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Beth Ann Swan, PhD, CRNP, FAAN
Thomas Jefferson University, bethannswan@gmail.com

Sheila A. Haas, PhD, NP, FAAN
Loyola University Chicago, shaas@luc.edu

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Beth Ann Swan
Sheila A. Haas

Health Care Reform: Current Updates and Future Initiatives For Ambulatory Care Nursing

Executive Summary

- While the signing of the Patient Protection and Affordable Care Act was a historical event marking the beginning of health care reform in the United States, it signaled the start of a golden age for ambulatory care nursing.
- Ambulatory care RNs are well-positioned to fully participate in health care reform initiatives.
- RNs are well-positioned to lead, facilitate, and/or participate in all patient care medical homes' and accountable care organizations' quality and safety initiatives through enhanced use of major ambulatory care RN role dimensions such as advocacy, telehealth, patient education, care coordination and transitional care, and community outreach
- RNs are also well-positioned to provide patient-centered care, coordinate care, and manage transitions across ambulatory care settings.
- For the golden age of ambulatory care nursing to become a reality, initiatives surrounding competencies, education modules, and leadership must be addressed immediately.

Beth Ann Swan

Sheila A. Haas

On March 23, 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA). A week later, on March 30, 2010, the House and Senate both approved a package of fixes, H.R. 4872, the Health Care and Education Reconciliation Act of 2010. In reviewing the table of contents of the 974-page act, there are 10 major titles, and under each title, there are many subtitles, articles, and sections (*Patient Protection*, 2010). Many of the health care reform activities over the next decade target new consumer protections, improving quality and controlling costs, increasing access to affordable care, and holding insurance companies accountable. While this historical event marked the beginning of health care reform in the United States, it signaled the start of a golden age for ambulatory care nursing.

Why Now?

Why is now the golden age for ambulatory care nursing and why is health reform the right prescription for ambulatory care nurses and their patients? To respond to this question, one needs to consider the intersection of health care reform and national reports published recently including the Carnegie Report, *Educating Nurses: A Call for Radical Reform*; Josiah Macy Jr. Report, *Who Will Provide Primary Care and How Will They Be Trained?*; Lancet Commissions Report, *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World*; and the Institute of Medicine/Robert Wood Johnson Foundation (IOM/RWJF) Report, *The Future of Nursing: Leading Change, Advancing Health* (Benner, Sutphen, Leonard, & Day, 2009; Frenk et al., 2010; Institute of Medicine [IOM], 2011; Josiah Macy Jr. Foundation, 2010). Many of the initiatives and activities identified in the PPACA intersect with and are supported by recommendations from the national reports listed in Table 1. Workforce recommendations are aligned with reform funding to expand the health care workforce. Achieving high value with innovative patient-centered care models for primary care intersects with improving the quality and efficiency of health care; and expanding opportunities for registered nurses (RNs) intersects with improving quality, and preventing and managing chronic disease and improving public health through care coordination and managing transitions, strategies that are foundational to patient-centered care.

While studies have demonstrated the effectiveness of using advanced practice nurses (APNs) and provisions of the PPACA allow for further access to care by APNs, only 13% of the RNs in the United States are educated at the advanced nursing practice level (IOM, 2011). One of the goals of the PPACA is to accomplish planned expansion and reach individuals not currently receiving health care services. As RNs are more available, especially in locations with no APNs, ambulatory care RNs are well-positioned to

BETH ANN SWAN, PhD, CRNP, FAAN, is Dean and Professor, Academic Affairs, Jefferson School of Nursing, Thomas Jefferson University, Philadelphia, PA.

SHEILA A. HAAS, PhD, RN, FAAN, is Professor, Loyola University Marcella Niehoff School of Nursing, Chicago, IL, and a *Nursing Economic$* Editorial Board Member.

NOTE: This column is written by members of the American Academy of Ambulatory Care Nursing and edited by Carol Ann Attwood, MLS, AHIP, MPH, RN, C. For more information about the organization, contact: AAACN, East Holly Avenue, Box 56, Pitman, NJ 08071-0056; (856) 256-2300; (800) AMB-NURS; FAX (856) 589-7463; E-mail: aaacn@ajj.com; Web site: http://AAACN.org

Table 1.
Health Care Reform Intersection with National Reports

Health Care Reform	National Reports
Quality affordable health care for all Americans	Increase the use of RNs and APRNs in primary care (IOM/RWJF) Practice to the fullest extent (IOM/RWJF)
Improving the quality and efficiency of health care	Improve patient care through nursing education (Carnegie) Expand opportunities for nurses to lead and diffuse collaborative improvement efforts (IOM/RWJF; Lancet) Achieve high value with innovative models (Macy)
Prevention of chronic disease and improving public health	Achieve high value with innovative models (Macy) Expand opportunities for nurses to lead and diffuse collaborative improvement efforts (IOM/RWJF; Lancet)
Health care workforce	Increase the proportion of nurses with baccalaureate degrees (Carnegie; IOM/RWJF) Ensure nurses engage in lifelong learning (Carnegie, IOM/RWJF)
Transparency and program integrity	Expand opportunities for nurses to lead and diffuse collaborative improvement efforts (IOM/RWJF; Lancet) Patient-centered outcomes research (IOM/RWJF; Macy)
Strengthening quality, affordable health care for all Americans	Prepare and enable nurses to lead change to advanced health (IOM/RWJF) Support students to be change agents (Carnegie)

fully participate in health care reform initiatives. Some examples specific to ambulatory care nurses and nursing include:

1. Last year, the law provided for rebuilding the primary care workforce through scholarships and loan repayment and forgiveness programs and strengthening community health centers through new funding to support the construction of and expand services at community health centers (*Patient Protection,* 2010). Funding opportunities were available for RNs through the Health Resources and Services Administration's Division of Nursing.
2. In 2011, the law provided for free preventive care for seniors such as annual wellness visits and personalized prevention plans; established the Community Care Transitions program to help high-risk older adults who are hospitalized avoid unnecessary re-admissions by coordinating care and connecting patients to services in their communities; and increased reimbursement for primary care (*Patient Protection,* 2010). Evidence supports RNs as critical to delivering these preventive services, as well as care coordination activities to avoid re-hospitalizations (Rich, 2002; Riegel & Carlson, 2002).
3. In 2012, the law provides for incentives for physicians to join together to form "Accountable Care Organizations" (ACO) effective January 1, 2012 (*Patient Protection,* 2010). ACOs are provider groups, at a minimum, primary care physicians, specialists, and hospitals that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group's clinicians (Shortell, Casalino, & Fisher, 2010). The goal of the ACO is to deliver coordinated, efficient, and effective care. ACOs that achieve quality and cost targets should benefit from financial gains; payment should be based on quality rather than quantity of care (Shortell et al., 2010).

In 2013, the law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve coordination and quality patient care (*Patient Protection*, 2010). Beginning January 1, 2015, physicians will be paid for value not volume (*Patient Protection*, 2010). RNs will be an integral member of the ACO team as they will develop evidence-based and content-driven strategies for standardizing and improving care coordination and care transitions.

Patient-Centered Medical Homes, ACOs, And Ambulatory Care Nurses

The PPACA authorizes states or state-designated entities to establish community-based interprofessional teams to support primary care practices within a certain area. "Health teams" may include nurses, nurse practitioners, medical specialists, pharmacists, nutritionists, dietitians, social workers, and providers of alternative medicine. The health team must support patient-centered medical homes (PCMH), which are defined as a mode of care that includes personal physicians, whole person orientation, coordinated and integrated care, and evidence-informed medicine

Table 2.
Ambulatory Care RN Role Dimensions for Health Care Reform Quality and Safety Initiatives

1. Work with established evidence-based (EBP) care management protocols.
2. Lead or participate in development and refinement of EBP protocols.
3. Collaborate on development of process and outcome indicators for EBP protocols.
4. Monitor (assessment and evaluation) current status of patients, often using telehealth modalities.
5. Make adjustments to treatment plan within specified EBP protocol parameters.
6. Collaborate and communicate with health team regarding patient status and needs.
7. Document all patient encounters in the EHR.
8. Refer patients who are out of alignment to MD/APN.
9. Maintain a long-term supportive relationship with patients and families.
10. Act as a resource and advocate for patients and families.
11. Collaborate on measurement of patient and family outcomes of care.
12. Find resources in the community.

SOURCE: Haas & Hackbarth (1995)

(*Patient Protection*, 2010). Eligibility for care coordination and performance bonuses in PCMHs could include implementation of model care management processes for chronic care patients such as disease registries, open access scheduling, patient self-management programs, linkage of electronic health records (EHRs) to specialty referral physicians and hospital, availability of nurse practitioners, physician assistants, dietitians, pharmacists, lists of board-certified specialists used by the primary care practice, and agreement to make performance data publically available (Shortell et al., 2010). Shortell (2010) views PCMHs as companion and complementary to ACOs or building blocks of ACOs (Shortell et al., 2010).

RNs are well-positioned to lead, facilitate, and/or participate in all PCMH and ACO quality and safety initiatives through enhanced use of major ambulatory care RN role dimensions such as advocacy, telehealth, patient education, care coordination and transitional care, and community outreach (see Table 2) (Haas & Hackbarth, 1995).

The PCMH model requires nurses to know their patients well, to plan and coordinate their care with the goal of delivering the *right care* at the *right time* in the most efficient way possible. Research demonstrates that RN-directed programs are associated with improved patient outcomes and reduced costs in high volume, stable chronically ill populations including patients with congestive heart failure, hypertension, diabetes, and patients requiring anticoagulation therapy (Fanning, 2002; Henrick, 2001; Riegel & Carlson, 2002). The ambulatory care RN role dimensions examined in this research are the same as listed for the PCMH and ACO; and are the same RN role dimensions required in the broader context of delivering patient-centered care in diverse ambulatory care settings.

Patient-Centered Care and Ambulatory Care Nurses

RNs are well-positioned to provide patient-centered care, coordinate care, and manage transitions across ambulatory care settings. According to the IOM (2001), patient-centered care is "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (p. 6). The Picker Institute delineated eight dimensions of patient-centered care: (a) respect for the patient's values, preferences, and expressed needs; (b) information, communication, and education; (c) access to care; (d) emotional support to relieve fear and anxiety; (e) involvement of family and friends; (f) continuity and secure transition between health care settings; (g) physical comfort; and (h) coordination and (j) integration of care (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993).

Despite multiple national reports calling for patient-centered care as one of the six strategies to improve quality care and substantial investment of resources in many initiatives to improve patient-centered care, health care organizations have not achieved measurable or sustainable change in ambulatory care settings due to some common misconceptions. For example, (a) a misconception that the acute care setting is the point of access for individuals requiring care coordination and transition management, when in fact the ambulatory care setting is the point of access; (b) a misconception that care transitions originate with a hospitalization rather than recognizing the multiple care transitions occurring among diverse ambulatory care settings; (c) a misconception that a measure of care coordination and transition management is handing patients written instructions prior to discharge, a single intervention of a hand-off but not a measure of performance of care being coordinated or the transition being managed; (d) a misconception that care coordination and transition management are discrete points of communication rather than a continuous conversation with ongoing communication; (e) a misconception that individuals with complex health care needs are equipped with self-management skills and decision-making skills to know what to do when their condition worsens or they develop a complication; and (f) a misconception that individuals with complex health care needs seek care in traditional primary care settings, when diverse ambulatory settings are serving vulnerable populations including uninsured, Medicaid, and geographically and economically disadvantaged.

Table 3.
Ambulatory Care Nursing Education and Practice Strategies

Strategies Related to Education	Strategies Related to Practice
Develop ambulatory RN competencies in care coordination and transition management.	Address the variability in ambulatory RN experiences related to care coordination and transition management.
Address the variability in ambulatory RN education.	Address the variability in the use of telehealth modalities and preparation of RNs using telehealth in ambulatory care (often related to reimbursement modalities).
Define the dimensions of care coordination and care transitions.	Address the variability in developing and using EBP protocols by ambulatory care RNs.
Improve preparation of providers practicing in ambulatory care in areas of quality and safety.	Address the variability in implementation of EHRs in ambulatory care.
Improve interprofessional education experiences in collaboration and teamwork in ambulatory care.	Address variability in RN documentation in ambulatory care.

How can ambulatory care nursing and nurses be part of the solution to change these misconceptions about the dimensions of care coordination and transitional care? Ambulatory care nursing education and practice strategies are described in Table 3.

Implications

For the golden age of ambulatory care nursing to become a reality, several initiatives need to be addressed immediately. First, the competencies for ambulatory nurse care coordination and transitional care need to be identified, developed, and verified by ambulatory nurse experts. Second, education modules with outcomes measures related to the competencies must be developed and used for continuing development of ambulatory care nurses who will be providing care coordination and transitional care. Third, ambulatory care nurse leadership must be at the table and take a proactive role as interdisciplinary teams are set up to develop and implement structures and processes, as well as defining outcomes for ACOs and PCMHs.

Two future initiatives also need to be planned and implemented. Ambulatory care nursing leadership must reach out to academic institutions so that prelicensure nursing students have the knowledge, skills, and competencies, as well as the vision to work as the ambulatory care nurses in the future (Haas, 2009). In addition, ambulatory nurses and leadership in ambulatory care must keep up with the rapidly evolving ambulatory care environment, regulatory changes, and demands for access, quality, and safety in all ambulatory care patient encounters. Finally, ambulatory care nurses must be involved in documenting and measuring the impact of care coordination and transitional care not only on patient outcomes, but also on cost effectiveness and improvements in the patient's and family's well-being. **$**

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