Health Care Reform and Ambulatory Nursing
Part I

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Session Objectives

At the conclusion of this session, attendees will be able to:

1. Discuss Select Issues in health care reform:
   - Need and rationale for reforming the U.S. health care system
   - Major focal areas of reform in the Affordable Care Act (ACA)
     - Provisions in ACA that affect ambulatory patient care in each focal area
     - Myths and misperceptions regarding provisions in ACA
     - New delivery models such as Patient-centered Medical Home (PCMH) and Accountable Care Organizations (ACOs)
Session Objectives (continued)

2. State the expected impact of health care reform (ACA) on ambulatory nursing practice
   - Increased demand and volume of patients
   - Wider focus on wellness and prevention and care coordination for chronic illness
   - Demand for enhanced patient-focused care, interprofessional teamwork, quality and safety, use of evidence-based practice and informatics
   - Incentives to drive increased accountability and transparency

Need and Rationale for Reforming the U.S. Health Care System

- The U.S. ranks #38 in health care world wide
- Over 40 million persons without health insurance in the U.S.
- Over reliance on technology and specialists rather than primary care, prevention, and care coordination
- U.S. citizens are often forced into bankruptcy due to catastrophic illness
Need and Rationale for Reforming the U.S. Health Care System (continued)

- U.S. spends 18% of GDP on healthcare and this is rising, yet outcomes are worse than other industrialized countries that spend 8% of GDP.
- U.S. outcomes are less than those of third world countries, because of lack of focus on prevention and access.
- Medical error is 3rd leading cause of death in the U.S.
- Scientific evidence takes on average 17 years to be put into practice.

Major Foci of Affordable Care Act (ACA)

- Heavy focus on health insurance reform to enhance access and coverage for care.
- Focus on primary care, health promotion and prevention requires planning in areas such as wellness assessment.
- Requirements for safe, cost effective, quality care demands enhanced implementation of evidence-based guidelines, care coordination and implementation of new delivery systems.
- More extensive use of informatics and EHRs.
Insurance Reform in ACA in 2010

Children:

- No children excluded from coverage because of pre-existing conditions; can stay on their parents' insurance until age 26

Insurance Reform in ACA in 2010

(continued)

Adults:

- No health insurance coverage limits—either lifetime or annual
- Health insurance policies issued after 2009 must cover prevention services without patient cost-sharing.
- Uninsured adults with pre-existing conditions can get insurance coverage through temporary program of national/state high risk health insurance pools.
- $250 rebate for Medicare Part D patients who hit the donut hole.

http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Health-Care-Reform-Legislation-Timeline.aspx
Insurance Reform in ACA in 2010
(continued)

- Small businesses with fewer than 25 employees can get a 35% tax credit for employer-based health insurance (increasing to 50% by 2014).

- Health insurance payouts must exceed 85% of premiums collected for large firms; 80% for individual and small group markets.

  http://www.nursingworld.org/ MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Health-Care-Reform-Legislation-Timeline.aspx

Insurance Reform in ACA in 2011

- Free annual Medicare wellness visit:
  - No more patient cost sharing on preventive services.
  - Wellness assessment by APRN reimbursed

- 10% Medicare bonus for primary care services furnished under Part B; includes care provided by APRN.
Insurance Reform in ACA in 2011 (continued)

- Health care reform fees imposed on drug manufacturers.
- National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation’s health.


Insurance Reform in ACA in 2011 (continued)

- Chain restaurants and food vending machines required to use nutritional labels for all items.
- Drugs manufacturers required to provide 50% discount for brand named drug prescriptions for Medicare Part D beneficiaries in the donut hole.
Insurance Reform in ACA in 2011
(continued)

- Innovation Center within the Centers for Medicare and Medicaid Services established to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Health-Care-Reform-Legislation-Timeline.aspx

Insurance Reform in ACA in 2012

- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
Insurance Reform in ACA in 2012 (continued)

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

  http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Health-Care-Reform-Legislation-Timeline.aspx

Insurance Reform in ACA in 2013

- **Medicaid** payment rates to primary care physicians furnishing primary care services adjusted upward to be no less than 100% of Medicare payment rates in 2013 and 2014.
Insurance Reform in ACA in 2013
(continued)

- Individual mandate to obtain health insurance--penalties imposed for not securing coverage.
- Employer mandate for firms with more than 50 employees to offer health insurance coverage with penalties imposed for not offering coverage.

http://www.nursingworld.org/MainMenuCategories/Healthcarean
dPolicyIssues/HealthSystemReform/Health-Care-Reform-
Legislation-Timeline.aspx

Insurance Reform in ACA in 2013
(continued)

- No discrimination by insurers based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or other factors HHS deems appropriate.
- Insurance rating variability only on age, family composition, geographic location, and tobacco use. No ratings based on health or gender.
- Various insurance changes establishing income-related limits on out-of-pocket liabilities for health care; limiting deductibles; setting a maximum on any waiting to be no greater than 90 days.

http://www.nursingworld.org/MainMenuCategories/Healthcarean
dPolicyIssues/HealthSystemReform/Health-Care-Reform-Legislation-Timeline.aspx
Implications of Insurance Reform in ACA

- More than 40 million uninsured and those denied insurance due to a prior condition will have insurance and be demanding access to and provision of care in 2014 –
  - Some will be those needing primary care including screening, diagnosis and treatment
  - Some will be chronically ill such as cancer survivors needing primary care and on-going screening as well as preventative and wellness services
  - Some will those who need specialty care for acute or chronic conditions

ACA Strategies for Prevention/Wellness

1. Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention wellness and public health activities
2. Establish a Prevention and Public Health Fund for prevention, wellness and public health activities including prevention research and health screenings
3. Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services

(The Henry J. Kaiser Family Foundation, June 2010)
ACA: Implications for Ambulatory Care Nurses

- Nurses need:
  - A seat at national planning councils/tables
  - To get involved in prevention research including participation in Education and Outreach Campaign for preventive benefits
  - To get involved in grant seeking for support of delivery of evidence-based and community-based prevention activities including addressing health disparities

Implications of ACA for Ambulatory Care Nursing Practice

There are roles evolving for registered nurses and APRNs providing ambulatory nursing care:

- Primary Care
- Prevention
- Wellness
- Transitional care
- Care Coordination

Nov. 15, 2012: CMS rule creates reimbursement opportunities for RNs ... The rule also creates new payment codes for care coordination activities
Implications of PPACA on Prevention and Wellness Programs

- Medicare will pay for a comprehensive risk assessment annually
  - Providers (APNs) doing risk assessment will be reimbursed 100% of MD fee schedule
  - No deductible or coinsurance for personalized prevention plan services when services are provided in outpatient areas
- Insurers must provide recommended immunizations, preventative care for infants, children, adolescents and additional preventive care and screenings for women without cost-sharing (The Henry J. Kaiser Family Foundation, June 2010)

Implications of ACA on Prevention and Wellness Programs

- Knowing that significant funding will be devoted to prevention and wellness should provide impetus for:
  - Expanding existing services
  - Creating new – such as rehabilitation services during, as well as, after cancer treatment that enhances quality of life and wellness
ACA: Patients Seek Access to Safe and Quality Care

- Funding for prevention and wellness will bring new players into the field
- Players will not be differentiated by price, rather by quality and safety
- Players will also be differentiated by convenience
  - Clinics will need to be open at times suited to consumer and also allow open access

Myths and Misperceptions about Health Care Reform

MYTH 1

- ACA cuts Medicare benefits, when in fact, it prohibits cuts to Medicare while there are provisions to cut soaring costs in Medicare.
  - Savings will come from decreasing unreasonable payments to providers, taxing high-premium plans (beginning in 2018) and decreasing fraud and waste.
Myths and Misperceptions about Health Care Reform (continued)

MYTH 2

- Persons on Medicare will have to get more or different insurance. This stems from confusion about the rhetoric around the ACA’s individual mandate.
  - If a person is on Medicare or has employer based insurance, they stay on those plans and no additional insurance is mandated.

Myths and Misperceptions about Health Care Reform (continued)

MYTH 3

- Medicare Advantage will be taken away
  - Medicare Advantage, that is privately administered, actually costs taxpayers about 14% more per enrollee per year, so ACA to bring these costs down and provide incentives for high quality care in Medicare Advantage plans.
Myths and Misperceptions about Health Care Reform (continued)

MYTH 4

- Patients have bought into the myth that they either won’t be able to see “their doctor” or a doctor at all.
  - Persons who stay in their current plan, if that plan allows them to choose their doctor, there will be no change.
  - ACA actually has provisions to attract more physicians into primary care, as well as, prepare more advanced practice nurses as primary care providers.

MYTH 5

- Supreme Court decision on the individual mandate has spawned several myths such as, “If I can’t afford to by health insurance, I’ll be taxed or worse.”
  - Persons who cannot afford the cheapest health insurance plan where the cost exceeds 8% of income, will be exempt from penalty and if they do not meet the 8% test and have to pay a penalty, the penalty in the first year is $95, it goes up to $695 in 2017 (Howard, 2012)
Myths and Misperceptions about Health Care Reform (continued)

MYTH 6
- Involves ACA provision that small businesses will be fined if they do not provide health insurance for employees.
  - ACA penalties are only for companies with over 50 employees and from now through 2013, eligible employers will receive a business credit for up to 35% of their contribution toward employee’s premiums.
  - For 2014 and beyond, the tax credit rises to as much as 50%.
  - Credits apply to companies with fewer than 25 full time employees whose average annual salaries are less than $50,000.
  - Companies with more than 50 workers that don’t provide coverage will be subject to a fine of two to three thousand dollars per employee per year (Howard, 2012)

Myths and Misperceptions about Health Care Reform (continued)

MYTH 7
- Touted during the presidential campaign, the idea that the ACA raids Medicare of $716 billion dollars.
  - Number came from the Congressional Budget Office (CBO) estimate of $716 billion in reduced spending between 2013 and 2022 that would accrue to Medicare due to provisions in the ACA.
  - Savings will be used to close the donut hole in the Medicare prescription drug plan and pay for preventative care and increased coverage for the uninsured.
  - In fact, all guaranteed Medicare payments were protected in the ACA (Howard, 2012)
Myths and Misperceptions about Health Care Reform (continued)

MYTH 8
- The ACA will bankrupt America.
  - Actually ignoring the need to reform health care will bankrupt America.
  - According to the CBO and Joint Committee on Taxation, the ACA will actually reduce the deficit by 210 billion between 2012 and 2021 by decreasing subsidies to private insurance companies and cracking down on fraud, abuse and waste as well as reining in profits (Howard, 2012).

Myths and Misperceptions about Health Care Reform (continued)

- A final myth states that the ACA will drive up premiums.
  - As the young adults who are mostly healthy come into plans, their premiums will help subsidizes care for less healthy persons (Brownlee, 2012).
  - Along with the ACA’s “medical loss ratio requirement” that dictates that 80 to 85% of premiums be spent on medical costs will keep premiums down (Howard, 2012).
  - Already there has been 1.1 billion in rebates from insurance companies who have not met this provision.
ACA: Patients Seek Access to Safe and Quality Care

- ACA authorizes states or state-designated entities to establish community-based interdisciplinary, inter-professional 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.
  - Health team must support patient-centered medical homes, which are defined as a mode of care that includes personal physicians, whole person orientation, coordinated and integrated care, and evidence-informed medicine.

PPACA Quality and Safety Initiatives

- Accountable Care Organization (ACO) 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, Casalino, & Fisher, 2010)
ACO Models (Shortell, Casalino, & Fisher, 2010)

- Integrated Delivery Systems
- Multispecialty Group Practices
- Physician-hospital Organizations
- Independent Practice Associations
- Virtual Physician Organizations (Shortell, Casalino, & Fisher, 2010)

ACOs

- Challenges to enhance quality and cost effectiveness, an ACO needs to be able to:
  - Care for patients across the continuum of care, in different institutional settings.
  - Plan, prospectively, for budgets and resource needs.
  - Develop and support comprehensive, valid and reliable measurement of its performance. (http://www.urban.org/)
ACOs
Initiatives to enhance quality and safety:
1. Use of comparative effectiveness research and analysis
2. Collaborative inter-professional teamwork
3. Development and use of evidence-based guidelines
4. Coordination of care across settings including the Patient Centered Medical Home
5. Efficient communication across settings and with patients in the community using EHR
6. Efficient, reliable and valid data collection at point of care

Comparative Effectiveness Research

- **Comparative effectiveness research** is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options.
- The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.

(http://effectivehealthcare.ahrq.gov/)
Nurses’ Role in ACOs

*Nurses can be leaders, facilitators and or participants in all ACO quality and safety initiatives including:*

- Enhanced use by ambulatory nurses:
  1. Telehealth
  2. Patient education
  3. Community outreach
  4. Care coordination
  5. Transitional care

Nurses’ Role in ACOs (continued)

*Nurses can be leaders, facilitators and participants in all ACO quality and safety initiatives including:*

Increased participation by nurses in:

1. Planning and organizing ACO delivery systems
2. Development of patient and provider methods of care delivery – interprofessional team methods
3. Implementation of evidence-based (EBP) protocols
4. Measurement of outcomes of EBP
5. Evaluation of electronic patient records that interface with all sites of care and track processes and outcomes of care
Ambulatory Nurses’ Role in ACOs

*Nurses can be leaders, facilitators and participants in all ACO quality and safety initiatives including:*

Enhanced use of primary care cancer survivor clinics staffed by APRNs will:

1. Leverage MD time
2. Provide primary and wellness care
3. Provide cost-effective care
4. Enhance patient and family engagement and satisfaction

Ambulatory Nurses’ Role in ACOs and PCMHs

- Ambulatory care nurse leaders need to be aware of the challenges and controversies that surround establishment of ACOs and expected performance parameters and outcomes, so that they can assume leadership in planning and implementation of ACOs
- **Potential outcomes** achieved by oncology nurses fully utilized in ACOs and PCMHs:
  - Decreased ED visits
  - Decreased hospital readmissions
  - Decreased errors and waste
  - Enhanced patient/family participation in care
  - Enhanced quality of life
  - Increased satisfaction with care
Challenges for ACOs

- Although ACOs are supposed to decrease costs and increase quality of care, the epicenter of ACO mission is the goal that the ACO be a patient centered organization where patient and providers are true partners in care decisions.

- Shared savings are also a major part of the ACO. Medicare would continue to pay providers and suppliers for specific items and services, but it would also develop benchmarks for each ACO against which ACO performance will be measured to assess whether it qualifies for shared savings, or be held accountable for losses.

Challenges for ACOs (continued)

- The ACA specifies that an ACO may include the following types of providers:
  - ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
  - Networks of individual practices of ACO professionals,
  - Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
  - Hospitals employing ACO professionals, and
  - Other Medicare providers and suppliers as determined by the Secretary.

Challenges for ACOs (continued)

- In a recent *Wall Street Journal* article (2013), Christiansen, known for concept of “Disruptive Innovation” and colleagues from Harvard (2013) argue that ACOs will fail because they are founded on three “unteachable assumptions:”

  1. First of all, ACOs cannot change physician behavior. Physicians need to move to increased use of evidence-based protocols and to provide care in less expensive settings.

  2. Second, ACOs won’t automatically change patient behavior. Currently, many ACOs let patients choose their providers, including specialists. This has been done to avoid consumer dissatisfaction with use of “gatekeepers” who authorize access to specialists or procedures. Gatekeepers have been traditionally employed by HMOs to contain costs.

  3. Finally, “ACOs will not save money on a grand scale . . . No dent in costs is possible until the structure (fee for service) of health care is fundamentally changed"
Challenges for ACOs (continued)

- Christensen’s predictions are in line with the Robert Wood Johnson National Commission on Physician Payment Reform Report Drivers of the high cost of U.S. health care:
  - **Fee-for-service reimbursement** where physicians are reimbursed for each service they provide. Pay is not necessarily linked to outcomes.
  - **Reliance on technology and expensive care** - reimburse technology-intensive procedures at higher rates than services focused on evaluating patients or managing the care for chronic conditions.

Challenges for ACOs (continued)

- **Christiansen’s Predictions (continued)**
  - **Reliance on a high proportion of specialists.** The U.S. has a high ratio of specialists to primary care physicians. The current payment system favors high cost procedures over time spent on evaluation or management of care.
Challenges for ACOs  (continued)

- **Christiansen’s Predictions** (continued)
  - Paying more for the same service or procedure when done in a hospital setting as opposed to an outpatient setting. For example, Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician’s office.
  - While physician salary and related expenses account for 20 percent of health care spending, the decisions they make influence an additional 60 percent of spending.
  - Systemic issues—specifically, the skewed incentives of fee-for-service payment. ([Report of the National Commission on Physician Payment Reform, 2013, pp. 2-3](#))

Challenges for ACOs  (continued)

- Ambulatory care nurse leaders need to be aware of the challenges and controversies that surround establishment of ACOs, as well as, expected performance parameters and outcomes, so that they can assume leadership in planning and implementation of ACOs
Future of Nursing Report Recommendations (IOM, 2010)

- In 2008, The Robert Wood Johnson Foundation (RWJF) and the IOM launched a two-year initiative to respond to the need to assess and transform the nursing profession.
- The Future of Nursing Report has four key messages:
  - Nurses should practice to the full extent of their education and training.
  - Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
  - Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
  - Effective workforce planning and policy making require better data collection and information infrastructure. (IOM, 2010)

ACA’s Effect on Care of Patients Provided by Nurses and APRNs

1. Nurses will become collaborative partners in designing and implementing and evaluating evidence-based protocols
2. Well designed and implemented electronic patient records will assist in care coordination, an informed patient-centered team, data collection, aggregation and analysis of outcomes of care
ACA’s Effect on Care of Patients Provided by Nurses and APRNs

3. Care coordination by nurses and APRNs will insure that patients and families will be better able to:
   - Provide care in the home
   - Use available community resources such as palliative care
   - Avoid unnecessary visits to ED or readmissions.

ACA Workforce Initiatives

- As ACA was evolving, HRSA was developing corresponding funding initiatives to enhance development of the nursing and health care workforce:
  - Expansion of the workforce diversity grant program permitting grants to be used for diploma and associate degree nurses to enter bridge or degree completion programs or for student scholarships and stipend programs for accelerated nursing degree programs
  - Authorizes $338 million in appropriations to carry out nursing workforce development programs – including the advanced education nursing grants, workforce diversity grants, and nurse education, practice, quality and retention grants
ACA Workforce Initiatives (continued)

- Authorizes HHS to award grants to advanced practice nurses who are pursuing a doctorate or other advanced degree in geriatrics and who, as a condition of accepting a grant, will agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years.
- Establishes a loan repayment program for individuals who are willing to practice in a pediatric medical or surgical subspecialty or in child mental and behavioral health care for at least 2 years in an underserved area [http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx](http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx)

ACA Workforce Initiatives (continued)

- Authorizes HHS to make grants to accredited educational institutions that support scholarships for mid-career public health and allied health professionals who seek additional training.
- Authorizes an Allied Health Loan Forgiveness Program to assure there is an adequate supply of allied health professionals to eliminate critical allied health workforce shortages at public health agencies, acute care facilities, ambulatory care facilities, and other underserved health facilities.
ACA Workforce Initiatives (continued)

- Establishes a Public Health Workforce Loan Repayment Program to assure an adequate supply of public health professionals to eliminate workforce shortages in public health agencies
- Nurse Loan Repayment expanded
  - Nurse Faculty Loan Program increased loan amounts with loan forgiveness for those who teach full time after graduation
  - [Link](http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx)

Consensus Model for APRN Regulation (2008)

- The goals of the consensus processes were to:
  - Strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice
  - Develop a vision for APRN regulation, including education, accreditation, certification, and licensure
  - Establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care
  - Produce a written statement that reflects consensus on APRN regulatory issues.

  (Summers, 2009, ANA Department of Nursing Practice & Policy)
Why Develop a Consensus Model for APRN Regulation?

- Lack of generally accepted definitions of APRN roles
- Lack of multiple non-equivalent education programs and processes leading to certification
- Multiple specialties and subspecialties with certification procedures and exams
- Inconsistencies in state by state recognition of advanced practice roles (Less than 30 states recognize or title protect CNS; not all states license/authorize CRNA same as NP; Summers, 2009)
- Challenges with determining eligibility for APRN licensure
  (Summers, 2009, ANA Department of Nursing Practice & Policy)

APRN REGULATORY MODEL

- APRN Regulation includes the essential elements:
  - Licensure,
  - Accreditation,
  - Certification
  - Education

  - The LACE APRN Regulatory Model

- **Licensure** is the granting of authority to practice.
- **Accreditation** is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.


- **Certification** is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- **Education** is the formal preparation of APRNs in graduate degree-granting or postgraduate certificate programs.
Consensus Diagram 1

APRN REGULATORY MODEL

APRN SPECIALTIES
Focus of practice beyond role and population focus
linked to health care needs.
Examples include but are not limited to: Oncology, Older Adults, Orthopedics,
Nephrology, Palliative Care

POPLATION FOCl

Family/Individual Across Lifespan
Adult-Gerontology*
Neonatal
Pediatrics
Women’s Health/Gender Related
Psychiatric-Mental Health**

APRN ROLES

Nurse Anesthetist
Nurse Midwife
Clinical Nurse Specialist **
Nurse Practitioner +

Consensus Diagram 2

Relationship between Educational Competencies, Licensure and Certification

Competencies
Identified by Professional Organizations (e.g. oncology, palliative care, CV)
CNP, CRNA, CNM, CNS in Population context
APRN Core Courses:
Pathophysiology, Pharmacology, Physical/health assessment

Measures of competencies

Specialty Certification*
Licensure: based on education and certification

Population Foci
Role
APRN

(Summers, ANA Department of Nursing Practice & Policy, 2009)
References

- ANA (2010). Health Care Reform Tool Kit
  http://www.nursingworld.org/healthcarenreformtoolkit

- ANA (2010). Health System reform: Key provisions related to nurses
  http://www.rnaction.orgsite/DocServer/KeyProvisions_Nursing-
  PublicLaw.pdf?docID=1241&verID=1

  http://www.rnaction.org/site/DocServer/PPACA-
  Timeline.pdf?docID=1262

- APRN Consensus Work Group & National Council of State Boards of
  regulation: Licensure, accreditation, certification and education
  http://www.nursingworld.org/ConsensusModelforAPRN

References (continued)

  DocumentVault/APRN-Resource-Section/APRN-Consensus-Model-
  FAQ.aspx

- AHRQ Effective Health Care Program.
  http://effectivehealthcare.ahrq.gov/

- The Henry J. Kaiser Family Foundation Health Reform Source, June
  2010. Summary of new health reform law(#8061)

- Institute of Medicine (2010) The future of nursing: Leading change,
  advancing health _http://iom.edu/

- The Urban Institute. http://www.urban.org/

- Shortell, S., Casalino, L. & Fisher, E. (210). What is an Accountable
  Care Organization? http://pnhp.org/blog/2010/07/09/what-is-an-
  accountable-care-organization/
Thank you. Any Questions?