



ANA ISSUE BRIEF

*Information and analysis on topics affecting nurses,
the profession and health care.*

Health System Reform: Nursing's Goal of High Quality, Affordable Care for All

Key Points

Nursing has many opportunities to provide leadership and guidance in a "reinvented" health care system.

Health reform expands access to care by providing coverage to most people who don't currently have it, and protecting those who already have coverage from the abuses of insurers.

The law directs significant new resources to prevention and primary care, quality, care coordination — all which rely heavily on nursing for success.

New workforce initiatives will coordinate effective development & deployment of

Cornerstones of effective reform

For more than two decades, ANA has advocated for health system reform providing high quality, affordable health care for all. After many months of difficult negotiation, federal health system reform was enacted in March, 2010, in the form of The Patient Protection and Affordable Care Act — or PPACA.

The new law roughly follows the key areas that ANA has set forth as necessary for effective health reform; the latest iteration of this policy was ANA's *Health System Reform Agenda* (2008). It employs the following overarching categories:

- **Access to care**
- **Quality care**
- **Cost of care**
- **Healthcare Workforce**

The law secures access to care for most of the 36 million people currently uninsured in the United States. It does so by expanding public coverage programs and strengthening consumer protections in private and public insurance plans.

Highlights of PPACA provisions

The following are highlights of PPACA's provisions. These provide a foundation to build on ANA's success in assuring that nurses' interests — such as education, patient care, the viability of America's healthcare workforce, and practicing to the full extent of their scope -- and their contributions to high quality care are protected and advanced.

Access to care

The law extends health coverage to 36 million more Americans (and legal residents) and protects those who already have coverage from many of the abuses of insurers.



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"The law creates a springboard of quality-based programs and pilots that promise to move the healthcare system forward in how it views allocation of resources and investment."



→ Removes many discriminatory practices that limit access to coverage:

- No discrimination based on pre-existing conditions (including health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability) .
- Insurance rates can only vary based on age, family composition, geographic location, and tobacco use.
- Mental health parity.

→ Increases funding for various care delivery sites and programs, *many of which rely on nurse-centered models of care:*

- Community Health Centers
- National Health Service Corps
- School-based health centers
- Nurse-managed Health Clinics

→ Creates a standard package of essential benefits—minimum level of coverage in individual and small group markets; required of all plans that want to be included in Insurance “Exchange” (or market). *Scope of benefits closely follows ANA’s recommended “essential benefits package.”*

→ Expands Medicaid to all individuals under age 65, at or below 133% federal poverty level (FPL).

Quality of care

While an important feature of health reform is an effort to get healthcare spending under control, the cost of care should not be considered in isolation. It must be discussed in relation to the quality of care achieved. The hard question in health reform asks how much *value* is achieved by each dollar spent. And is value gauged by the benefit to the individual or the group, community or system? These difficult questions have not been completely resolved by PPACA; however, the law creates a springboard of quality-based programs and pilots that promise to move the healthcare system forward in how it views allocation of resources and investment. The new law -

→ Adopts implicitly the 6 requirements for quality care espoused by IOM, and *adopted by ANA*. Care should be: safe, effective, patient-centered, timely, efficient and equitable.

→ Develops a national quality improvement strategy—HHS leads, with consultation from National Quality Forum (*of which ANA is an active member*).

→ Supports comparative effectiveness research. Creates non-profit

“Health reform supports a systems approach to improve care and the workplace, creating opportunity for nursing leadership & research.”

Institute to support, synthesize, engage in and disseminate effectiveness research. Includes evaluation of delivery models, as well as services, items and treatments. *This offers an opportunity to build the evidence base for high quality, cost effective outcomes in nursing-led models of care.*

→ Supports systems approach to improve care and the workplace, *creating opportunity for nursing leadership and research.* New Center for Quality Improvement and Patient Safety, housed in AHRQ, is charged with conducting and gathering research that identifies health care providers (individuals and institutions) that:

- Deliver consistently high quality, efficient health care services; and
- Employ best practices adaptable and scalable across care settings.

→ Provides opportunities for *NDNQI nurse-sensitive measures* to be adopted by HHS. Goal to develop and update provider-level outcomes measures to hospitals, physicians and other providers, such as nurses. Criteria for awarding HHS grants give priority to measures meeting requirements that mirror portions of NDNQI.

→ Creates incentives for benefits design that improves quality, emphasizing nursing’s strengths. Health insurers must report to HHS regarding their plan/benefits designs and reimbursement structures to improve health outcomes by implementing activities such as effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (*all of which require intensive nursing involvement and leadership*).

→ Recognizes and invests in importance of preventive care, wellness programs, chronic disease management and coordination of care (*the provision of which is heavily reliant on nursing*).

- 10% Medicare bonus for primary care providers, including NPs, CNSs and PAs.
- Eliminates cost-sharing for preventive benefits under Medicare, Medicaid, and “Qualified” health plans.
- Invests in National Prevention, Health Promotion and Public Health Council to coordinate federal activities and funding for wellness and prevention; includes responsibility to create national strategy to improve nation’s health.
- Grant programs to support delivery of evidence-based and community-based prevention and wellness services, *typically an nursing stronghold.*

Cost of Care

In addition to evaluating systemic resource allocation for value, PPACA



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creates some basic investments and consumer protections to make sure that all uninsured Americans (and legal residents) have basic health coverage, regardless of their health status or income. Some of the more important of these are:

→ Shared responsibility — individual mandate, coupled with employer “pay or play”; subsidies and expansion of public programs funded by federal and state governments (i.e., taxpayers).

→ Protects from financial ruin as a result of high medical expenses:

- Guaranteed renewal
- No rescissions
- No lifetime or annual limits on coverage or payout
- Maximum cost-sharing ceilings in qualified plans
- Sliding scale subsidies.

→ Premium and cost-sharing subsidies for individuals/families—through the regulated marketplace Exchanges—on a sliding scale, dependent on income, up to 400%FPL.

→ No deductibles or cost-sharing for recommended preventive care—Medicare, Medicaid, and “qualified” plans.

Healthcare Workforce

Title VIII of the Public Health Service Act provides federal support for nursing education and workforce development; however, it has not been nearly enough. ANA has invested significant effort to assure that the new health reform law (PPACA) provides substantial reinforcement of Title VIII priorities for programs that recruit new nurses, promote career advancement, strengthen nurse faculty development, and improve patient access to quality care by directing nurses into service areas of greatest need.

Further, it recognizes that scope of practice barriers need to be removed in order for nurses to provide the full continuum of nursing care in a reformed health system, particularly in the delivery of primary care. It also acknowledges the country’s need for comprehensive, ongoing healthcare workforce planning through a central entity.

→ Authorizes dependable funding stream for Title VIII programs supporting nursing workforce development – includes advanced nursing education grants, workforce diversity grants, and nurse education, practice, quality and retention grants (\$338M in FY 2010; sums “as necessary” through FY 2016).



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→Nursing Student Loans –increases funding

→Enhanced nursing education and training grants and financial incentives for:

- Allied health professionals in underserved areas (loan forgiveness).
- Mid-career healthcare and public health professionals to advance education and training (grants).
- Nursing education and training in pediatric and geriatric specialties, as well as for healthcare professionals willing to serve as direct care workers in long-term or chronic care setting.
- Nursing Faculty recruitment and development –
 - ◇ expands loan repayment and scholarship program to provide loan repayments if student serves at least 2 years as faculty member.
 - ◇ increases federal investment and loan amounts.
 - ◇ extra financing available upon individual spending 4 out of 6 years as fulltime faculty.
 - ◇ priority for doctoral students.
- Grants for facilities to promote nurse career advancement
- \$50M to establish graduate nurse education (GNE) demonstration program under Medicare, for up to five eligible hospitals.
- Nursing schools or facilities that demonstrate enhanced collaboration and communication among nurses and other healthcare professionals.
- Enhancing diversity in nursing workforce

→Models of care delivery emphasize primary care, providing opportunity for nursing leadership and robust contributions:

- Nurse-managed health centers - \$50M in grants for NMHCs that provide comprehensive primary care and/ wellness services to underserved and vulnerable populations.
- Medical homes – authorizes HHS grants for patient-centered medical homes under Medicare:
 - ◇ community-based, interdisciplinary, inter-professional healthcare teams to support primary care;
 - ◇ emphasizes coordination and integration of care and evidence-based healthcare.



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- ◇ available under Medicaid, but called “health home.”
- Accountable Care Organizations (ACOs) – Establishes “shared savings” program where a group of healthcare providers and suppliers contract with one another to manage and coordinate care for Medicare patients;
 - ◇ ACOs which agree to quality performance standards and meet financial benchmarks receive incentive payments based on savings to Medicare;
 - ◇ Only available for Medicare for now, not Medicaid.
 - ◇ “ACO professional,” who can manage or lead the ACO, includes NPs, CNSs and PAs.



Resources

➔ ANA’s detailed analysis comparing elements of *ANA’s Health System Reform Agenda* (2008) and the Patient Protection and Affordable Cost Act (PPACA), as well as other helpful resources, can be found on ANA’s health reform website at: http://www.rnaction.org/site/PageServer?pagename=nstat_HCRT_Resources

➔ Detailed analysis of the entire bill, along with an array of other healthcare analyses and data, may also be found at the excellent Kaiser Family Foundation website at: <http://healthreform.kff.org/>

➔ The Patient Protection and Affordable Cost Act (PPACA) can be accessed in its entirety at the U.S. Government Printing Office (GPO) website online at:

<http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf>

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