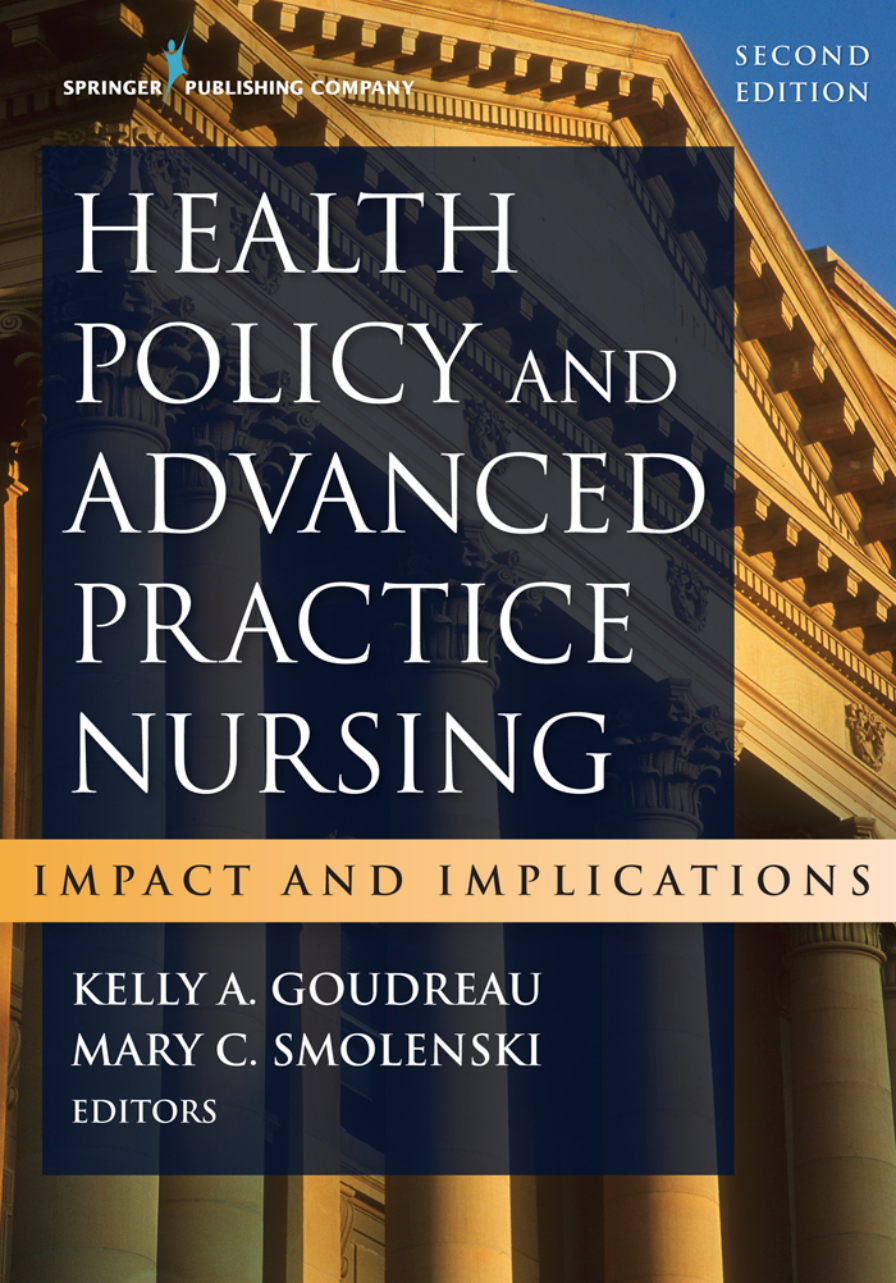
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IMPACT AND IMPLICATIONS
KELLY A. GOUDREAU
MARY C. SMOLENSKI
EDITORS

Health Policy and Advanced Practice Nursing

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Health Policy and Advanced Practice Nursing

Impact and Implications

SECOND EDITION

Kelly A. Goudreau, PhD, RN, ACNS-BC, FAAN
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This book is dedicated to the practitioners and students of nursing who seek to improve the health care environment. It is through your curiosity, perseverance, and advocacy that the world we know will change. We are hopeful that this book will assist you to see what it is, how it will impact your practice, and what may be in the future.

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Preface

As we develop the second edition of this book, the Patient Protection and Affordable Care Act (PPACA), more commonly known as Obamacare, celebrated its seventh anniversary. It had succeeded in providing millions of Americans with health care coverage who were uninsured and changed the landscape of the health care system. In the midst of this change that put major emphasis on health promotion and prevention as essentials, Advanced Practice Registered Nurses (APRNs) made many strides toward full practice authority and these successes continue. This second edition highlights many of these successes. In spite of successes, the "health" care system, which Dr. Loretta Ford addressed in the Foreword of the first edition, is teetering on the edge of reverting to a "sick" system. This is a perfect time and opportunity for nursing to help move health care from a "curative" culture to a true "culture of health" system. Individuals have tasted the benefits of a health promotion/disease prevention system and embraced its tenets. They are ready for more.

The past few years have kindled in the people of the United States and around the world a desire to become involved and speak up, whatever their views may be. In the United Kingdom, Brexit was a good example. In the United States and worldwide, rallies on January 21, 2017, post–presidential inauguration, spoke to a variety of concerns from health care, women's issues, education, human rights, work issues, and the economy, to name a few. The worldwide universality of this outcry was remarkable, and it continues on a local level. Legislators are being bombarded with phone calls, letters, faxes, emails, and demonstrations at their offices and town halls. Technology has made it easier to have one's voice heard but this desire for change comes from within. People want to be heard and impact policy change. Health care is now also at the forefront of these efforts. When looking at rankings for happiness on a world scale and factors that contribute to this, the countries that score near the top in several polls (Bloomberg and the World Economic Forum) all ensure health care coverage for their populations. The United States ranks 28th in the happiness factor in the 2016 World Economic Forum poll, not even near the top 10. Can it be that healthy people are happy, productive people?

People seem to be ready to take more control of their health care and have a need for knowledge and guidance. The second edition of this book continues to investigate how health policy impacts APRN practice and how, through practice,

APRNs can help improve the lives of their patients/clients. In the first section, efforts such as the J & J Campaign for Nursing's Future and the Consensus Model are brought up to date to show the influence they have had on the nursing practice. The Institute of Medicine (now the National Academy of Medicine) report *The Future of Nursing* pushed for nurses to practice to the full extent of their education and progress toward the defined goals is outlined. A new chapter is presented on independent practice with a case study outlining how state legislative rulings can affect practice. The growing success of the Doctor of Nursing Practice (DNP) programs and graduates is discussed, showing the interest of nurses wanting to be involved and take on more responsibility, including health policy change. A new chapter under special populations provides a review of the evolution and impact of genetics and genetics health policy on APRN practice. A new research chapter titled "Connecting Research, the Research Agenda, and Health Policy" discusses how a research agenda can have a powerful influence on health policy from many perspectives. In Unit IV, organizational perspectives on health policy and APRN practice are updated while in Unit V, global perspectives on APRNs and credentialing are provided by international experts showing how advanced practice nurses are faring worldwide. Finally, the current state of practice for each of the APRN roles is presented.

APRNs have played a role in pushing for full plenary authority as well as contributing to changes to the health care system. Some practice efforts have been more successful than others. An example is well described in the last chapter of the book by Zambricki on Certified Registered Nurse Anesthetists' (CRNAs') efforts to gain full practice authority in the Veterans Affairs (VA) system. As she points out, this is not the time to burn bridges, sit back, or slow down. The same waters may need to be crossed more than once! If the health care system is truly to be a patient-centered system, a culture change needs to happen. If it is to be a patient-choice system, individuals need to be aware of the options open to them, educated about their care including health promotion/prevention and the evidence to support this, and be knowledgeable of the consequences of their choices. Who better to play an integral part in making that happen than APRNs and nurses whose education and roles are grounded in health and well-being, and who better to push for policy changes in the health care system that support patient-centeredness, but APRNs? It is uncertain at this time what changes and deletions may be made to the PPACA with the new Congress or how individual states may deal with these changes. It is also unclear how this will impact APRNs and their practice. All the more important then it is to keep up to date about health policy issues, learn how to interact with lawmakers for positive change for our patients and our practices, and become involved. It is only through a concerted, coordinated effort that as APRNs we can help create a health-oriented culture and address the issues of access, quality, and affordability in our health care system.

Hopefully, this book will help the faculty guide graduate students toward a better understanding of the importance of health policy change and its widespread impact and guide students in taking an active role in these changes. **In addition to the book, we have prepared an instructor's manual of PowerPoint slides. Qualified instructors can obtain a copy of these by emailing textbook@springerpub.com.** The timing is right, and people are ready for the change. Let's grab the opportunity and make an impact!

Kelly A. Goudreau
Mary C. Smolenski

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I would like to acknowledge the support and patience of my coeditor, Dr. Mary Smolenski. She has been the strength of this edition, and I so very much appreciate her support during some trying times in my personal life.

To my husband, Serge Goudreau, who has been my personal rock during this past year. Thank you does not seem to say enough . . . but thank you.

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Health Policy and Advanced Practice Nursing: Impact and Implications, Second Edition

UNIT I

Health Policy From an Advanced Practice Perspective

CHAPTER 1

Prolific Policy: Implications for Advanced Practice Registered Nurses

Melissa Stewart

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 Registered Nurses (APRNs) 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. APRNs 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 a 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.

To 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 oneself as not being politically active, one cannot escape the consequences acquiesced to in 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 why 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 1.1 Stages of Policy Development

Stage 1 Policy agenda	Assessment
Stage 2 Policy formulation	Diagnosis
Stage 3 Policy adoption	Plan
Stage 4 Policy implementation	Implement
Stage 5 Policy evaluation	Evaluate

TABLE 1.2 Five Stages of Policy Making Compared With the Nursing Process

STAGE 1 POLICY AGENDA	STAGE 2 POLICY FORMULATION	STAGE 3 POLICY ADOPTION	STAGE 4 POLICY IMPLEMENTATION	STAGE 5 POLICY EVALUATION
Those problems that receive the serious attention of public officials	Development of pertinent and acceptable proposed courses of action for dealing with a public problem	Development of support for a specific proposal so a policy can be legitimized or authorized	Application of the policy by the government's administrative machinery	Efforts by the government to determine whether the policy was effective and why or why not

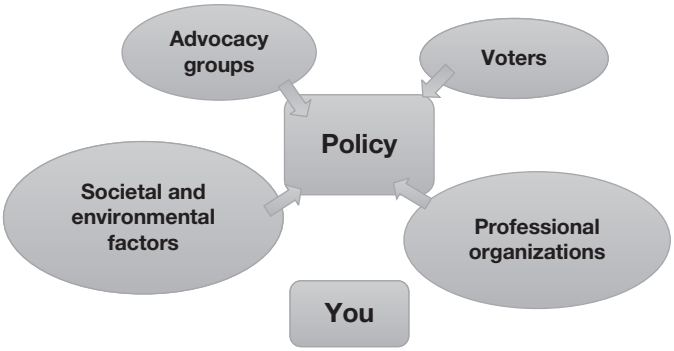

FIGURE 1.1 Drivers of policy.

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 [AANP] 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 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 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 from 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 Congress, it goes to a conference committee to get the modifications added to the original. 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.

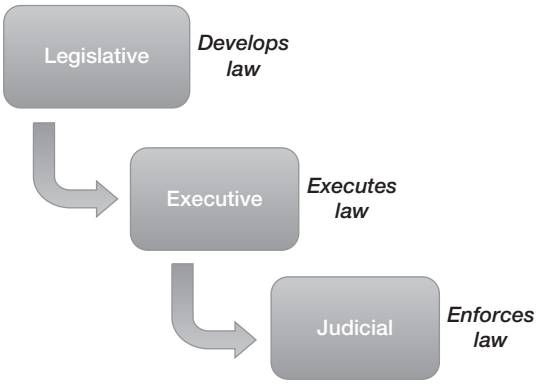

FIGURE 1.2 Point of access for maximum influence.

It is not uncommon, and probably most likely, that organizations and/or lobbyists of special interest groups will try to have as much impact as possible 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 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 (Table 1.3). Although healing related to insult or injury has

TABLE 1.3 Nursing Theorists With a Prevention Focus

THEORIST	THEORY
Florence Nightingale	Environmental theory
Dorothea Orem	Self-care deficit
Betty Neuman	Systems theory
Nora Pender	Health promotion model

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, 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. Barnes et al. (2017) noted that APRNs have 20% higher odds of working in an area of practice that is suffering from provider shortages like primary care when they are reimbursed 100% of the physician fee-for-service rate. 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. Slowly significant policy gains are being made as the AANP publicly identify that 21 states allow APRNs to practice independently to the full extent of their training with unrestricted licensure (AANP, 2016). 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.

RESULT-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. Costs of health care services in the United States continue to soar beyond that of other countries, while U.S. health care consumers continue to experience lower quality in care delivered than that of other industrialized countries (Squires, & Anderson, 2015). It is estimated that by year 2019, health care

spending will comprise 20% of the U.S. gross national product (Alonso-Zaldivar, 2010). The United States also pays far more per capita than any other nation when compared with other industrialized nations, almost 50% more than the next closest country, France, in health care expenditures (Squires, & Anderson, 2015). Health care costs in the United States continue to surpass those of other countries even though fewer Americans are covered in comparison to other countries and Americans consume less hospital and physician visits than other industrialized countries (Squires & Anderson, 2015).

According to National Public Radio, the Robert Wood Johnson Foundation, and the Harvard School of Public Health (2012), a 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; two recent studies have found that approximately one in seven hospitalized patients experiences 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 often 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, Hernandez-Boussard, Banka, and 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 affect 1.7 million hospitalized patients each year (Klevens et al., 2007), or approximately one 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 elevating 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, is 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 on 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