This view of health policy from the perspective of APRN practice is a call to action for advanced practice nurses to learn about the impact and implications of current initiatives in health policy. This knowledge will assist them in determining how they define and create positive change for their patients and have an impact on community, national, and world health. This is the only text that satisfies the need for policy discussions for all APNs. It is designed to meet the requirements of both the IOM report on The Future of Nursing and the DNP criteria V for inclusion of health policy and advocacy in the curriculum. The text encompasses evolving health care policy and reform in the United States, Canada, and internationally; addressing its impact on advanced practice nursing, APRN roles, care for special populations, health care quality, and patient safety.

The book brings together a wealth of information written by luminaries in the field. Dr. Goudreau is a past president and board member of the National Association of Clinical Nurse Specialists (NACNS), and Dr. Smolenski was director of Certification Services at the ANCC for 11 years, directing certification for 150,000 nurses in over 30 specialties.

The text discusses issues surrounding the regulation of APRNs, how the local regulatory environment shapes their practice and how APRNs can shape their local regulatory environment. Additionally, the text offers in international perspectives on how APRNs can and are impacting patient care globally. In order to provide content relevant to a universal APRN readership, each section of the text endeavors to present information from all four APRN perspectives: NPs, CNSs, CRNAs, and CNMs. For all of these roles, the book covers the implications of current and future health policy changes for APRN practice.

**Key Features:**
- Addresses the role-specific policy informational needs of all APRNs including NPs, CNSs, CRNAs, and CNMs
- Brings together in one volume all of the requisite information about health care policy and reform and its impact on advanced practice nursing
- Meets the requirements of the IOM report on The Future of Nursing and the DNP criteria V for inclusion of health policy and advocacy in the curriculum
- Offers guidance on how APRNs can influence policy development
- Covers impact and implications of health care policy and reform in the United States, Canada, and internationally
Health Policy and Advanced Practice Nursing
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This book is dedicated to APRNs everywhere. The hardest part of becoming the best that you can be, is to incorporate the global perspective and consider the implications of health policy to your practice. It is our sincere hope that this text will assist you to begin the journey regardless of where you are in your career. As a new or developing APRN, welcome. As an existing APRN in mid-career, welcome. As an APRN at the end of your career … it is about time you joined the battle! All joking aside, the need for APRNs to become engaged in the dialogue has never been more important than it is right now. We are pleased to be able to dedicate this perspective on health policy to all of you so that you can engage in discussion, dialogue, and discourse about the future of APRNs everywhere around the globe.
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As this nation, finally after 100 years of political strife, adopts a national health policy and embraces universal health care, the opportunities and options for advanced practice nurses could not be more politically, socially, and economically timely and opportunistic. One of the most hopeful trends in the new health care legislation, the Patient Protection and Affordable Care Act (PPACA) is a perfect match for nursing because of its transformation of the current sick care system to a bona fide “health care system.” With the term Patient Protection, which is often ignored in reports, indicates that the PPACA has at its core, prevention and health promotion to achieve optimal population health. Since Florence Nightingale’s leadership in creating a healthy environment in which healing can take place, nursing has had at its caring core prevention and health promotion to preserve and protect the health of individuals and populations. Not that this has been recognized, reported, respected, or rewarded among colleagues or the public media. In this world of high-tech medicine, public attention is focused on the dramatic, esoteric, and unique procedures that help a few unfortunate patients. Granted much can be learned from these marvels, but application to the larger populations is in question. However, achieving this monumental effort to reorient this humongous health care sector with all its social, economic, and political woes, legislative stalemates, and professional territorial battles would not be easy. But a crisis is an opportunity for change and now is nursing’s time to jump into the fray.

Internally, unifying our nursing forces and resources across a diversely educated populace is the first hurdle. Externally, we must remove artificial barriers to changes in state practice laws, address the competition among a host of nursing organizations, settle disagreements on the political strategies, and do whatever is called for to form a united front. All this will require a well-organized, well-funded, fast-moving national campaign—one that not only unifies nursing and nursing organizations, but also cultivates new partners outside the traditional health professionals, such as other stakeholders, consumer groups, industries and corporations, and faith-based and public service agencies. It is a huge undertaking, but there are a number of signs on the horizon to encourage us. Politically, we must stop requesting changes in state practice laws, one task at a legislative session. Nursing, and in particular APRNs, must seek full statutory authorization and autonomy to practice to the full extent of the practitioner’s preparation. We must gain our freedom to practice now.

The timeliness of the Institute of Medicine’s The Future of Nursing, the Consensus Report on Licensure, Accreditation, Credentialing and Education, and many other recently
published documents (The Governors’ Report, Florida watchdog tax group, etc.) offer monumental support for nurses everywhere and, in particular, nursing leaders especially APRNs to move quickly and decisively to achieve the goals of addressing the nation’s problems of access, quality, and affordability in health care. Perhaps most importantly, it is an opportunity for nurses to re-orient a medically disease-focused sick care system to a true health system with prevention at the core of the services. Knowledge is power. Gaining a better understanding of the political landscape and its impact on nursing and the APRN practice environment, by learning through textbooks such as this and then through active involvement at any level in the political process itself, can only strengthen nursing and its influence on health policy. Nursing leaders and nurses everywhere must not miss the opportunities that this new enabling environment in health care offers to innovate, invent, imagine, and inspire. Our patients deserve this, the nation needs it, and now is the time!

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The original concept for this book was to bring into discussion the many events, campaigns, initiatives, documents, and legislative efforts that have laid the groundwork for change and have impacted advanced practice registered nurse (APRN) practice in today’s world. As a book written by APRNs from an APRN perspective, it was also intended to identify the implications that these changes might have for current and future practice, and get APRNs thinking about them and involved in creating conditions that will improve patient outcomes. Many books give you an outside-in view of events. This book is to give you an inside-out view, placing you right in the middle of things, helping you to see the importance of understanding the basics of health policy development, and recognizing that each person can play a part in the process.

Health policy is not something that most APRNs or APRN faculty can hold near and dear to their hearts. Political events of the past few years along with current-day partisanship have unfortunately turned more people off to the political process than enamored them to it. Discomfort with the health policy process can be viewed in the same way that research used to be viewed. Everyone realized that research was important and necessary, it seemed to be a little complex and scary, and it got a mention and some cursory attention in curricula with the hope that someone else would take care of it. Well, that has certainly changed over the past few decades with the influence of graduate education, the advent of evidence-based practice, and the need to have data-supporting practice in order to initiate changes. Everyone is much more concerned about research-based evidence, patient safety, and quality.

Health policy has taken on that same persona as research once had and more APRNs and consumers in general have taken up their banners for specific causes. The world has become a smaller place and with the influence of television and social media, initiating interest in change has never been easier. Action is the harder task. Whereas some advanced practice groups such as certified registered nurse anesthetists (CRNAs) have been thrown into the political arena to defend their practice and reimbursement, others are only beginning to see the need for involvement. This book hopefully points out numerous areas where APRNs are already taking action to create better practice environments and conditions, how they can work to define positive change for their patients/clients, and how they can have an impact on the health of communities and the nation through the health policy process.
It is our hope that this book will show you, the reader, how health policy has and will affect your practice as an APRN, regardless of role. This “boots on the ground” perspective is intended to show you a global point of view on how nurses in advanced practice are presently making a difference and how you too can make a difference. Join the dialogue, speak your concerns, and become engaged. Learn from your predecessors and take up the challenge … the world is yours.

Kelly A. Goudreau
Mary C. Smolenski
Many thanks are in order as this book comes to fruition. First of all, many thanks to Margaret Zuccarini, Publisher at Springer Publishing Company, for her question, “Hey, Kelly … do you have any ideas for a new book?” Thanks to the team at Springer who assisted in pulling together all the bits and pieces and made this book a reality.

A special thanks to the contributors to this book. In every book, there is a story and this one has been interesting with life events that happened and are happening (aging parents, deaths, births, new jobs, moving, being overwhelmed and overcommitted, and retiring). The product of the contributors’ labors is within these pages for you to digest and learn from the lessons lived.

Finally, many thanks to those who put work into the chapters not only as authors, but as editors and supporters of the authors. Your expertise is valued beyond all.

Thank you all for assisting us in the development and completion of this text. May it guide you well in your learning.
UNIT I

INTRODUCTION TO HEALTH POLICY FROM AN ADVANCED PRACTICE PERSPECTIVE
Prolific Policy: Implications for Advanced Practice Registered Nurses

Melissa Stewart

True health care reform cannot happen in Washington. It has to happen in our kitchens, in our homes, in our communities.

—Mehmet Oz

Policy can serve as a vehicle for movement or progress in practice. Policy can open doors for opportunity and provide methodology for systematic solidarity in action. Unfortunately, many health care practitioners allow policy to happen around them but not through them. To truly be an effective advocate, policy must become a tool used to sharpen our practice to meet the needs of our consumers. Tomajan (2012) defined advocacy as “work on the behalf of self and/or others to raise awareness of a concern and to promote solutions to the issues. Advocacy often requires working through formal, decision-making bodies to achieve desired outcomes.”

Milstead (2013) defined policy as “A purposeful, general plan of action, which includes authoritative guidelines, that is developed to respond to a problem. The plan directs human behavior toward specific goals.” Policy statements detail values and guidelines to provide precise direction. Actions in the legislative arena at every level, local, state, and federal, directly impact the practice arena, and what occurs in the practice arena in turn impacts legislative action. In order to support the profession and provide for those entrusted to our care, it is essential that advanced practice nurses assume advocacy roles and strengthen their leadership skills in order to become policy leaders. Nursing leaders need a basic platform of understanding, both in advocacy and policy, to combine resources to accomplish identified goals. Advanced practice nurses must recognize that policy is an integral part of everyday professional nursing practice.
OUR RIGHT TO PROMOTE WELL-BEING

We the people of the United States, in order to form a more perfect union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America.

The authors of the preamble to the Constitution called for union of Americans to create optimal conditions for the safety and well-being of America’s citizens. This sacred document established a priority to promote welfare among American citizens. Government action toward this directive is derived through policy. Prudent, pragmatic approaches are designed through policy to yield optimal results.

As practitioners, policy often surfaces as regulatory mandates or organizational improvements. Personally and professionally, policy surrounds us daily. From the protection of patient confidentiality to the code used to charge a payer, policy is deeply embedded in our everyday life. The power to influence policy through the political arena is a right of every American. Legislative representatives are servants of the voters who empower them with their political appointment. The right to vote and contact political figures is often an underutilized resource. Although one may choose to label self as not being politically active, they cannot escape the consequences acquiesced from the political arena.

To many health care professionals, policy is just not appealing enough to hold the providers’ attention. The tedious nature of policy is how regulatory changes can sneak in and make chaos out of a once highly functional practice. Legal terms in law, ambiguous terminology in regulations, and robotic language in organizational policy can serve to disengage health care providers. Unfortunately, the perceived pleonasm of policy can deter the health care practitioners who need to understand and implement the directives in practice. According to Anderson (2011), there are five stages of policy making (Table 1.1).

Stage 1 is policy agenda. In stage 1, the focus is on problems that receive attention of public officials. In policy formulation, stage 2, concentration is on the development of courses of action, acceptable and proposed, for dealing with a public problem. Stage 3 is policy adoption when support for a specific proposal is procured so the policy can be legitimized. Policy implementation is the focus of stage 4; this is where the administrative machinery of government begins to apply the policy. Finally, in stage 5, policy evaluation, policy is evaluated for effectiveness, barriers, and consequences. Table 1.2 compares the five stages of policy making with the nursing process.

Policy is born out of need for communal actions. The need may be identified within an organization to achieve optimal performance from employees, or because of market changes or new legislation passed. Socially, policy is developed to help maintain a civility among populations. Common drivers that influence policy are social and environmental factors, voters, professional organizations, and advocacy groups (Figure 1.1). Irrespective of the reason for the policy, once created individuals are affected by policy.

<table>
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<th>Table 1.1 Stages of Policy Development</th>
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<td>Stage 1 Policy agenda</td>
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<td>Stage 2 Policy formulation</td>
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<td>Stage 3 Policy adoption</td>
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<td>Stage 4 Policy implementation</td>
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<td>Stage 5 Policy evaluation</td>
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Social and environmental factors include newsworthy topics such as unemployment, illegal aliens, and the stock market crash. The stock market influences companies’ revenue, which in turn impacts employment. The crash of the stock market caused a decrease in capital for companies that translated into layoffs and downsizing. With the loss of employment comes the loss of benefits such as health care benefits. The Affordable Care Act was framed as a way to provide health care coverage for the unemployed and illegal aliens. From bill to law, the Affordable Care Act has ignited political astuteness from political influencers.

It is imperative that health care professionals understand the political process. Health care providers, either (or both?) individually, or through professional organizations or advocacy groups, directly influence local, state, and national policy on a regular basis. Professional organizations and advocacy groups through the weight of their votes impact policy. Because the legislative and executive branches of government comprise elected officials, votes and organized groups of voters carry strong lobbying influence when dealing with these two political arms.

Within professional organizations, such as the American Association of Nurse Practitioners and the American Nurses Association, member-created resolutions help to push an issue up to the state and national level for organizational support. In the past, a house of delegates would vote on resolutions to help the direction for national organizational boards. The new trend is to have various specialty committees work together to offer expert support. The Institute of Medicine (IOM) often holds roundtables for specific health care issues as a way to provide direction and influence to members, legislators, and other significant parties.

Knowledge of where to introduce proposed policy can determine success or failure. Through the three branches of government, that is, legislative, judicial, and...
executive, policy is created, implemented, and enforced. The legislative branch, the House of Representatives and the Senate, creates law. The executive branch, which consists of the president federally, at the state level the governor, and at the city level the mayor, implements law. The judicial branch, courts and regulatory agencies, enforces law. To be effective when advocating for law, point of access is critical.

Appropriate point of access for impact is contingent on what a provider is trying to accomplish, because this will determine where personal or professional influence should be introduced. For example, if a bill is in the House, which may limit the practice of the advanced practice registered nurse (APRN), the practitioner may want to contact legislators and attend committee meetings about the bill. Whereas if the bill has passed into law and the provider wants to ensure the law is interpreted into practice appropriately the APRN would want to connect with the executive branch’s assigned government entity tasked with implementing the new law. Government entities often tasked with implementing health care laws are the Centers for Medicare and Medicaid Services (CMS), or the State Department of Health and Human Services. Finally, the APRN accesses the judicial arm of government through reporting illegal activity or serving as an expert witness to safeguard intent of the law. Each state’s Board of Nursing serves as a judicial arm of government protecting the state’s citizens from negligence and/or error of practitioners. Knowing when and where to access can help the health care provider to maximize their influential potential (Figure 1.2).

In the process of developing law, a bill has to go through several stages of debate, revision, and voting before it sees the light of day. A proposal from a member of Congress, either the Senate or the House of Representatives, proposes an idea for a new law or an idea to alter a law that already exists. After the proposal is submitted, it then becomes the proposing official’s job to get the proposal written into a bill. Once the bill is created, it must be submitted to one of the two houses of Congress, the Senate or the House of Representatives. The bill is then assigned to a particular committee that deals with the subject of the proposed law. It is the assigned committee’s job to debate the value of the law, including its necessity to be passed, and the pros versus the cons. If the bill is favorably passed by the committee it then goes in front of the entire House or the Senate for debate. It is similar to the debate that occurred within the committee but now the whole branch of Congress debates the merits and implications of the proposed bill. Once a bill has met with the approval of one of the branches of Congress, it then moves to the other branch to go through the same process. Throughout the journey in Congress, the bill is modified in an effort to be passed by the general consensus. Once the bill is passed by both branches of

FIGURE 1.2 Point of Access for Maximum Influence.
Congress, it goes to a conference committee to get the modifications added to the original bill figured out. After the bill has been revised, both houses of Congress vote on it. Finally, the bill is submitted to the president of the United States, who has the power to either put the law into effect or veto it. Even if the president decides to veto the bill, the legislative branch can vote to overrule his decision. If two thirds of the representatives vote to overrule it, the bill becomes a law anyway.

It is not uncommon, and probably most likely, that organizations and/or lobbyists of special interest groups will try to have as much impact on the early stages of this process, as the idea is being proposed, accepted, and written up as a bill. Getting in on the ground floor of a proposal submission and following it allows for maximum input and to ensure that there is clarity in terminology. It also helps to craft components of the bill with the best interests of the particular group. Most, if not all of the initial bills, are written by House or Senate staffers, who research elements of the proposal and work on draft after draft until it is ready for committee assignment. The work continues throughout the whole process, because as outlined previously, the bill can be modified, changed, and possibly lose the impact that was originally intended. Knowing where the bill is in the process, what committee it is assigned to and who is on that committee, and contacting legislators and committee members with facts and data to support (or rebuke) the bill are important steps that any APRN can take.

**POLICY SHIFT TOWARD ILLNESS PREVENTION**

As the 21st century unfolds, a new paradigm in health care begins to emerge with the implementation of the Affordable Care Act. The expansion of health care deliverables, coupled with the movement in health maintenance through prevention services, presents new challenges to address. Redefining providers’ scope of practice, adjusting to result-oriented payment structures, and establishing new delivery realms such as transitions in care are just a few of the issues that must be addressed to successfully move forward (CMS, 2011a, 2011b).

The present prevention/wellness movement in health care has always held a presence in our delivery system, especially in the practice of nursing. Nursing theorists such as Florence Nightingale, Dorothea Orem, Betty Neuman, and Nora Pender, are just a few who include wellness through prevention as a construct in their theories (Figure 1.3). Although healing related to insult or injury has historically been the crux of health care, the 21st century is focused on personal sustainability through health prevention. With the ever-growing shortage of primary care physicians, frontline access providers are becoming less and less available to the public. In an attempt to address the frontline provider crisis, which has traditionally been a physician,

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<th>THEORIST</th>
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<td>Florence Nightingale</td>
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<td>Dorothea Orem</td>
<td>Self-Care Deficit</td>
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<td>Betty Neuman</td>
<td>Systems Theory</td>
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<td>Nora Pender</td>
<td>Health Promotion Model</td>
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**FIGURE 1.3** Nursing Theorists With a Prevention Focus.
APRNs and in particular nurse practitioners (NPs) are assuming this role to meet the public access crisis.

SCOPE OF PRACTICE

Although APRNs are meeting the need of the consumer they are still limited by reimbursement and collaboration agreements. Even though APRNs are delivering the same level of care in many cases as is rendered by a generalist physician, they are not reimbursed 100% of the treatment billing codes like their physician colleagues. Instead, APRNs are reimbursed at the rate of only 85% of the code allotment. Payer discrimination between APRNs and physicians only serves to fiscally limit investment in their practices. The harnessing of APRNs through collaboration agreement mandates between APRNs and physicians further attempts to publicly restrict the independent role of the APRN. To maximize the role of APRNs, the legislatively created scope of practice in each state will need to remove these independent practice barriers. The issues of payment and collaborative agreements are regulatory mandates that are hindering the progression of APRNs as they attempt to maximize their practice autonomy. Understanding these issues and having a knowledge of the legislative system can assist in removing the barriers of practice maximization.

RESULTS-ORIENTED PAYMENT

Result-oriented reimbursement for health care services was derived from the exponentially rising costs of care with a perception of an ever decreasing quality of care outcomes. Health care services in our present delivery system continue to have large mounting costs while consumers experience lower quality in care delivered than that of other industrialized countries as evidenced in comparable preventable mortality, number of uninsured, and care system efficiency scores (Davis, Schoen, & Stremikis, 2010). It is estimated that by year 2019, health care spending will comprise 20% of the U.S. gross national product (Alonso-Zaldívar, 2010). The United States also pays far more per capita than any other nation when compared with other industrialized nations (Organization for Economic Co-operative Development, 2011). Hospital care consumes the largest and growing section of the U.S. health care system. According to Millman Medical Index (2012), inpatient and outpatient services now represent 32% and 18% of the U.S. health care budget, respectively. Mergers and acquisitions are taking place as health care reform unfolds with insurers, for-profit companies, and private equity firms entering into the health care delivery market (Caramenico, 2012). Despite hopes for savings through the efficiency of size, these unions of companies and investors have been associated with rising health care costs and a systemwide decrease in patient satisfaction (Berenson, Ginsburg, Christianson, & Yee, 2012; Office of Attorney General Martha Coakley, 2010). According to National Public Radio, the Robert Wood Johnson Foundation, and the Harvard School of Public Health (2012), a recent survey of U.S. residents with illness found that 73% felt that the cost of health care was a very serious problem and 45% felt that quality was a very serious problem. The survey found that the United States has a below-average life expectancy rate and an above-average infant mortality rate (Organization for Economic Co-operative Development, 2011). Quality in care continues to be a growing concern in health care as two recent studies have found that approximately one in seven hospitalized patients experience an adverse event (Landrigan et al., 2010; Office of Inspector General [OIG], 2010), with 44% to 66% of these events found to be preventable. Unfortunately, more than not, hospital
administration may not even be aware that these events have occurred. As noted in the OIG report, only 14% of events that cause harm to patients are captured by hospital tracking systems (OIG, 2012). Downey and colleagues (Downey, Hernandez-Boussard, Banka, & Morton, 2012) examined the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators between the years 1988 and 2007, and found little overall change in that time frame. This lack of progress in safety is a poor response to the IOM’s publication of the 1999 report, which estimated that almost 100,000 patients die each year from medical errors (IOM, 2000). Another reflection of the quality of care seen in today’s health care system can be observed in health care-acquired infections (HAIs), which inflict 1.7 million hospitalized patients each year (Klevens et al., 2007), or approximately 1 in 20 patients. HAIs afflict the U.S. health care system at a cost of $35.7 to $45.0 billion each year (Scott, 2009), resulting in 100,000 deaths and untold disability (Klevens et al., 2007). According to a recent survey, 8% of hospitalized patients report getting an HAI (National Public Radio, Robert Wood Johnson Foundation, & Harvard School of Public Health, 2012). The health care system continues to face many challenges in quality of care coupled with escalating costs, which is evident in the slow progress toward reducing adverse events. In response, the CMS through the Patient Protection and Affordable Care Act (PPACA), along with some private insurance companies, are trying to implement financial incentives that will reward quality care while (at the same time) penalizing care that does not meet quality standards.

Fiscal transparency is a type of health care value-based purchasing incentive (Woodward, 2012). Transparency of measures allows consumers and referrers to make choices between different hospitals and providers based on quality and performance, and cost of services. There are approximately 27 states and the District of Columbia that publicly report HAIs (Frieden, 2010). Provider data on hospital-acquired conditions (HACs), process measures, and patient satisfaction surveys are accessible for public viewing online through Hospital Compare (CMS, n.d.). Beyond referrals and the individual consumer, use of the reporting of quality measures can be a factor in a provider negotiation of insurance contracts and third-party payers. Transparency in value-based purchasing can impact a provider’s revenues.

To address the gross disparity between cost and outcomes in care, the PPACA directed the CMS to initiate a value-based purchasing system to financially incentivize quality in health care and lower societal health care costs. At present, in the shift toward outcomes-oriented reimbursement, there are two categories for financial incentives. The first category penalizes payment for the care rendered to an individual patient who acquires an HAC. The second category penalizes or rewards the entire fee for all services and patients who are treated at a facility. The incentive that is selected depends on whether a facility’s reimbursement is a payment for individual (line item) services or a bundled payment. Unfortunately, the PPACA provides only a framework for change. A proactive stance in health policy formulation is needed that is based on the best information available.

APRNs must engage in the national redesign and construction of health care under a quality care/wellness delivery paradigm. The literature strongly supports the cost effectiveness of NPs as well as strong quality in care delivery and outcomes of other APRN roles such as clinical nurse specialists (CNSs) (Blackmore et al., 2013; Clavelle, 2012; National Nursing Centers Consortium, n.d.; Schiff, 2012). As the nation moves to redefine health care and apply fiscal incentives, it is a nursing duty to ensure patients receive optimal care for a reasonable fee. It is imperative that advanced practice nurses such as APRNs lead nursing in their political efforts to move health care toward a more patient-centric delivery model.
NEW DELIVERY MODELS

As the nation’s health care system revolutionizes its way into a new paradigm of health delivery, policy will need perpetual refurbishment. New areas of health care delivery will unfold such as the newly reimbursable transitions in care, which originated from CMS’s ninth Scope of Work’s (SOW) Care Transitions pilot. CMS’s care transitions pilot was framed around Mary Naylor and Erik Coleman’s work in transitioning the patient from an acute level of care to home, where self or caregiver deliver personal care. The focus of both Naylor and Coleman’s work is to decrease patient readmissions in chronic care patients by injecting a health care provider’s presence into the transitional time frame, which is usually 30 to 45 days postdischarge.

CMS’s pilot focused on decreasing the readmission rate of Medicare patients with one or more of five diagnoses—chronic obstructive pulmonary disease, congestive heart failure, myocardial infarction, diabetes, and pneumonia. Both Naylor and Coleman used a coaching model for patient intervention. Naylor’s model utilized an APRN to do home visits, whereas Coleman’s model used a registered nurse who did home visits and telephonic coaching. Selected quality improvement organizations (QIOs) were awarded contracts to participate in the care transitions pilot. The QIOs were charged with forging a working relationship with established hospitals for pilot patients. Once recruited, patients were to be enrolled into the QIO’s coaching program. Naylor’s and Coleman’s work helped to inaugurate basic face-to-face and telephonic communication between hired health care providers and patients.

Of the pilot contracts awarded, one QIO found that they were able to make some impact in decreasing readmissions but not as profound as they wanted. This QIO chose to delve deeper in the communication between patient and provider by implementing the Medagogy© Model and Understanding Personal Perspectives Instrument© in their coaching program (Stewart, 2012). Then the pilot was able to decrease the enrolled population’s inherited 18% readmission rate down to 3% (Griggs, 2011). The marked improvement yielded from their improved patient education efforts and patient engagement led to CMS’s acknowledging their work as the nation’s most innovative pilot in 2011. Because of the success of the pilot, CMS has created two billing codes that physicians, physician assistants, nurse midwives, CNSs, and NPs can bill under to receive reimbursement for their care transitions work (CMS, 2013). This serves as one example of how nursing, through the work of Naylor, Coleman, and Stewart, made an impact on a policy change at CMS that has improved the bottom line for both patients and providers.

CONCLUSION

Policy making, as it relates to health care during the first part of the 21st century, has been at an all-time record high. Although it is generally agreed that health care is overregulated, much of the policy that is sought at this time regards dramatic change in the status quo, to include breaking down traditional provider definitions and creating what would almost appear to be new hybrids of medical professionals. As attempts are made to curtail and control spending, one of the fundamental questions proposed is what constitutes “good” health care, which generates the next question—What role/who is qualified to provide it? A resounding call has been made to utilize APRNs as primary care providers in the face of the projected shortage of approximately 45,000 primary care physicians expected in the next decade (AARP, 2013). Unfortunately, at present, only 16 states allow APRNs to practice autonomously and without oversight. The vast majority of states require limitations
to practice, most prominently the requirement that a collaborating practice physi-
cian must be contracted in order for any form of health care provision at the APRN
level to occur. And despite having data that the quality of care provided by APRNs
is commensurate to that of physicians, many managed care organizations do not
credential APRNs as primary care providers. This limits the ability to be reimbursed
by insurance companies.

Of particular need within the APRN and nursing community at large is to
acknowledge, embrace, and embark on participating in the political action process so
necessary for these times. The intent of the development of laws in the United States
was citizen freedom to create and implement action through regulation for the good
of all citizens. The process was meant to represent the population of the country and
directly address the needs of the citizens. The initiation and support of legislation is
a fundamental right of our birth as Americans; however, it is a laborious process in
our whirlwind existence that is unfortunately far too often seen as the responsibility
of others. As nurses, we must step up and drive policy—it is in the best interest of all.

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