CGEAN Perspectives

JONA
Volume 47, Number 5, pp 248-249

Are Nurse Leaders Prepared to Lead Across the Continuum of Care in the New Paradigm?

O. Ed. Reitz, PhD, MBA, RN, NEA-BC
Shelly Malin, PhD, RN

The movement toward linking reimbursement with outcomes necessitates providing care across a continuum of settings, leading to the need for a new healthcare paradigm. Issues related to shifting to this new paradigm include disagreement about what this paradigm encompasses, the fragmentation of the healthcare system, and overreliance on the medical model as a framework for driving health policy decisions. We advocate for nurse leaders to guide the development of this new paradigm.

A consensus that healthcare costs in the United States were unsustainable led to provisions of the Patient Protection and Affordable Care Act (ACA)[1] to encourage changes resulting in increased efficiency, increased quality of care, and decreasing the growth of per capita costs. Although the political rumblings of dismantling the ACA can be heard far and wide, the drivers that led to the passage of the ACA, lack of affordable access, will not go away with repeal. Attempts to control costs associated with healthcare have resulted in an increased emphasis on linking financial compensation with patient outcomes. Alternatives to address the healthcare needs served by the ACA means that the movement toward correlating reimbursement with patient outcomes will continue in the near future. Challenges to shift to this new paradigm include disagreement to what this paradigm encompasses, increased consumer awareness, the fragmentation of the healthcare system, and overreliance on the medical model (MM) as a framework for driving health policy decisions.

Are Nurse Leaders Prepared to Lead Across the Continuum of Care in the New Paradigm?

A review of current evidence reveals a lack of consensus regarding the new paradigm shift in healthcare. Although most agree that healthcare must be provided across the continuum in community and home as well as acute care facilities, there is no agreement about methods to reach this goal. The ACA and Medicare's Hospital Readmission Reduction Program will require effective community-based services.[1] A new paradigm that not only provides healthcare is needed; it needs to provide a framework to create conditions that will promote long-term health. This framework ideally includes a vision broad enough to encompass wider societal issues including social determinants of health (such as housing, food availability, employment, financial resources, and the availability of safe drinking water). The framework must incorporate an interdisciplinary approach to research looking outside the traditional boundaries of healthcare research to address issues such as access, mental health, information technology infrastructure, and other complex social issues.[2] Only then will we be able reduce per capita costs and improve the patient experience, thus improving the health of populations.

Without a robust framework, the fragmentation of the US health system will be exacerbated with the move toward population health reimbursement models. One of the provisions of the ACA was the development of the Accountable Care Organization (ACO).[1]

Author Affiliations: Associate Professor (Dr Reitz), Advocate BroMenn Endowed Professor (Dr Malin), Illinois State University Mennonite College of Nursing, Normal.

The authors declare no conflicts of interest.

Correspondence: Dr Reitz, Illinois State University Mennonite College of Nursing, 209 Edwards Hall, 5810, Normal, IL 61790-5810 (*oreitz2@ilstu.edu*).

DOI: 10.1097/NNA.0000000000000481

Effective ACOs need to reduce costs while increasing the level of quality. One way to achieve these goals is to continue to address the realities of fragmentation and inefficiency in the current system.[3] Difficulties may relate to the lack of fixed boundaries between acute care, long-term care, public health, and home health facilities. Acute care facilities, once the primary setting where healthcare was provided, will now have to work as equal partners with community clinics, long-term care facilities, public health departments, home healthcare agencies, and new innovative methods of providing service such as telehealth. A comprehensive approach with clearly defined populations and responsibilities will be needed to successfully define and implement this new paradigm. A truly interdisciplinary approach will be required integrating not only medical, nursing, and other healthcare professionals but also political and economic leaders. Most importantly, engaging the patient and family in the creation of the system and in understanding individual and family health behaviors is paramount to success.

The ACOs must meet quality standards to receive financial incentives. Cost savings are achieved by improving provider and hospital coordination. The ACOs could also serve as a transition to a population-based reimbursement model.[4,5] One example, Kaiser Permanente[6] has a clinical structure and coordination model that reflects many of the ACO principles. Integrated care is provided across the continuum, and performance metrics are instituted systematically across care settings, promoting accountability among practitioners. This plan has been recognized as one of the most cost-effective models for providing quality care while controlling costs. Given the initial success of this model, the ACO seems to be 1 potential approach to providing cost-effective care within the new healthcare paradigm.

A shift from the MM that emphasizes clinical intervention and the treatment of disease to a holistic model of care where the patient is a partner, not a passive recipient of care provided by an integrated interdisciplinary team of providers in the most efficient setting, will be needed. This shift is unlikely if led by individuals primarily grounded in the MM. The MM's reliance on a reductionist approach and focus on the biological source of disease has been its major criticism. The effectiveness of the MM on the overall health of a particular population has been inconclusive. The MM fails to take the broader sociopolitical dimensions of health into consideration. Unlike the traditional MM that defines health as the lack of disease, nursing has had a holistic approach to health emphasizing health promotion and overall wellness of the individual in the context of family and community. In alignment with the vision and goals of national nursing organizations,[7] we believe that nurses are well prepared to lead this shift to a paradigm embracing both cure and care, with the patient as equal partner in shaping the system.

References

1. An Act Entitled the Patient Protection and Affordable Care Act. US Government Publishing Office Web site. https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm. Accessed February 19, 2017
2. Mancino D, Feeg V. The health care paradigm is shifting—is nursing ready to lead change? *Dean's Notes*. 2014;35(4):1-4.
3. Kang A, Bhangoo K. New paradigms in Indian healthcare: pioneering solutions for the developing markets. *Amity Bus Rev*. 2016;17(2):52-65.
4. Kelleher KJ, Cooper J, Deans K, et al. Cost saving and quality of care in a pediatric accountable care organization. *Pediatrics*. 2015;135(3):e582-e589.
5. Koury C, Iannaccone L, Strunk A, et al. The accountable care organization summit: a white paper on findings, outcomes, and challenges. *Hosp Top*. 2014;92(2):44-57.
6. Aon Hewwitt Value Initiative. Benchmarking Study. 2011. Kaiser Permanente. https://info.kaiserpermanente.org/html/hcr_ca/accountable_care_organizations.html. Accessed April 6, 2017.
7. American Nurses Association (ANA) and Health Care Reform. American Nurses Association (ANA). http://nursingworld.org/MainMenuCategories/Policy-Advocacy/HealthSystemReform. Accessed February 3, 2017.