Chapter 5

The Economics of Caring for Populations: A Primary Health Care Perspective

Donna M. Nickitas

Chapter Objectives

By the completion of this chapter, you will be able to:

1. Define an economic and social value framework for nursing practice.
2. Discuss the economics of primary health care.
3. Describe examples of innovative care models developed and implemented by the American Academy of Nurses Edge Runners.

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Background

This chapter addresses the economic implications of caring for populations through a nursing social and economic value framework using a primary health care perspective. This perspective addresses the social determinants of health with a focus on underserved and vulnerable populations and espouses that all individuals and communities, but especially vulnerable populations, must have access to affordable health care and opportunities that promote their health and wellness. Improving health care in the United States using this primary health care perspective requires the pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care (Berwick, Nolan, & Washington, 2008). The Institute for Healthcare Improvement (IHI) developed the Triple Aim as a statement of purpose for fundamentally new health systems that contribute to the overall health of populations while reducing costs (Stiefel & Nolan, 2012, p. 2)

For the purposes of this chapter, the term "population" emerges from the work by Jacobson and Teutsch (2012), who describe the useful distinction of a population as total population or a subpopulation. A total population reflects the residents of a geopolitical area in which a subpopulation may reside. Subpopulations consist of groups defined by income, race/ethnicity, disease burden, or served by a particular health system or workforce such as registered professional nurses or advanced practiced nurses. In either case, it is essential to specify the population so that nurses and other health providers work toward fulfillment of the Triple Aim, which includes partnership with communities and populations with the intent of redesigning primary care of population health toward a care model of improved financial management and macro system integration.

The integration of macro health systems will require nurses to have a care perspective that aligns population health care with better health, better outcomes, and lower costs of care. This macro level integration identifies and includes the Triple Aim outcome measures (Stiefel & Nolan, 2012) of health outcomes, disease burden, and behavioral and physiological factors. These measures are important as they address how care is delivered and how outcomes of care are measured. "Nurses are positioned to be at the forefront of crucial healthcare reform to profoundly affect health outcomes and reduce health disparities" (Mahony & Jones, 2015, p. 283).

With adoption of the Patient Protection and Affordable Care Act (ACA, 2010), there is a resurgence of interest in measures that address the social determinants of health (SDH) and how to improve health status (Mahony & Jones, 2015). In fact, Title IV of the ACA mandates improved disease prevention and public health systems, increased access to preventive services, and provisions for healthier communities, with recognition and attention to the SDH. The World Health Organization (WHO, 2015) defines the social determinants as "the conditions in which people are born, grow,

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live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels…"

Addressing the social determinants of health as well as other factors such as poverty, unequal access to health care, lack of education, stigma, and racism provides a greater understanding of how the social determinants affect the health of populations. Nurses must learn how best to understand and recognize the effects of poverty, economic inequities, stress, social exclusions, and job insecurity within populations, especially with those who are medically underserved and most vulnerable (Mahony & Jones, 2015).

When nurses and other health care providers, consumers, and communities are informed and educated about population health, they can transition their focus from federal and state initiatives to local efforts that create conditions for health at their own community level—the level where people work, play, and live. This transition requires a greater understanding about income, education, and where people live as potential predictors of health as well as investing in health care delivery systems that address social determinants of health as a driving force to optimize health, health care quality, and health equity. For example, the Robert Wood Johnson Foundation (RWJF) has made a commitment to advance the nation's health through a movement toward "a culture of health" to address health disparities and health equity specifically within the context of the social determinants of health (Plough, 2014). Developing a culture of health (COH) requires a valuable link between primary health care and population health as well as community services and policies that foster a culture of health. As full partners with physicians and other health professionals in redesigning health care in the United States, nurses play a key role in promoting a culture of health and a steadfast commitment to advancing the nation's health (IOM, 2011).

To improve the health of populations, a framework must be adopted that takes into account the SDH as well as accounting for nursing's economic impact and social values. Using such a framework will achieve the common goals of quality, efficiency, and cost savings in meeting the primary health care needs of underserved and vulnerable populations. For nurses to engage and effectively influence populations, they must be able to assess the effects of SDH and learn how to use this framework to affect the economic and social values of nursing to shape health programs toward population primary health care.

Nursing's Economic and Social Value Framework

Social Value Framework

Nursing's social value can be framed within a primary health care perspective that addresses the social determinants of health and prevents health conditions from developing among underserved or vulnerable populations.

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Embedded in these social values are advocacy, cultural sensitivity, social justice, and a population-focused practice framework aligned with the World Health Organization's (WHO, 2008) call to reduce health disparities as well as with the Institute of Medicine's (IOM, 2012) integration of primary health care. In this social value framework, public health is a shared goal of population health improvement and community engagement to define and address population health needs.

Nurses have strong historical roots in advocacy and action that includes determining how to best distribute resources to populations (Lewenson & Nickitas, 2016). Public health nurses have contributed, and continue to contribute strategically in population-based efforts to enhance care. They use data to influence public policy and have a rich heritage of using such data to improve health outcomes (McBride, 1993). This practice dates back to Florence Nightingale, who demonstrated the relationship between data and improvement in care through statistical analysis and graphic representation (Goldwater & Zusy, 1990). Knowing how to use measurable metrics to drive improvements in population health will fundamentally reshape how care is delivered, including evolving toward value-based payments that increase quality at lower costs.

Nursing's Economic Framework

Today, the majority of health care decisions are best understood as economic decisions or at least as having key economic components (Chang, Price, & Pfoutz, 2001). Nursing's economic value and contribution to utilization costs and payer information cannot be underestimated and has real impact on the financial viability of the health care system. As health care costs increase, and efforts to improve the efficiency and effectiveness of the health care system occur, nurses must have a better understanding of health economics. "Economic value of professional nursing refers to a monetary assessment of the services provided by nurses" (Dall, Chen, Seifert, Maddoox, & Hogan, 2009, p. 97). Each nurse must understand his or her economic value and identify and measure that value within the broader context of nursing's value beyond just reduction in health care spending. It is time for every nurse to become a nurse economist (Nickitas, 2011).

In fact, in her book *Notes on Nursing*, Florence Nightingale suggests that nurses have an obligation to understand the financial aspects of patient care (Chang et al., 2001). They must take into account how their human capital (knowledge, expertise, and skills) contributes to ensuring cost-effective, high-quality care (Patterson, 1992). Furthermore, Keepnews (2013) suggests that an improved understanding of nursing's economic value is a tool for explicating and asserting nursing's broad value, both economic and social. This value is essential for "nursing's identity as a discipline focused on care and compassion and key to the professional's social contract "(Keepnews, 2013, p. 2). However, social values alone are not enough; nurses must have the economic acumen of health care finance and

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understand how the economics of care drive behavior, value, and consumption of health care.

New metrics from electronic health records (EHRs) provide an opportunity to measure nursing care in ways that previously had not been possible. This emerging information across health care settings, from acute care to primary population care in the community, can be used to inform operational and clinical decision-making (Welton & Harper, 2015). Much of nursing care measures, values, and costs remain unknown. For example, in ambulatory or public health in the primary care population model, nursing care costs are captured and subsumed within procedure codes for bundled payment or fee-for-service reimbursement. This means that health insurance and the health care industries seek reimbursement for care when doctors and other health care providers receive a fee for each service (such as an office visit, test, procedure, or other health care service) or by a bundled payment—also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing, or packaged pricing—which is defined as the reimbursement of health care providers (such as hospitals and physicians) on the basis of expected costs for clinically defined episodes of care (Cromwell, Dayoff, & Thoumaian, 1997; Miller, 2009; Satin & Miles, 2009).

Pappas (2013) challenges nurses to ask: Where do we fit in the care value equation, and how will nurses improve overall population health, achieve better experience, and lower cost? "The variation in nursing resources provided are unknown and there is no alignment among nursing direct-care time and costs, billing for nursing services, and payment for care" (Welton & Harper, 2015, p. 14). It is the profession's collective responsibility and effort to describe what constitutes the components of nursing care value and how best to cost out nursing services wherever nursing care occurs. Costing out nursing services will require that nurses master the fundamentals of health care finance.

Health Care Finance

Health care financing is a challenging topic but not impossible to understand. It is essential that each nurse, regardless of his or her position, understands the economics of care and how the Affordable Care Act will affect health care economics. Health economics is defined as a branch of economics concerned with issues related to effectiveness, value, and behavior in the production and consumption of health and health care (Altarum Institute, n.d.). It is important to note that health care production includes both the component of distribution, in this case across populations, as well as resources allocated within the health economy. Thus, within the production process is health care spending. Health spending is a combination of a product of the *price* of health care services and the *utilization* of those

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services. Price and utilization are the key drivers of overall health care spending in the United States.

The United States spent $2.9 trillion on health care in 2013, or about $9,255 per person, according to a new detailed accounting of the nation's health care dollars. "The share of gross domestic product devoted to health care spending has remained at 17.4 percent since 2009. Health care spending decelerated 0.5 percentage point in 2013, compared to 2012, as a result of slower growth in private health insurance and Medicare spending. Slower growth in spending for hospital care, investments in medical structures and equipment, and spending for physician and clinical care also contributed to the low overall increase" (Hartman, Martin, Lassman, Catlin, & National Health Expenditure Accounts Team, 2015, p. 1150).

The Centers for Medicare and Medicaid Services (CMS) estimate that American health spending will reach nearly $5 trillion, or 20% of GDP, by 2021 (Ginsburg et al., 2012). An analysis of Medicare spending from 2000 to 2011 found that in 2011 per capita spending increased with age, from $7,566 for beneficiaries age 70, to $16,145 at age 96, and then declined for even older beneficiaries (Neuman, Cubanski, & Damico, 2015).

Nursing Care and Health Care Spending

Health care spending is being influenced by the delivery reforms as a result of the Affordable Care Act, which is altering care patterns and spending for populations with significant health needs. One of the provisions of the ACA is to develop a national quality improvement strategy that will improve delivery of services and population health outcomes. Nurses are leading with care models and strategies that are improving care management for high-need vulnerable populations by better care management and care coordination, which reduce preventable hospitalizations. Through evidence-based care, improved analytics, and metrics to measure outcome, nurses are controlling cost of care as well as meeting the challenges of economic accountability. The real challenge now is how best to engage, empower, and entrust that each nurse becomes accountable to the economic liabilities of poor care, readmission penalties, and preventable errors such that investment toward quality population primary health care are fully realized and rewarded. Nurses must appreciate how the costs of quality primary health care generate potential savings and sustain population health. The economics of care are built upon an understanding and acceptance that every care encounter is a return on investment in an individual, family, or population's health and well-being.

Nurses have a stake in transforming America's fragmented, expensive, and often inaccessible health care system. The American Academy of Nursing's (n.d.) Raise the Voice campaign has promoted and published primary health care models generated by nurses on their website. These care models have the potential to save the health care system money, reduce adverse

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events, improve patient and population outcomes, and promote health. It is time for a new health care delivery system that focuses on population health and wellness and uses nursing's economic and social value system to shift care away from hospitals and into communities, creating systems where nursing units of service, interventions, procedures, surveillance, and assessments are valued and population health outcomes are improved and adverse events reduced.

In fact, nurses have developed innovative models of care that are adding value to health care by improving financial savings as well as improving quality, safety, and better outcomes for patients, families, and populations in their home communities. Some of these innovative models of care are known as *Edge Runners*, named by the American Academy of Nurses (n.d.) for nurses who were known to develop and implement practice models to promote and manage illness across diverse and underserved populations. Edge Runners have developed care models and interventions that demonstrate significant clinical and financial outcomes. These nurse-led care models are team-based approaches that ensure better health through care coordination. Nurse-led care models improve efficiency through care coordination. The Agency for Healthcare Research and Quality (AHRQ, 2014) defines care coordination as care that deliberately organizes patient care activities and shares information among all the participants concerned with a patient's care to achieve safer and more effective care.

An essential aspect of Edge Runner care models is care coordination, an essential part of professional nursing practice and one of the standards of practice for nurses. It is aimed at providing and managing care needs along the continuum of care and across different settings. Good care coordination supports population primary health care that aligns with the Affordable Care Act by bundling acute and postacute payments and incentivizing value-based care. Incentives for innovation and improvement for care coordination must be recognized. Paying for quality performance is an essential component of the nursing economic framework. To the extent that nurses demonstrate and link quality outcomes to improved care coordination, eliminate error and complications, and eliminate waste, nursing's social value is fully realized. Continued efforts must be made to identify and define both the economic and social value of nursing. Every nurse must recognize the economic and social value his or her clinical practice and stay abreast of health care finance, including how knowledge and practice adds value and provides cost savings.

When nurses are accountable both clinically and economically, they shape their nursing practice models toward improvement and away from financial catastrophe. Clinical care is accountable when population preferences are respectful and responsive to the needs of the populations served. The imperative for nurses is to link population preferences and needs to lower costs.

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Edge Runner Models of Care

The key to lowering health care costs is to provide models of care that improve efficiency and effectiveness in how services are delivered. For care to be truly valued and determined to have economic value within the health care system, it must promote the value of the registered nurse in caring for vulnerable populations and using care coordination. The Nurse-Family Partnership (NFP) and the Transitional Model of Care (TMC) have demonstrated significant economic, social, and clinical value. In both cases, these models have focused on the specialized needs of a population. The NFP is a community-based program, and nurses work with first-time low-income mothers or vulnerable mothers from pregnancy until the child is 2 years old. The NFP programs have spread to 800 cities and towns, reaching more than 115,000 mothers and children (Tavernise, 2015). Nurses make home visits, helping mothers gain the confidence to care for themselves and their child. The NFP has been estimated to save $9,118 per child and as much as $26,298 as a return to society, for a net return savings of $17,180 (Karoly, Kilburn, & Cannon, 2005).

The TMC was developed and implemented by Mary Naylor, PhD, RN, FAAN, of the University of Pennsylvania School of Nursing. It has used advanced practice registered nurses (APRNs) to facilitate transitions across care settings (from in-patient to out-patient/home) successfully to reduce hospital readmissions and lower cost. The TMC is a well-designed approach that delivers care to the right people at the right time to improve outcomes for everyone: patients, providers, and payers. The TMC initially focused on comprehensive in-hospital planning and home follow-up for the population of chronically ill, high-risk older adults who have been hospitalized—as well as their family caregivers. It now has expanded to prevent hospitalization of community-dwelling older adults.

It is important for nurses to appreciate and recognize how nurse-led models of care make a difference. Nurse-led models of care focus on wellness, primary health care, and prevention rather than on traditional acute or episodic care. As health care delivery shifts from fee-for-service models of care to value-based models, nurses are well positioned to use clinical and administrative data to measure nursing care, the quality of that care, and patient satisfaction with that care (Nickitas, 2014). The NFP has effectively harnessed the value of clinical and financial data to illustrate how nurses are tackling important health problems and rigorously evaluating them. This care model demonstrates that nurses are using their economic and social value to drive change toward care, quality outcomes, and equity, and it has caught the attention of President Obama, who has funded the program on a national scale since 2010. Such visiting programs have been paid for through the Affordable Care Act (Tavernise, 2015). These outcomes are addressing the persistently high rates of infant mortality while improving quality of life for mothers and infants, as well as increasing productivity and satisfaction for nurses.

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Population Primary Health Care and the Affordable Care Act

The Affordable Care Act (ACA) has provided unique opportunities for nurses to create models of care that improve the public's health, including provisions that improve access to care and quality care, while controlling costs. There are many new initiatives to expand access to health care coverage and services for tens of millions of Americans. In fact, since the open enrollment period in 2013 for federal and state health insurance exchanges as a provision of the ACA, approximately 16 million Americans gained coverage, and that number is expected to grow to an estimated 30 to 34 million in the next few years (Clipper, 2015).

To promote a population primary care health model, nurses have a moral and ethical obligation to understand the key social determinants of health care and to seek effective ways to distribute resources to populations to meet their primary health care needs. This means addressing care gaps and avoiding service duplication. Population health outcomes have been identified in the ACA for actual demonstration projects that can be adapted as models of care and resonate with a primary health care perspective.

With the insurance expansion and increased access to population primary health care demand, the nursing workforce is well positioned to meet this demand through demonstration projects and primary care initiatives. Advanced practice registered nurses (nurse practitioners, certified nurse-midwives, certified registered nurse anesthetists, and clinical nurse specialists) provide safe, high-quality, effective care. By utilizing APRNs to the full extent of their education and training, nurses can augment the delivery system and transform health care so it is accessible to all, promoting wellness, managing chronic diseases, and improving health outcomes. Increasing access and expanding population primary health care is possible with a nursing workforce that is prepared and oriented toward a value-based health care payment system. A value-based system replaces the traditional fee-for-service system with metrics focused on better care and better outcomes at lower costs.

Advanced practice registered nurses, specifically primary care nurse practitioners (NPs), have the capacity to care for underserved and vulnerable populations. It is important to note that although APRNs contribute high-quality services across the continuum of care, they are not reimbursed or paid at the same service level as physicians. Not all NPs have a national provider identifier (NPI) for billing purposes. The NPI, or the practice of incident of billing, makes it possible to distinguish the services provided by the NP from those provided by the MD. "Under the incident of billing, physicians bill Medicare using their own NPI services that were actually provided by the NP" (Buerhaus, DesRoches, Dittus, & Donelan, 2015, p. 151). For example, nurse practitioners and clinical nurse specialists (CNs) are paid by Medicare at 85% of the amount that would be paid to physicians for the same level of services.

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The payment or reimbursement model is a barrier to APRN practice. It affects both the economic and social value framework of nursing. The Centers for Medicare and Medicaid Services cannot differentiate the incident of billing to NPs, when billed under the MD provider, and are unable to account for the quality and costs of the APRN. APRN services are assigned a lower value than physician services. This barrier raises a problem for Americans who are seeking to enroll in federal and state insurance exchanges as a result of the ACA and gain access to care by APRNs. To change reimbursement policy for APRNs and remove outdated policies by insurance companies will require all professional nurses to be informed and educated about how third-party payers arrange direct reimbursement to APRNs who are practicing within their scope of practice under state law. APRNS deserve to be reimbursed at 100% of the Physician Fee Schedule, especially as expanded access from the ACA brings many more underserved and vulnerable populations to the health care market.

The Affordable Care Act focuses on preventive health care with much attention to supporting primary health care. By law, all citizens must have a primary care provider by 2014 (ACA, 2010). By promoting primary care and a population primary health care model, nurses are at the front line of health care reform. Through population-focused cared, health disparities and social determinants of health can be fully addressed. Underserved and vulnerable populations can become actively engaged in their own care, which in turn increases the effectiveness of the population primary health care model.

Conclusion

From unmet primary health care needs to the high-need, high-cost of preventable hospitalizations, the economic and human suffering of poor access to care to underserved and vulnerable populations where they live, work, and play has enormous financial costs. Clear and abundant evidence shows that primary health care improves overall health and well-being. Targeted application of preventive services, based on unique patient history and evidence-based practice, may be a more cost-effective way to promote health and prevent disease (Goetzel, 2009).

Today nurses are expected to deliver care across different settings, increase patient and provider satisfaction, reduce hospitalizations, and enhance cost savings (Naylor, et al., 2013). To accomplish this, nurses must be ready to step up to the challenge to identify and quantify their economic and social value. There are increasing opportunities to practice at the top of their professional license (IOM, 2011) and to affect the culture of health as never before. The sure way to accomplish this is for nurses to continue to develop and implement models of care that include population primary health care. These models are unique to nursing and focus on improved

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patient outcomes at lower cost. The economics of care for populations supported and embedded in the ACA are for prevention and wellness as well as for improving quality and how health system performance is measured and evaluated. Nurse-led models of care and nurses practicing population primary health care are well positioned to demonstrate quality measures that improve delivery of services, outcomes, and population health. The long-term objective of population health is to leverage nursing practice to places where people live, work, and play to improve quality and safety and to reduce the costs of health care.

Chapter Activities

1. Discuss the impact the ACA has had on nursing practice and be ready to present (or "pitch") this to your colleagues.
2. Reflect on your own understanding of how economics affects primary health care.

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