PART I

Health Care, the Economy and Value-Based Purchasing

CHAPTER 1

How We Got to Where We Are!

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OBJECTIVES

- Understand historically how health policy has developed in this country.
- Describe how access, cost, and quality impact our healthcare payment system in this country.
- Discuss the impact of health policy on healthcare delivery systems.
- Anticipate ways in which the Affordable Care and Patient Protection Act can potentially influence healthcare delivery and outcomes.

How Did We Get into This Mess?

Presently, health care is a wonderful, complicated economic and quality quagmire with many issues requiring our attention. The term *health care* is a misnomer; in the United States, we most frequently address "illness care." We use the term *health care* in this book only because it is the common nomenclature for our illness system. Historically in this country, we have focused on the treatment of illness rather than studying and implementing what brings about good health.

We know that our present piecemeal, *tertiary approach* to illness care has many serious problems. (This is in contrast to an emphasis on *primary care*, as found in Australia, where the majority of healthcare dollars is spent on home visits and keeping individuals well.) Our dubious position as the only highly developed nation that still fails to provide basic health services to all its citizens creates unacceptable disparities in the health of our population, and persistently maintains a fragmented approach to provision of health care. Research on promoting and achieving health is happening, but much larger amounts of money are spent on such pursuits as treating cancer, heart problems, and strokes—the leading causes of death—*after* they occur rather than on learning *how we can achieve health and promote wellness*.

So, how did we get into this quagmire? Examining our path can give us a better understanding of the present situation and unresolved dilemmas and offers us some idea of what may come next.

Collectively, the rules and regulations that define who gets which healthcare services, who can deliver them, and how those services are paid for are the core of the health policies that continuously affect every citizen's well-being. The World Health Organization (WHO) defines health policy as

> ". . .decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people."

These decisions include those of the executive, legislative, and judicial branches of government. Over time, a number of partially successful attempts to repair the healthcare system in our country have occurred through the development of policies at all levels of government. However, they often address specific, isolated problems rather than creating a well-coordinated system that makes health care accessible and affordable to everyone.

Healthcare policies in the United States attempt to address three specific aspects related to public health concerns: (1) *access* to healthcare services, (2) *cost and cost control* of healthcare services, and (3) *quality of care* available to the population. The remainder of this chapter examines the development of healthcare policies that address these three concerns.

Foundations of Health Care: The Early Days of Our Country

Early in this country's history, care was provided by women in the family who tended to the health needs of relatives in the home. There was no formal education or training for these women. Instead, they relied on their personal knowledge and experience. If they received any education or training at all, it was from other family members or neighbors who were "healers," or if they could read, they learned about it from books.

Physicians, if available, were consulted in more complicated or extreme medical situations, and home visits were the norm. Formal medical education was not accessible until the

1800s. A person could become a physician by apprenticing with another practitioner, and little scientific basis for the profession existed. There was no mechanism for testing competence, and licensure was not a requirement to practice.

Health care was a private matter, paid for by patients or their families with cash or barter. There was no regulatory interference or supportive services from federal, state, or local governments to protect and improve people's health. As our nation matured, governmental regulation of many aspects of health-related issues occurred. Over time, our governments became more and more involved in ensuring public well-being through the following:

- Regulations about the direct provision of health care through agencies and hospitals
- The promotion of sanitation and the prevention of epidemics through formal public health departments
- Health professions education and licensing, especially for physicians and nurses

Eventually, as presented in the following sections, governments became involved not only in the regulation of, but the actual payments for, healthcare services.

The development of the public health system serves as a good example of the gradually increasing governmental regulation of health-related issues. The origins of the Public Health Service date back to 1798 when Congress passed An Act for the Relief of Sick and Disabled Seamen. Public health activities first began in larger cities in the early 1800s with the dramatic increase in immigration into the United States. The main focus was sanitation and prevention of epidemics of smallpox, typhoid fever, tuberculosis, and diphtheria, among other highly contagious diseases. Regulations were concerned with waste removal, swamp drainage, and street drainage. If epidemics occurred, homes or ships would be quarantined. As immunizations were developed, public health officials got involved with administering them. The first state board of health was formed in 1869 in Massachusetts. By 1900, each state had a board of health that worked on the preceding issues with local boards of health. Today, myriad public laws and regulations affect people's health, and departments of health at the national, state, and local levels assess health needs, monitor compliance with health regulations, and implement programs to improve the public's health.

Policies Addressing Access to Care

Access, or the *availability of care*, is a huge issue in the U.S. healthcare system. And, while legislation has been enacted to improve access of care, the problem is one that is growing rather than shrinking. The Institute of Medicine (IOM) (1993) defined access as the timely use of personal health services to achieve the best health outcomes. Access is not just about the ability to pay, however. Access also includes effective and efficient delivery of healthcare services, meaning that the services need to be culturally appropriate and geographically available, as well as delivered at a cost the user can afford.

Our system is unique in the developed world in that we do *not* systematically provide access to basic healthcare services for the entire population (*primary care*). One key factor in gaining access to services in this country is the ability to pay for them. The greatest contributing factor for access to healthcare services and getting recommended care is the availability of health insurance.

As of 2012, Medicare and Medicaid, federal and state policies that provide health programs, pay for various kinds of care for 32.2% of our citizens. The Indian Health Service offers basic health care to Native Americans living on reservations. Private insurance, most commonly obtained through employers with costs shared between employers and employees, covers 55.1% of the U.S. population, although many find themselves "underinsured" when it is time to pay the healthcare bills. Those individuals who have no healthcare coverage at all are left to pay healthcare bills directly, from their own pockets, or to seek care through safety net providers such as free clinics, rural health clinics (RHC), or federally qualified health centers (DeNavas-Walt, Proctor, & Smith, 2012). However, since the implementation of the Affordable Care Act, known as ACA and "Obamacare," the rate of uninsured citizens has dropped from 15.7%, or 48.6 million individuals in 2010, to 10%, or 32.9 million individuals in 2014.

Access to Direct Services: Hospitals and Beyond

Access to care beyond that available in the home was addressed by:

- Creating hospitals, nursing homes, and in-home care programs by trained nurses. Hospitals and nursing homes existed in the early 1800s, but in those days they existed on voluntary charitable contributions and served the indigent.
- Quarantine hospitals, opened and closed sporadically by public health officials to deal with epidemic diseases such as smallpox, yellow fever, or, later, tuberculosis.
- Access to health care for the wealthy who could pay for the services (i.e., hiding a family member with a psychiatric illness in an insane asylum).

By the mid-1800s, hospitals, for better or worse, became accepted as tertiary treatment centers for all types of diseases. Instruments such as the stethoscope, thermometer, sphygmomanometer, and microscope were introduced; air was viewed as a disinfectant, so good ventilation became important; antiseptic and sterile procedures were gradually introduced; better ways had been discovered to manage pain in surgery; and, later, the x-ray was invented.

In the early 1900s, visiting nurse agencies were started, especially in larger cities, to make health care more accessible for primarily poor residents. If able, clients paid a small fee for services provided. These services were financed, in part, through raised funds to support their work with the poor. Public health departments broadened to include maternal and child services and, in the slums of large cities, to detect tuberculosis (which had become the leading cause of death) and to control then-named venereal disease. In 1935, federal monies were made available to strengthen the work performed by local and state public health departments.

The Social Security Act

A major societal shift occurred in 1935 with the passage of the Social Security Act, which dramatically affected health care in the midst of the Depression. Until this event, local and state governments, individuals, and families had been responsible for providing healthcare services for the poor. In a landmark legislative effort, the Social Security Act shifted that responsibility to the federal government. Although not specifically intended to provide healthcare services, the Social Security Act provided funds for health-related programs for the poor in areas such as public health, maternal and child health, crippled children's programs, and benefits for elderly adults and disabled individuals.

The Social Security Act also dramatically affected the nursing home industry. This Act specified that money be given to private nursing homes but excluded public institutions (this latter exception was later repealed). Thus, for-profit and proprietary nursing homes (those privately owned) proliferated to serve the welfare patient. These homes gave first priority to paying patients because the government reimbursement was substantially lower than fees for services. (Sound familiar?)

Healthcare Access Changes Post–World War II

Our healthcare system, as we know it today, emerged after World War II. Through funding from the 1946 Hill-Burton Act, government money was made available to build hospitals, as more medicines, anesthesia agents, and technologies became available. National legislation emphasized *secondary/tertiary care*—highly technical hospital-based care, rather than *primary care*—defined as preventive, restorative, or medical treatment given while the patient lives at home. Hill-Burton funds focused especially on building hospitals in rural areas, creating geographical access to services that had not previously been available. Hill-Burton also required state-level planning for healthcare services.

Psychiatric treatment also changed dramatically. With the advent of psychotropic medications, more psychiatric patients could be treated in outpatient settings. In 1963, the federal government established community mental health centers for this purpose. Thus, many psychiatric patients who had been hospitalized for years were able to leave the hospitals and function in the community setting. Unfortunately, those who were more severely mentally ill suffered greatly because less money was available for their care.

Medicare and Medicaid: New Forms of Access

Until 1965, the federal government financed little in the way of direct healthcare services, concentrating only on public health issues and providing services for military personnel and Native Americans. Less than half of elderly adults and disabled Americans had health insurance. State and local governments established and supported special facilities for mental illness, mental retardation, and communicable diseases such as tuberculosis.

Then, in a wave of entitlement programming, the federal government became enmeshed in health care by establishing Medicare and Medicaid. Naturally, this Social Security Act Amendment (Titles XVIII and XIX) benefited elderly adults and poor persons and gave them more access to health care, but providers—hospitals, other healthcare organizations, physicians, and even suppliers and the building industry—benefited as well. Medicare often became *the largest source* of revenue for healthcare providers, resulting in the building of more hospitals and the expansion of long-term care programs. As more personnel were needed for the expansions and new buildings, additional federal programs were funded to supply more physicians, nurses, and allied health professionals.

Although Medicaid was (and is) particularly fraught with tension between federal regulators and states where the plan is administered, both Medicare and Medicaid opened previously unavailable access to elderly, disabled, and poor individuals. Both Medicare and Medicaid pay for hospital and long-term care, primary care, and some preventive services.

Medicare induced significant changes in long-term care. The federal government redefined who was eligible to care for Medicare patients by establishing care standards and requirements for skilled nursing facilities (SNF) and intermediate care facilities (ICF) that raised the level of care available to the public.

Medicare and Medicaid also infused the home health industry with money to expand agencies and services. Whereas there were approximately 250 home health agencies in 1960, by 1968 there were 1,328 official agencies providing home health services. Federal funding over the next 20 years gradually refocused home health on postacute services. Unfortunately, money became less available for the chronically ill client who needed longer-term services. Services also changed in the home health industry as home health funding began to include rehabilitative services—physical therapy, occupational therapy, speech therapy, and social work services. This continues today.

In 1965, the Older Americans Act mandated and funded Area Agencies on Aging (AAA). These agencies fund a wide array of services for elderly adults including:

- Senior centers with nutrition and recreation programs
- Health promotion and screening programs
- Mental health evaluation and treatment
- Respite care
- Case managers to plan care for elders so that they can stay in their homes rather than be institutionalized
- Services to the homebound, such as meals, homemaker services, chore services, and transportation

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In 1980, the Omnibus Budget Reconciliation Act aided home care by expanding Medicare benefits to 100 visits per year and lifting a 3-day hospitalization requirement. For the first time, for-profit home care agencies could become Medicare-certified providers. In addition, advanced technology, such as ventilators, renal hemodialysis, and infusion therapy—originally found only in hospitals—all moved into the home, expanding the need for a home care nurse. This need was coupled with prospective payment for hospitals and resulted in earlier discharges and greater use of home care. The number of home care agencies increased exponentially. Battles ensued in response to the escalating cost of home care, and in 1984, visits were restricted to the homebound client. Later, after a 1989 court ruling (*Duggen v. Bowen*), eligibility requirements were eased once again.

Because Medicare standards required hospitals to renovate and rebuild in the 1970s, for-profit hospitals, like many other businesses, began to offer publicly traded stocks. Stockholders expected these hospitals to make a profit so stocks would increase in value and provide good dividends. In this arrangement, hospitals had to pay attention to stockholder interests. The profit-making motive applied to not-for-profit hospitals as well. They had to make profits too—using the money for pay increases, new equipment or building projects, and investments—but called it *excess of revenue over expenses* rather than profit. Investor-owned nursing homes and home care facilities also increased, creating access for those with private or public insurance.

The Medicare Pharmacy and Modernization Act of 2003 provides Medicare participants with access to coverage for prescription drugs. Coverage, which started in 2006, is provided through private standalone prescription drug plans or Medicare Advantage prescription drug plans administered by approved insurance companies. Prior to this act, Medicare beneficiaries had no prescription drug coverage.

Since that time, beneficiaries have seen their premiums and copays rise and have experienced closer monitoring of their utilization management. Although Medicare drug legislation has certainly provided relief for the costs of drugs, especially for lower-income beneficiaries, all beneficiaries experience a gap in coverage, often called the "doughnut hole." When Medicare recipients reach a level of spending on prescriptions (adjusted yearly), coverage stops completely and resumes when the individual spends a ceiling amount (also adjusted yearly). This means that beneficiaries with a limited income or no *gap insurance* may have limited access to needed drugs for a substantial portion of the year, with higher-spending (sicker) beneficiaries reaching their spending cap earlier (Stuart, Simoni-Wastila, & Chauncey, 2005).

This spending gap resulted in serious health consequences for Medicare beneficiaries, along with costs of more than $100 million a year in preventable hospitalizations (Morrison et al., 2012). The Affordable Care and Patient Protection Act (ACA), signed into law in March 2010, includes provisions to address the coverage gap and maintain quality outcomes for chronic illness. The U.S. Department of Health and Human Services (DHHS) reports that, as of 2012, seniors had already saved more than $4 billion in prescription drug costs as a result of the coverage assistance provided by the ACA (U.S. DHHS, 2012).

Safety Net Providers

Safety net healthcare services have gradually emerged in an effort to fill the care gaps in our system. These include services for underserved and uninsured rural and inner-city populations, non-English-speaking immigrants, homeless persons, and migrant workers. Two examples of legislated support for the poor and uninsured can be found in the clinics and services targeted toward these populations.

The Community Health Center (CHC) Act, passed in 1965, provided funds for comprehensive health and supportive social services to be provided through clinics established to make primary care available to specific types of populations in the clinic's service area. CHC are funded through federal grants available through the U.S. DHHS and operate under specific rules and conditions. They are required to provide services to anyone who needs access, regardless of the person's ability to pay.

The Rural Health Clinic (RHC) Act, passed in 1971, established higher rates of Medicare and Medicaid payments to rural primary care practices, provided that they employ a nurse practitioner (NP) or physician assistant and meet the qualifications for federal approval as a RHC. RHCs can be free-standing clinics or can be associated with a rural hospital or nursing home. Although there are no specific requirements to provide care to the uninsured, most RHCs do strengthen the rural safety net beyond just Medicare and Medicaid patients.

As the movement toward advanced nursing practice gained momentum, schools and colleges of nursing established primary care and nursing practice centers and community health services, collectively known as *nurse-managed care*. Community nursing centers (CNCs), community nursing organizations (CNOs), and nursing health maintenance organizations (HMOs) have been sponsored by local communities, community groups, and churches, and also by university schools and colleges of nursing that provide the majority of these access points. Most nursing centers provide care to poor and underserved population groups (Harris, 2009). Many of these centers are also partially supported on the federal level by the Division of Nursing located within the DHHS, Health Resources and Services Administration, Bureau of Health Professions. Nursing centers are specifically targeted for funding in the ACA and should see the benefit of this funding in coming years.

Policies Addressing Cost

Cost, and controlling the cost of providing care, is one of the most perplexing issues facing the U.S. healthcare system today. The *cost* of health care can be defined as *the value of all the resources used to produce the services and expenditures* and refers to the amount spent on a particular item or service (Andersen & Davidson, 2007). Both cost and controlling cost are important concepts, but expenditures are more easily measured and tracked and thus are more commonly used to analyze financial aspects of the healthcare system.

Consumers and third-party payers have seen consistently higher rises in healthcare costs and expenditures than in other segments of the economy, with rates of increase slowing slightly for the past few years but continuing to rise (Rice & Kominski, 2007; Rice, 2007). Given that U.S. healthcare spending grew 5.3% in 2014, reaching $9,523 per person, insurance companies, employers, federal and state governments, and users of direct healthcare services are all vitally interested in payment systems and cost control.

Blue Cross/Blue Shield: Setting Trends in Paying for Care

The emergence of health insurance was a significant change in healthcare financing, moving payment for health care from personal business transactions to a third-party mediator. Initially, insurance coverage was created either to provide health care for people involved in rail or steamboat accidents or for mutual aid where small amounts of disability cash benefited members experiencing an accident or illness, including typhus, typhoid, scarlet fever, smallpox, diphtheria, and diabetes.

Then, in 1929, Justin Ford Kimball established a hospital insurance plan at Baylor University in Dallas, Texas. He had been a superintendent of schools and noticed that teachers often had unpaid bills at the hospital. By examining hospital records, he calculated that "the schoolteachers as a group 'incurred an average of 15 cents a month in hospital bills. To assure a safe margin, he established a rate of 50 cents a month.' In return, the school teachers were assured of 21 days of hospitalization in a semiprivate room" (Raffel & Raffel, 1994, p. 211). This was the beginning of the Blue Cross plans that developed across the country. Blue Cross offered *service benefits* rather than a *lump-sum payment*—also called *indemnity,* the type of benefits offered by previous insurance plans.

Following the success of Blue Cross, in 1939 the California Medical Association started the California Physicians Service to pay physician services. This became known as Blue Shield. In this plan, doctors were obligated to provide treatment at the fee established by Blue Shield, even though the doctor might charge more to patients not covered by Blue Shield. Blue Shield was, in effect, for people who earned less than $3,000 a year. In one of many unsuccessful attempts at national healthcare reform, physicians designed and agreed to this plan to *prevent the establishment of a national health insurance plan.*

While Blue Cross was quite successful, Blue Shield was not. As inflation occurred and patients made more money, the base rate was not changed, so fewer people were eligible for the Blue Shield rates. "Blue Shield made the same dollar payment for services rendered, but because the patient was above the service-benefit income level, the patient frequently had to pay an additional amount to the physician" (Raffel & Raffel, 1994, p. 213).

After World War II, private insurance companies proliferated and offered health insurance policies both to individuals and to employers. Large employers were expected to offer employees healthcare benefits due in large part to unionization. Health insurance became an *entitlement*. Soon private insurance companies (third-party payers) enrolled more than half the U.S. population. The McCarren-Ferguson Act of 1945 "gave states the exclusive right to regulate health insurance plans. . . . As a result the federal government has no agency that is solely responsible for monitoring insurance" (Finkelman, 2001, p. 188).

The Federal Role in Cost Containment

To administer the complex Medicare and Medicaid programs that had been established, the federal government initiated the HCFA, now called the Centers for Medicare and Medicaid Services (CMS), within the DHHS. Payment for Medicare and Medicaid services was based on the *retrospective* cost of the care—figured and billed to the government by healthcare organizations and by physicians seeing patients. This fee-for-service system did not limit what providers could charge for their services, and initially there was no systematic approach to fees: Providers charged what the market would bear. In the 1970s, faced with escalating healthcare expenditures, states began controlling the amount they would pay to a provider for a particular service. The rationale for setting rates that would be paid was to encourage providers to voluntarily control the costs of the care they delivered.

The federal government, along with states, was spending a tremendous amount of money on health care. In fact, the gross domestic product (GDP) for health care has grown from 6%, when Medicare and Medicaid were introduced, to 17.8% as of December 2016. To find money to support these programs, the government was faced with increasing taxes, shifting money from other services such as defense or education, or curbing hospital and physician costs. Curbing costs was the first choice for policymakers.

Hospital Prospective Payment: A New World for Hospitals and Providers

The next direct step by the federal government to control healthcare costs, particularly those generated in hospital settings, was the implementation of a *prospective* pricing system for Medicare patients. As previously noted, prior to this hospitals and providers simply billed Medicare for their services and were paid in full. In 1983, the Health Care Financing Administration (HCFA) implemented a plan to pay a set price to each hospital for each diagnosis regardless of how much the facility actually spent to provide the care. This payment strategy was called *diagnosis-related groups* (*DRGs*). If hospital staff could provide care for a patient with a hip fracture, for example, at less than the DRG payment, they could keep the money and, in a sense, make a profit. If the cost of care for the patient went above the DRG payment, the hospital lost money. DRGs required hospitals to become more efficient and aware of costs. Yet, the requirements of the DRG policy induced providers to release patients from the hospital as quickly as they could and to shift costs to other third-party payers who did not engage in prospective payment (e.g., home health agencies, SNF), leaving doubt as to the "bottom line" in cost savings to the healthcare system overall.

Prospective payment was expanded in 1989 to include physician services outside the hospital with the introduction of the *resource-based relative value system* (*RBRVS*). This policy, through Medicare Part B legislation, applied the same concept as hospital DRGs to the outpatient setting. Two goals of RBRVS were to control costs and to put more emphasis on primary care and prevention.

Health Maintenance Organizations

In another attempt to hold down healthcare costs, the Health Maintenance Organization Act of 1973 provided federal grants to develop *HMOs*. This act required employers with more than 25 employees to offer an HMO health insurance option to employees. HMOs had a good track record of bringing down healthcare costs because they had traditionally been serving younger, healthier populations. Thus, starting more HMOs sounded like a way to cut healthcare costs. This act provided a specific definition of what an HMO was and gave the states oversight (or licensing) responsibility.

The concept of *managed care*, as delivered by HMOs, has taken hold in the public sector as well. Both Medicare and Medicaid (in many states) have taken their own steps to promote managed care by contracting with private insurers or HMOs to take on the primary care of groups of people enrolled for healthcare coverage and to serve as gatekeepers to specialty services. These measures were intended to control healthcare costs for federal and state governments and to improve the quality of care. In actual practice, results have been mixed as the costs of health care continue to climb.

The Health Insurance Portability and Accountability Act of 1996

The *Health Insurance Portability and Accountability Act* (*HIPAA*) addresses several significant issues including access, quality, and cost. Major portions of HIPAA address the financing of health care. This act "establishes that insurers cannot set limits on coverage for preexisting conditions, . . . guarantees access and renewability [of health insurance], . . . [and] addresses issues of excluding small employers from insurance contracts on the basis of employee health status. In addition the law provided for greater tax deductibility of health insurance for the self-employed" (Finkelman, 2001, p. 192).

HIPAA started the *medical savings accounts,* a tax-free account provided by employers. Here the employee can annually set up an account and pay in the amount of money the employee expects to have to pay for health coverage for the year. The money paid into the account takes place before taxes are taken out by the employer. At the end of the year, if the money is not spent, it goes back to the employer.

The Balanced Budget Act of 1997

The *Balanced Budget Act (BBA)* significantly lowered payments for psychiatric care, rehabilitation services, and long-term care. Because ambulatory services, SNFs, and home care services were rapidly expanding and costing more healthcare dollars, the idea was to curb spending by placing these services under prospective payment. *Prospective payment* means that the payer (led by Medicare and Medicaid) determines the cost of care before the care is given:

- The provider is told how much will be paid for the given care.
- An *ambulatory payment classification system* was created, establishing a fixed dollar amount for outpatient services diagnoses.

- SNF experienced prospective payment through the *resource utilization group* (*RUG*) system.
- Home care was regulated by the *Outcome and Assessment Information Set* (*OASIS*) system.

BBA mandated payment reductions limiting DRG and RBRVS payment rates (as described previously), as well as reduced capital expenditures, graduate medical education, established open enrollment periods and medical savings accounts for Medicare recipients. Benefits for children's health care were increased through the creation of the Children's Health Insurance Program, more commonly known as CHIP, that "expands block grants to states increasing Medicaid eligibility for low-income and uninsured children, establishing a new program that subsidizes private insurance for children or combining Medicaid with private insurance" (Finkelman, 2001, p. 398). BBA also created new penalties for fraud.

BBA had a major impact on health care, causing a number of hospitals, long-term care facilities, and home care companies to fold. Profit margins were drastically reduced, and rural hospitals were disproportionately affected. This act encouraged *outsourcing*, the act of obtaining services (contract labor) from outside of the organization, a practice that continues today (Roberts, 2001). BBA had such profound cost-cutting effects that in December 2000, Congress passed relief legislation providing additional money for hospitals and managed care plans.

Another positive aspect of the BBA was a major impact on recognition of the nursing profession. Under BBA, NPs and clinical nurse specialists (CNSs) practicing in any setting could be directly reimbursed for services provided to Medicare patients at 85% of physician fees. This occurred to both better serve populations not receiving medical care and to save costs because studies had determined that NPs could deliver as much as 80% of the medical care at less cost than primary care physicians could with comparable, and sometimes better, clinical outcomes. This federal legislation overrode state legislation that, in some cases, required NPs to work under direct physician supervision, with reimbursement made only to physicians. This act was reauthorized in 2009, after a long battle in Congress.

Policies Addressing Quality

Quality in health care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes" (Andersen, Rice, Kominski, & Afifi, 2007, p. 185). Quality of care, measured in patient or population outcomes, is now considered to be the result of the entire system of care. In many cases, aggregate results of care are public information and are readily available on the Internet (see, for instance, www.medicare.gov/hospitalcompare).

Throughout the development of our healthcare system, the quality of care has been assumed to be the business of individual providers, such as physicians and nurses, and specific delivery institutions, such as hospitals, long-term care facilities, and home health agencies. The blame for errors and the praise for cures were held to be between the provider or agency and patient. Outcomes of care were not collected or measured by any external, governmental organization. This is not the case today, however.

The quality care movement began in the 1980s but took a strong hold in the 1990s. In 1999, the Institute of Medicine released a shocking report, *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000; Richardson & Briere, 2001). This report identified multiple systematic failures in the process of delivering care. It was followed in 2001 by a second hard-hitting report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, that provided specific recommendations for improvement of quality and safety. These two documents confirmed what quality experts had been saying: *Despite the enormous cost of health care in the United States, tens of thousands of patients are injured or die as a result of errors in the course of receiving care.* Yet, despite the research and the number of patient safety initiatives intended to reduce the number of preventable deaths due to medical errors, researchers have suggested that as many as 400,000 patients die from medical errors each year while patients in our hospitals (Leger & Phillips, 2016).

In the case of quality, a mix of public policymakers and private foundations and organizations is concerned with promoting and monitoring quality across the healthcare system. The quality movement goes much further than specific clinical outcomes, although these are critically important. Outcomes of personal, emotional, or social importance to patients are also developing, such as *patient satisfaction* or *quality of life* indices. Policy decisions at the federal level have shaped current efforts to ensure that the highest quality of care possible is provided in our healthcare system. Through ACA, these outcome measures are also used as key metrics in determining hospital reimbursement rates by CMS:

- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing (VBP) Program
- Hospital-Acquired Condition (HAC) Reduction Program

Governmental Agencies Concerned with Quality

The DHHS is the overarching federal administrative agency concerned with monitoring the quality of health care in the United States. Several components of the DHHS infrastructure assume national leadership and focus on quality issues. For instance, the Agency for Healthcare Research and Quality (AHRQ) engages in testing and reporting safety improvement strategies and makes available significant research awards to determine the best evidence for safe and effective practice guidelines. Another activity of the AHRQ is reporting disparities in health services based on race, ethnicity, and socioeconomic status. AHRQ also houses the National Clearinghouse for Quality Measures, where standards and processes for measuring healthcare outcomes can be found. The AHRQ website (www.ahrq.gov/qual/measurix.htm) offers a wealth of information on measures used to assess quality in health care. AHRQ issues two reports annually to describe the quality of health care in the United States, the *National Healthcare Quality Report* and the *National Healthcare Disparities Report*, both available at the AHRQ website. AHRQ now focuses extensively on comparative effectiveness research to determine the effectiveness, benefits, and harms of different procedures, medications, and treatments in improving health outcomes. Existing and new data are examined to recommend best practices based on scientific evidence (AHRQ, 2013). Comparative effectiveness research will be increasingly important as issues of access, cost, and quality are debated.

The Centers for Disease Control and Prevention (CDC) is also concerned with safety and quality. One focus of the CDC is the promotion of health information technology systems to reduce human error. Another is the collection of disease surveillance data that track both chronic and acute infectious diseases in the private sector and in health departments. Much of the quality data is housed at the Division of Healthcare Quality Promotion, whose mission is to protect patients and healthcare personnel and to promote safety, quality, and value in the healthcare delivery system. This division has three branches that are directly linked to quality: the Epidemiology and Laboratory Branch, the Prevention and Evaluation Branch, and the Healthcare Outcomes Branch. The CDC website provides substantial information (www.cdc.gov).

The U.S. Food and Drug Administration (FDA) promotes quality and safety outcomes through improving regulations for packaging and labeling of drugs and by maintaining strict reporting requirements. In addition, the FDA is responsible for the regulation of biologics, cosmetics, medical devices, radiation-emitting electronic products, and veterinary products.

CMS plays a significant role in transforming healthcare delivery and financing from volume-based to value-based payments (American Hospital Association, 2011). CMS collects, monitors, and reports patient and process outcomes of the healthcare system. These performance measures are used by insurers to determine reimbursement. Hospitals technically volunteer to report critical quality outcomes. Financial incentives are offered through the Medicare program to hospitals that report their outcomes on quality measures on a public website (www.cms.gov). A financial disincentive is levied against eligible hospitals that choose not to participate and contribute data. CMS publishes hospital outcomes, as well as outcomes from nursing homes, on its website Hospital Compare (www.medicare.gov/hospitalcompare). Other agencies and organizations publish data on health plan outcomes, medical group outcomes, and selected outcomes by individual physicians.

CMS introduced what is commonly termed "pay for performance" strategies. For the fiscal year (FY) 2016 HAC Reduction Program, hospitals are expected to prevent the development of eight iatrogenic conditions, including:

- Pressure ulcer
- Iatrogenic pneumothorax
- Central venous catheter-related bloodstream infections
- Postoperative hip fracture (falls with injury)
- Perioperative pulmonary embolism or Deep vein thrombosis
- Postoperative sepsis
- Postoperative wound dehiscence
- Accidental puncture or laceration

These conditions are commonly called "never events," meaning they should never occur under any circumstances. Medicare no longer pays for extended hospital stays or treatment for preventable complications if they occur during the patient's hospital course. Several of these conditions (pressure ulcers, falls with injury, and vascular catheter infections) are presumed to be directly attributable to nursing care (Buerhaus, Donlan, DesRoches, & Hess, 2009). Therefore, nurses—especially nurse leaders—are in a key position to lead improvement in this quality endeavor.

The Affordable Care and Patient Protection Act

The ACA, enacted on March 23, 2010, is the most sweeping healthcare legislation since the inception of Medicare and Medicaid in 1965. Numerous attempts have been made to reform U.S. health care, but the ACA is the first to attempt to accomplish this overarching objective. It was passed after a hard-fought battle that extended from the 2008 presidential campaign into President Barack Obama's first months in office. The political battle to repeal and replace ACA is ongoing as evidenced by the recent failure of the proposed American Health Care Act (https://www.congress.gov/bill/115th-congress/house-bill/1628) in March 2017.

The overall goals of the ACA are to strengthen and systematize U.S. health care and to provide near-universal coverage for American citizens and legal immigrants. The legislation is complex and multifaceted—a true attempt at system reform. The ACA seeks to strengthen patient rights and protections, make coverage more affordable and widespread, ensure access to care, and create a stronger Medicare system to care for the growing number of elderly adults in our country. **TABLE 1.1** provides a broad overview of the ACA; a useful, detailed summary of the ACA and its many components can be found at the Kaiser Family Foundation Health Reform website (http://kff.org/health-reform).

TABLE 1.1 Patient Protection and Affordable Care Act (P.L. 111-148)

Overall approach to expanding access to coverage	■ Requires most U.S. citizens and legal residents to have health insurance. Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133% and 400% of the federal poverty level (the poverty level is $19,530 for a family of three in 2013), and creates separate exchanges through which small businesses can purchase coverage. Requires employers to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers. Imposes new regulations on health plans in the exchanges and in the individual and small group markets. Expands Medicaid to 133% of the federal poverty level.
Individual Mandate	
Requirement to have coverage	■ Requires U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty that will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009, the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).
Employer Requirements	
Requirement to offer coverage	■ Assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage, but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit, or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014.) Employers with up to 50 full-time employees are exempt from any of the above penalties.
Other requirements	■ Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

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TABLE 1.1 Patient Protection and Affordable Care Act (P.L. 111-148) *(continued)*

Expansion of Public Programs	
Treatment of Medicaid	■ Expands Medicaid to all non-Medicare-eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL, based on their modified adjusted gross income (under current law, undocumented immigrants are not eligible for Medicaid).
Treatment of CHIP	■ Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extends funding for CHIP through 2015.
Health Insurance Exchanges	
Creation and structure of health insurance exchanges	■ Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
Eligibility to purchase in the exchanges	■ Restricts access to coverage through the exchanges to U.S. citizens and legal immigrants who are not incarcerated.
Qualifications of participating health plans	■ Requires qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
Basic health plan	■ Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133–200% FPL who would otherwise be eligible to receive premium subsidies in the exchange. Individuals with incomes between 133–200% FPL in states creating Basic Health Plans are not eligible for subsidies in the exchanges.
Abortion coverage	■ Permits states to prohibit plans participating in the exchanges from providing coverage for abortions. ■ Prohibits plans participating in the exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Changes to Private Insurance	
Temporary high-risk pool	■ Establishes a temporary national high-risk pool to provide health coverage to individuals with preexisting medical conditions. U.S. citizens and legal immigrants who have a preexisting medical condition and who have been uninsured for at least 6 months will be eligible to enroll in the high-risk pool and receive subsidized premiums.
Medical loss ratio and premium rate reviews	■ Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs, and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011.) ■ Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the exchanges based on unjustified premium increases. Provides grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010.)
Dependent coverage	■ Provides dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment.)
Consumer protections	■ Develops standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment.)
State Role	
State role	■ Enrolls newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinates enrollment with the new exchanges, and implements other specified changes to the Medicaid program. Maintains current Medicaid and CHIP eligibility levels for children until 2019 and maintains current Medicaid eligibility levels for adults until the exchange is fully operational. Permits states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges. (Effective January 1, 2014.)

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TABLE 1.1 Patient Protection and Affordable Care Act (P.L. 111-148) *(continued)*

Cost Containment	
Medicare	■ Restructures payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phases-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provides bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for MA plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modifies rebate system with rebates allocated based on a plan's quality rating. Phases-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Caps total payments, including bonuses, at current payment levels. Requires MA plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning in 2014. Requires the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years. ■ Reduces annual market basket updates for inpatient hospitals, home health, skilled nursing facilities SNF, hospices, and other Medicare providers and adjusts for productivity. (Effective dates vary.) ■ Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year (FY) 2014.) ■ Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012.) ■ Creates an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011.) ■ Reduces Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012.) ■ Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective FY 2015.)
Medicaid	■ Extends the drug rebate to Medicaid managed care plans. (Effective upon enactment.) ■ Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions. (Effective July 1, 2011.)

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Waste, fraud, and abuse	■ Reduces waste, fraud, and abuse in public programs by allowing provider screenings, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of durable medical equipment (DME) suppliers, and enrollment moratoria in areas identified as having an elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develops a database to capture and share data across federal and state programs, increases penalties for submitting false claims, strengthens standards for community mental health centers, and increases funding for anti-fraud activities. (Effective dates vary.)
Improving Quality/Health System Performance	
Medicare	■ Establishes a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves the stated goals of improving or not reducing quality and reducing spending, it develops a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016.) ■ Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of healthcare services, and achieve patient satisfaction. (Effective January 1, 2012.) ■ Establishes a hospital value-based purchasing (VBP) program in Medicare to pay hospitals based on performance on quality measures and extends the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develops plans to implement VBP programs for SNF, home health agencies, and ambulatory surgical centers. (Reports to Congress were due January 1, 2011.)
Primary care	■ Increases Medicaid payments in FSS and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013.)
National quality strategy	■ Develops a national quality improvement strategy that includes priorities to improve the delivery of healthcare services, patient health outcomes, and population health. Creates processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to, and payment under, federal health programs. (National strategy was due to Congress by January 1, 2011.)

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TABLE 1.1 Patient Protection and Affordable Care Act (P.L. 111-148) *(continued)*

Prevention/Wellness	
National strategy	■ Develops a national strategy to improve the nation's health. (Strategy due one year following enactment.) Creates a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in FY 2010) Creates task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment.) ■ Establishes a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010.)
Coverage of preventive services	■ Authorizes the Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011.) ■ Reimburses providers 100% of the physician fee schedule amount, with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. (Effective January 1, 2011.) ■ Provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women. Requires qualified health plans to provide recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
Wellness programs	■ Provides grants for up to five years to small employers that establish wellness programs. Permits employers to offer employee rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.
Nutritional information	■ Requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Other Investments	
Workforce	■ Improves workforce training and development: • Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios to promote training in outpatient settings and ensure the availability of residency programs in rural and underserved areas. Increases workforce supply and the support training of health professionals through scholarships and loans; supports primary care training and capacity building; provides state grants to providers in medically underserved areas; trains and recruits providers to serve in rural areas; establishes a public health workforce loan repayment program; provides medical residents with training in preventive medicine and public health; promotes training of a diverse workforce; and promotes cultural competence training of healthcare professionals. • Addresses the projected shortage of nurses and the retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. Offers grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. Supports the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services.
Requirements for non-profit hospitals	■ Imposes additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limits charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and makes reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Imposes a tax of $50,000 per year for failure to meet these requirements.
American Indians	■ Reauthorizes and amends the Indian Health Care Improvement Act.

A Look to the Future

Issues of access, cost, and quality will remain driving forces in the healthcare world for years to come, and perhaps forever. *Ever-tightening governmental funding and regulations*, such as the value-based reimbursement issues and the requirements of the ACA, force healthcare providers and institutional leaders to pay attention to patient outcomes in ways never before expected.

Our *aging population* of baby boomers, now rapidly retiring, will continue to strain our healthcare system in both private and public sectors. Shortages of healthcare professionals (such as nurses, physical therapists, and, in some parts of the United States, physicians) to care for them, as well as those who are newly insured through the provisions of the ACA, will continue to be a problem. Women especially feel the impact of this because they live longer and possibly face living at the poverty level in their older years. According to March 2015 data from The Kaiser Family Foundation, 91% of the nursing workforce are women and, in the general workforce, earn 77% of what their male counterparts make (Pew Research, 2015). Retirement incomes will continue to reflect this societal problem.

Economic issues continue to plague federal, state, and local budgets as all face major deficits. Increasing taxes has not been popular, although as of 2013 federal taxes have increased. Increased spending cuts are also not popular. ACA creates an additional burden for federal and state budgets, with many state governors working on ways to both cut Medicaid payments and not support ACA requirements for Medicaid (a states' rights issue as yet unresolved).

The effects of the ACA, particularly the impact of accountable care organization (ACOs) and provider payments, will bear watching, especially as they are implemented in safety net and rural areas. Hospital closures in the past have disproportionately affected safety net and rural areas, and it is possible that some provisions of the ACA may have unintended consequences for citizens. As more citizens become insured and seek primary care, a dedicated effort will need to be made to ensure there are enough primary care providers to meet the anticipated needs. Federal laws to ensure the full scope of practice for NPs and other advanced practice nurses may be required to adequately meet patient needs, especially because some states continue to artificially limit advanced practice.

Alternative therapies generally focus on health promotion. In the midst of all the cost-cutting in our illness care system, alternative therapies have been enjoying increased popularity with the American public, even though consumers most often pay out of pocket for the services. As patients visit physicians and receive medications for diseases, they frequently discover this does not cure the problem. In many cases, the medications cause other medical problems. Alternative therapies provide a way to stay healthy, as well as to treat disease, and bring comfort without producing as many side effects and as much pain. These are likely to assume even greater importance in health care in the future.

Another issue affecting our future in health care is the technology explosion. As telehealth capabilities increase, healthcare availability expands to meet the demand, opening the door for increased access to care for selected populations. *Electronic health records* (*EHRs*) have great potential for increasing patient safety and the efficiency of care, and yet present the ethical challenge of protecting patients' personal health information and the cost of implementation is burdensome on healthcare organizations. Facilities that have accepted federal monies for EHR systems will have to meet the federal "meaningful use" requirements (http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives). This is slowly being incorporated into practice settings of all kinds and has significant implications for nurse leaders and providers (Wilson & Newhouse, 2012). In addition, the Internet has vastly improved clinician information on *evidence-based practice*. Consumers continue to access the Internet to research their specific illnesses and determine which providers are most effective. They use this information to evaluate how effectively their provider is determining their care (Meadows, 2001) and will continue to do so with even more frequency in the future.

The science of *genomics* adds a new dimension to health care that looks to have an ever-increasing presence in the future. Currently, scientists have joined forces with private companies that supply enormous funds to map genes. With commercial enterprises involved, it has created great ethical implications because business leaders believe this information can produce future profits.

On one side of the U.S. healthcare landscape are people with excellent insurance, high levels of computer literacy, and life situations that allow them to seek the best care available, wherever it is available. These people will be able to obtain the "personalized medicine" offered by genetic breakthroughs. On the other side of the landscape are the uninsured and those who are losing benefits, such as retirees, who may lack access to such sophisticated technologies. The growing numbers of uninsured and underinsured people, as well as the documented health disparities in health status of racial and ethnic minority populations and all populations living in poverty, will eventually force our legislators to address the inequalities of access and quality of care in our system.

Another contributor to future changes in our healthcare system will be the effects of global warming, magnetic field fluctuations, solar flares, and the earth's poles changing directions. The impact of extreme weather events, including ice-age conditions, heat waves, fires, volcanic eruptions, earthquakes, floods, and storms, is predicted to lead to higher levels of insect- and water-borne illnesses and the reduction of food production and safe drinking water. Healthcare providers will need to address the physical and mental health needs that arise from these conditions (Blashki, McMichael, & Karoly, 2007). Hospitals and other institutional providers will need to be even more focused on disaster preparedness and be ready to deal with increasing numbers of patients needing care for illnesses related to heat exposure and poor air quality (Longstreth, 1999). Drug-resistant organisms are predicted to increase, bringing new challenges in the treatment of infectious diseases, such as with the fungal meningitis outbreak in 2013 and, more recently, the Zika virus outbreak of 2015–2016. These developments require significant adaptation in healthcare delivery and are likely to disproportionately affect children, elderly adults, and poor people.

The problem is that healthcare costs are still high, with many individuals and employers finding health care unaffordable. Recent health policy changes hold promise to better manage healthcare resources but are fraught with political and economic unknowns. This is a time in the development of our healthcare system when nursing leadership is of paramount importance. Nurses represent the lived reality of the system; they see and hear on a daily basis patients' stories of both healing and unnecessary complications. Nursing knowledge and leadership are critical to improving our healthcare system and ensuring access, cost, and quality care for all.

That which is, already has been; that which is to be, already is.

—*Ecclesiastes* 3:15

Summary

Chapter 1 shows how the United States became a tertiary care, illness-based system that often does not meet the needs of our population, even those who are lucky enough to have health insurance. Historically, when people were ill someone in the home cared for them. Amazingly, we are moving back toward that model again. Meanwhile, we can examine how insurance companies surfaced; how Social Security, Medicare, and Medicaid coverage emerged as the most prominent player in health care; how legislation like the Hill-Burton Act drove the healthcare industry to build hospitals and provided money for hospital (tertiary) care rather than for home care; and how value-based reimbursement and prospective payment have affected finances in health care. This has led to an ineffective healthcare system, which probably will not be able to pay for itself in a few years. With the present poor U.S. economy, health care is now at a crisis point. Hopefully, nurses using the knowledge presented here to understand how we got to our present situation in health care, we can more effectively deal with our current situation.

Discussion Questions

1. What implications does CMS pay for performance have for nurse administrators and managers? Why?
2. What changes might you anticipate in your employment setting as the effects of the ACA move forward?
3. What implications do the increasing number of elderly and frail elderly adults hold for nurse leaders across settings?
4. In your opinion, what health policy has had the greatest impact on health care in the United States? Why?

Glossary of Terms

Access the availability of health care to the population; the use of personal health services in the context of all factors that impede or facilitate getting needed care. This includes effective (culturally acceptable) and efficient (geographically accessible) delivery of healthcare services.

Ambulatory Payment Classification System prospective payment system for ambulatory settings giving a fixed dollar amount for outpatient services diagnoses.

Cost the value of all the resources used to produce services and expenditures.

Diagnosis-Related Groups (DRGs) prospective payment plan for hospitals where reimbursement is based on the diagnosis of the patient.

Entitlement what a population expects from government (started in 1935 with Social Security).

Gross Domestic Product (GDP) monetary value of all private or public sector goods and services produced in a country on an annual basis less imports.

Health Insurance Portability and Accountability Act (HIPAA) legislation that ensures that written, oral (telephone inquiries and oral conversations), and electronic (computer or fax) patient health information is kept confidential and private.

Health Maintenance Organizations (HMOs) type of health insurance that provides a full range of integrated care but limits coverage to providers who are employees of or contract with the insurance organization.

Health Policy the entire collection of authoritative decisions related to health that are made at any level of government through the public policymaking process.

Indemnity lump-sum payment for healthcare services based on the retrospective cost of the care.

Managed Care healthcare coverage where insurance companies and Medicare/Medicaid contract with private insurers or HMOs that assume the primary care of groups of people enrolled in a plan and serve as gatekeepers to specialty services. These measures were intended to control healthcare costs and to improve the quality of care.

Outcome and Assessment Information Set (OASIS) prospective payment system for home care.

Outsourcing where another organization that can provide services (such as housekeeping, food service, and groundskeeping) efficiently for a healthcare organization is hired to perform those services.

Primary Care basic healthcare services provided as the first and continuing point of contact for prevention and health promotion, diagnosis and treatment, and referral.

Prospective Payment where the payer determines the cost of care before the care is given; the provider is told how much will be paid to give the care.

Quality of Care extent to which the provided healthcare services achieve or improve desired health outcomes; these are based on the best clinical evidence, are provided in a culturally competent manner, and involve shared decision making.

Resource-Based Relative Value System (RBRVS) prospective payment system for physician services.

Resource Utilization Group (RUGs) prospective payment system for skilled nursing facilities.

Secondary/Tertiary Care highly technical hospital-based care or long-term care.

Utilization Review (UR) where providers are required to certify the necessity of admission, continued stay, and professional services rendered to Medicare and other insurance beneficiaries.

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