclude reimbursement for same cause readmission if it is within one month after discharge and fining hospitals whose readmission rate is too high, to name just two examples. Similarly, hospital acquired conditions, including those reflecting nurse sensitive indicators such as urinary tract infections, no longer generate additional reimbursement. These payment changes have created delivery changes that nurses see regularly in practice. The shift to virtually all reimbursement being tied to value has the potential to completely redesign the U.S. health care system. Notably, these changes are exterior to the ACA and rooted in Medicare rules.

The impact of Medicare payment reform cannot be overstated for two primary reasons: 1) Medicare is the payer of health care for a large proportion of Americans, a scenario that is growing steadily with the aging of the Baby Boomer cohort; and 2) Medicaid and commercial insurance often follow Medicare practices, potentially meaning that the value-based scenario could represent nearly all of health care reimbursement, and reimbursement shapes practice behavior.

Yet what about nursing roles in a reformed system? Workforce researchers Fraher, Ricketts, Lefebvre, and Newton (2013) underscore the pivotal role of registered nurses, as follows:

Because of sheer numbers—the U.S. health care system employs 2.7 million registered nurses—it is nurses who are arguably in the most pivotal position to drive system change. ... More attention needs to be given, first, to identifying the competencies nurses need in these new roles and, then, to providing continuing professional development opportunities for nurses who wish to undertake the new functions (p. 1813).

Educational essentials of baccalaureate and higher degree programs (AACN, 2006, 2008, 2011) include skills such as care coordination that are foundational to the emerging payment reform models described above. Nevertheless, there is scant empirical evidence exploring nurses' work setting migrations over time. It is also unclear if health care reform is associated with a change in the composite educational preparation of nurses outside the acute care setting. This is particularly key in the era in payment reform, given that associate degree prepared nurses—the largest proportion of the nursing workforce in most regions—typically do not have course work to prepare them to work in population-focused settings or in settings outside of traditional acute or long term care. Thus, this study seeks to clarify if the role and setting shifts portended by health and payment reform are actually emerging.

Specifically, the current study seeks to explore changes in the nursing workforce practice settings by education preparation and other demographic factors. One small state undergoing rapid transition away from fee-for service, Vermont, provides the ideal laboratory to assess the impact of health reform on nurses' practice setting and was therefore chosen as the study setting. 124 (57%) primary care practices in the state are “Blueprint Practices,” the state's term for an integrated approach to patient centered medical homes (Department of Vermont Health Access, 2014; University of Vermont AHEC, 2013). The state has also passed landmark legislation in 2011 that includes aggressive movement away from tradition fee-for service. Roughly half the state's health services areas were deemed prepared for full risk sharing as the state prepared for an “all payer” model inclusive of a Medicare waiver to enable all-inclusive, capitated, reimbursement rather than fee-for-

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