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# A Policy Analysis of the Provisions of the Patient Protection and Affordable Care Act Related to Access to Primary Care for Older Adults

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A POLICY ANALYSIS OF THE PROVISIONS OF THE PATIENT PROTECTION  
AND AFFORDABLE CARE ACT RELATED TO ACCESS TO PRIMARY CARE  
FOR OLDER ADULTS

by

Tonya M. Fontaine

A Major Paper Submitted in Partial Fulfillment

of the Requirements of the Degree of

Master of Science in Nursing

in

The School of Nursing

Rhode Island College

2015

## **Abstract**

This paper begins with a comprehensive literature review of health care around the globe, health care in America, and the Patient Protection and Affordable Care Act (ACA). A problem has emerged from the ACA, in which it is unclear if the health care workforce is prepared to take care of all insured Americans, which now includes a large population of newly insured under the ACA. Primary care and the elderly population are a focus, as primary care is most affected by the ACA, and the aging population is growing and will continue to grow. The ACA policy is analyzed using Russell and Fawcett's *The Conceptual Model of Nursing and Health Policy Revisited* (2005) and McLaughlin & McLaughlin's *Policy Analysis Process* (2007). Policy recommendations are suggested based on evidence-based research.

## **Acknowledgements**

First, I would like to thank my First Reader, Dr. Patricia Thomas, for without her, this project would not be possible. When I originally chose the topic for my Master's Project, I had a great vision, but not enough direction to navigate my way through to the end. Professor Thomas has been my map, guiding me through this project, holding up a lantern so I could see the light at the end. You were always encouraging and dedicated to my learning and success. I am truly grateful for your patience, enthusiasm, and confidence in me. Thank you for all you have done.

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A POLICY ANALYSIS OF THE PROVISIONS OF THE PATIENT PROTECTION  
AND AFFORDABLE CARE ACT RELATED TO ACCESS TO PRIMARY CARE FOR  
OLDER ADULTS

**Background and Problem Statement**

Health care reform was among the top issues of the 2008 presidential election in the United States, and continues to be a focus of concern for members of Congress and President Barack Obama. During President Obama's administration, Congress passed the Patient Protection and Affordable Care Act (Patient Protection and Affordable Care Act, 2010), which was signed into law on March 23, 2010. This statute has become the most influential piece of legislation in decades. The Patient Protection and Affordable Care Act will herein be referred to as the ACA.

Issues with the United States (U.S.) health care system are long standing, and President Obama is not the first to address health care reform. Throughout U.S. history, several other presidents have promoted more incremental reform, but failed to pass any legislation creating a national health system. President Lyndon Johnson played a strong role in the development of Medicare and Medicaid, and the prescription drug coverage feature was added to Medicare under President George W. Bush. The ACA had ample support because there was a democratic majority in both houses of Congress. It should be noted that there was significant Republican opposition, which continues to the present. The Republican party argues that the ACA will cause insurance premiums to rise, hurt quality of care, create nearly \$570 billion in tax increases, add over \$500 billion to the national debt, and ultimately, increase health care costs (Republican National Committee,

2011). Despite Republican disapproval, however, the ACA had ample support from the American public due to widespread problems with the U.S. health care system.

Overwhelming problems with the U.S. health care system fueled the decision to create the ACA. Before the ACA, there were 57 million uninsured people in the U.S., which accounted for 17% of the total population (Foster, 2010). In many other industrialized countries, all citizens are provided with national health care coverage. One of the goals of the ACA is to provide health care insurance to all people in America (Patient Protection and Affordable Care Act, 2010). Prior to the ACA, people were denied health care coverage based on pre-existing conditions. However, the ACA forbids insurance companies to deny coverage related to pre-existing conditions (Patient Protection and Affordable Care Act, 2010). This provision is providing immense help to people battling chronic diseases. Additionally, before the ACA, health insurance was unaffordable for many people and caused bankruptcy due to medical bills. The ACA is offering more affordable health care coverage to decrease the burden of health care costs (Patient Protection and Affordable Care Act, 2010).

The ACA was enacted to accomplish two primary goals: (a) make health care accessible to all people, and (b) improve health outcomes, increase quality of care, lower health care costs and improve the process of delivering care (Wilson, 2014). To achieve the first goal of providing access to care for all people in America, the ACA has expanded Medicaid and created marketplaces to purchase insurance. The marketplaces or exchanges are for people who are not able to obtain an insurance plan through their employer or are not eligible for other government coverage. Over 30 million people are expected to gain health insurance through the ACA (Cantlupe, 2013).

A reduction in the costs of health care is the second major goal of the ACA because the U.S. spends more on health care than any other industrialized nation, yet has worse health outcomes. Indeed, the U.S. has lower life expectancies and higher mortality rates than many other industrialized nations, most of which have national health care provided to all citizens (Wilson, 2014).

In 2010, U.S. total health care expenditure reached \$2.6 trillion, which equates to more than \$8,000 per person (Wilson, 2014). In 2011, nearly 18% of the U.S. gross domestic product (GDP) was devoted to health care costs, making the American health care system the most expensive in the world. Experts estimate by the year 2020, America's health care spending will reach 20% of the GDP (Berwick & Hackbarth, 2012).

Adding to the financial burden, a significant portion of health care spending goes to waste, impacting the quality of care and health care outcomes. Waste can be broken down into six categories:

1. failures of care delivery
2. failures of care coordination
3. overtreatment
4. administrative complexity
5. pricing failures
6. fraud and abuse (Berwick & Hackbarth, 2012).

Failures of care delivery can be defined as care that lacks evidence based practice, including, but not limited to, patient safety and preventative care. Failures of care coordination include care that is fragmented and not coordinated with other disciplines.

Lack of coordination of care results in hospital readmissions and decline of functional status. Overtreatment is care that is provided in excess, which scientifically will not help the patient. Administrative complexity includes accreditation agencies, government, and payers who create inefficient processes. For example, payers who fail to standardize their forms cause health care providers to consume unnecessary time figuring out complex billing procedures. Pricing failures are defined as costs for services that are much higher than what would be expected in an industrialized nation. For example, the cost of a CT scan or MRI in the U.S. is several times more expensive than in other countries. Lastly, fraud and abuse occurs when people issue fake bills and scams (Berwick & Hackbarth, 2012). See Appendix A for U.S. health care waste.

The U.S. is facing a health care worker shortage, which will continue to worsen with an increase in the number of newly insured people attempting to access health care. Dr. Atul Grover, Chief Public Policy Officer American Association of Medical Colleges, states, “I worry about giving 30 million people a card and a false promise” (Cantlupe, 2013, p. 4). How will the health care workforce be affected by the millions of newly insured people? Will all Americans have access to care as the ACA hoped for, or will they continue to suffer from lack of access due to an increase in demand for health care services and a decrease in supply of health care workers? The purpose of this project is to perform a policy analysis of the provisions of the Patient Protection and Affordable Care Act (ACA) that relate to access to primary care by older adults, and to examine if the primary care work force is adequate to meet the needs of an expanding elderly population.

## **Literature Review**

Data and research articles were collected through scholarly searches on Ovid, PubMed, MEDLINE, CINAHL, and Google Scholar. Key words and phrases used to search for information included but were not limited to: Patient Protection and Affordable Care Act, health care workforce, health care provider, primary care, shortage, quality, workload, aging population, health care policy, and policy analysis. The search was performed between May 2014 and May 2015. Research articles within the past five years were reviewed, with a focus on the most current research.

### **Stakeholders**

As defined by the Agency for Healthcare Research and Quality (AHRQ), stakeholders are “persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision. Stakeholders may be patients, caregivers, clinicians, researchers, advocacy groups, professional societies, businesses, policymakers, or others” (Agency for Healthcare Research and Quality, 2014). According to the definition, everyone in America is a stakeholder in the ACA, as this piece of legislation affects everyone in the US. On a federal level, the top stakeholders are President Barack Obama, members of Congress, and all government officials. In Rhode Island, some of the major stakeholders are the previous Governor Lincoln Chafee, new Governor Gina Raimondo, Lieutenant Governor Elizabeth Roberts, Dr. Kathleen Hittner Health Insurance Commissioner, Dr. Michael Fine former Director of the Rhode Island Department of Health, Dr. Nicole Alexander-Scott new Director of the Rhode Island Department of Health, Christine Ferguson first Director of HealthSource R.I.,

Anya Rader Wallack, new Director of HealthSource RI, members of HealthRight, local and state representatives, and healthcare facilities and providers.

### **Health Care Around the Globe**

The World Health Report 2000 ranked the United States health care system as 37<sup>th</sup> out of a total of 191 countries (World Health Organization, 2000). These rankings were based on critical social values which included reducing health disparities, improving health, providing responsive services that protect people's dignity, and protecting home impoverishment from medical expenses. In 2006, the U.S. was number one in health care spending per capita. However, it also ranked 39<sup>th</sup> in infant mortality, 42<sup>nd</sup> for adult male mortality, 43<sup>rd</sup> in adult female mortality, and 36<sup>th</sup> for life expectancy (Murray & Frank, 2010). In 1974, mortality among males ages 15 to 60 years old was the same in both the U.S. and Australia. Death rates, the ratio of deaths in an area in relation to the total population, in a given time frame, per 1000, are also called mortality rates. Every year since the early 70's, the death rate has decreased more in Australia than in the U.S. In 2006, Australia's death rate was 40% lower than the U.S. (Murray & Frank, 2010).

In 2012, the Public Broadcasting Service (PBS) released a report comparing U.S. health outcomes to other countries around the world. PBS used data from the Organization for Economic Co-operation and Development (OECD) to form their report. The OECD is an international economic group comprised of 34 members from different nations. This PBS report began by putting a price tag on U.S. health care at the current time. In 2012, the U.S. was spending \$8,233 per person on health care, which is 17.6 percent of the gross domestic product (GDP). The U.S. spends two-and-a-half times more than most other developed countries including Sweden, France, and the United

Kingdom (Kane, 2012). Despite spending more money on health care than other countries, the U.S. lags behind in performance. According to data from 2010, the OECD reported that the U.S. has fewer physicians per person than in other countries. There were 2.4 practicing physicians per 1,000 people, which was below the OECD average of 3.1 practicing physicians per 1,000 people. In 2009, there were 2.6 hospital beds per 1,000 people in the U.S., and the OECD average was 3.4 beds per 1,000 people. Additionally, between 1960 and 2010, U.S. life expectancy increased by almost nine years. However, Japan increased their life expectancy over 15 years, and other OECD countries averaged over 11 years. In 2010, the average American was expected to live to age 78.7 years, which is also below the OECD average of 79.8 years (Kane, 2012). Despite these setbacks, the U.S. is the world leader in health care research and cancer treatment. The U.S. has a higher five-year survival rate for breast cancer than other OECD countries, and colorectal cancer survival is also among the best (Kane, 2012).

### **Health Care Waste**

According to the OECD, America creates more health care waste than most other countries (Kane, 2012). Waste can be measured in money, unnecessary medical tests, inadequate and over use of technology, and complicated billing systems to name a few measures. In Sweden, all medication prescribing is done electronically; whereby a message is sent from the prescriber directly to the pharmacy. This process decreases medical errors and is thought to save pharmacists 1-2 hours of work daily. The U.S. utilizes both paper and electronic prescriptions. Additionally, the U.S. is doing more testing and surgeries than most other countries, but as stated previously, the U.S. has poorer health outcomes and a shorter life expectancy than other OECD countries. A

chart of diagnostic tests and surgeries in the U.S. can be found in Appendix B. It is believed that the U.S. performs more expensive diagnostic testing than other countries due to fear of litigation, increased reimbursement, and simply because patients ask for more tests and services (Kane, 2012).

### **Chronic Disease Management**

Obesity remains a major problem in America. Obesity is a risk factor for many diseases such as hypertension and diabetes. Adult overweight and obesity rates are highest in the U.S. compared to other OECD countries, and rates continue to grow (Kane, 2012). Child overweight and obesity rates are also very high in the U.S. with one-third of children being overweight or obese. The OECD average for children (aged 5-17 years) who are overweight and obesity are 21.4% for females and 22.9% for males. Greece ranks 1<sup>st</sup> in child overweight and obesity rates, but the U.S. ranks 2<sup>nd</sup> with 35.9% of female children and 35.0% of male children being overweight or obese. Countries who are below the OECD average are Germany, France, and Japan (Kane, 2012).

Chronic conditions are being managed poorly in the U.S. primary care system. Asthma is considered a condition that can be appropriately managed by primary care services and should only require hospital admission on few occasions (Kane, 2012). The OECD average rate of hospital admission for an asthma exacerbation is 51.8 per 100,000 population (Kane, 2012). In 2008, the U.S. had 120.6 per 100,000 population hospital admissions for asthma exacerbations; that is almost two-and-a-half times more than the OECD average. In 2009, Canada only had 15.7 per 100,000 population hospital admissions for asthma. Similarly, hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) are high in the U.S. The OECD average for hospital

admissions for COPD exacerbations was 198 per 100,000 population. In 2008, the U.S. had 230 per 100,000 population admissions for COPD. Whereas in 2009, Canada only had 183 per 100,000 population (Kane, 2012).

These poor health outcomes could be improved with better health care and coordination of care. The Commonwealth Fund surveyed seven countries (Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States), and 16% of U.S. patients reported a delay in being notified of abnormal test results, which was the highest reported among the seven countries surveyed. Additionally, 75% of primary care physicians surveyed reported always receiving correspondence from specialists (The Common Wealth Fund, 2010). This means that 25% of the time, specialists are not communicating about their services with primary care providers. This is a lack of coordination of care.

### **The Patient Protection and Affordable Care Act (ACA)**

The ACA was signed by President Barack Obama and became a law on March 23, 2010 (Patient Protection and Affordable Care Act, 2010). This complex piece of legislation is over 2,000 pages long and represents the largest expansion of America's social safety net since the creation of Medicare and Medicaid in 1965 (Wilson, 2014). Due to its complexity and length, few people have been able to review all the provisions of the legislation other than policy specialists. Overall, the ACA offers broad guidelines rather than specific directions in order to achieve its goals.

#### Health Care Access

As stated previously, the two prominent goals of the ACA are to: (a) make health care accessible to all people, and (b) improve health outcomes, increase quality of care,

lower health care costs and improve the process of delivering care (Wilson, 2014). In order to achieve the first goal, the ACA prevents insurers from denying coverage to persons with a pre-existing condition and extends insurance to people lacking health insurance.

The exchanges, or marketplaces, make it possible for people who lack insurance to browse different insurance plans and purchase a policy which meets their needs. The ACA provides subsidies to make insurance plans on the exchanges affordable. It also provides subsidies for the expansion of Medicaid to cover people with incomes up to 138 percent below the poverty line. However, in June 2012, the Supreme Court ruled that states had the choice to whether or not to accept the expansion of Medicaid from the ACA. As of April 2015, 21 states have chosen not to expand Medicaid eligibility (Buettgens, Holahan, & Recht, 2015). Additionally, young adults are allowed to stay on their parents' insurance plan until they are age 26 (Wilson, 2014). The ACA also mandates that all uninsured individuals must obtain health insurance, either through eligibility for government-funded insurance, through the exchange or through their employer, or they will be forced to pay a penalty fee (Wilson, 2014).

In order to achieve the second major goal of the ACA, legislation requires redesigning health care delivery and financing. A chart highlighting the ways the health care system was pre-ACA as compared to post-ACA can be seen in Appendix C.

### Payment Reform

Changing the fundamental way America thinks of and delivers health care is a challenging aspiration. To effect these changes, the ACA modifies the way health care services are paid for and the manner in which care is delivered. For example, the ACA

establishes a new payment system in which payments will be based on “value” (performance on health care outcomes) instead of “volume” (traditional fee-for-service) (Wilson, 2014). This type of health care reimbursement is dramatically different from the previous method in which health care was paid for on a “fee-for-service” basis, meaning reimbursements were made based on the services a patient received (Wilson, 2014). For example, a person went to the Emergency Department with a cough and fever, for which they had blood drawn for laboratory tests and a chest x-ray performed. Through clinical assessment and diagnostic testing, the patient was found to have pneumonia. The Emergency Department was reimbursed for the care the provider gave, the laboratory tests, and the chest x-ray. However, under the ACA, payment reforms include “value-based purchasing” and bundled payments based on patient diagnosis (Wilson, 2014). For example, if the same person went to the Emergency Department now, after the enactment of the ACA, reimbursement would not be made based on the specific care or diagnostic tests, but instead, reimbursement would be made based upon the overall diagnosis of pneumonia. This new form of reimbursement is based on the estimated amount of services and care that is expected to be provided for a certain diagnosis. This reimbursement criteria of “bundled” payments was created by the Centers for Medicare and Medicaid Services (CMS) (Centers for Medicare and Medicaid Services, n.d.). CMS experts argue that traditional fee-for-service payment methods can result in fragmented care and minimal coordination of care between health care disciplines. The CMS position is that fee-for-service care places more importance on the quantity of care versus the overall quality of care. Therefore, the CMS states that bundled payments offer incentives to health care providers to offer quality, coordinated

care, which will improve health care outcomes (Centers for Medicare and Medicaid Services, n.d.).

The goals of payment reform are to decrease health care costs, while increasing quality and efficiency by placing more responsibility on health care workers to achieve higher performance standards (Wilson, 2014). In addition to the new bundled payments, hospitals and health care providers will now be reimbursed based on three key categories: patient experience, outcome measures, and rates of preventable readmission (Berwick & Hackbarth, 2012).

#### Patient Experience and Outcomes

The patient experience is being measured by surveys called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). HCAHPS is the first to provide a national standard for collecting and publicly reporting patients' perspective on care. The survey has 32 questions and provides a score based on patient satisfaction (Agency for Healthcare Research and Quality, 2013).

Outcome measures are based on pre-set standards for common, costly conditions; such as congestive heart failure, heart attacks, pneumonia and hospital-acquired infections. Hospital readmissions are considered preventable if they occur within 30 days of discharge from the hospital. Hospitals will face decreased reimbursement rates for failure to meet these outcome measures. In August 2013, 2,225 hospitals in the U.S. lost \$227 million in payment reductions from Medicare related to readmissions (MacDonald, 2013). In addition to these revenue losses, Medicare reimbursement cuts will be rising from 1% to 2% between 2013 and 2017 (MacDonald, 2013).

The ACA is not only changing how health care is paid for, but it is also changing how health care is being delivered. The ACA is seeking to reduce healthcare costs by encouraging providers and hospitals to form a network which coordinates care for patients in and out of the hospital setting. These organizations are called Accountable Care Organizations (ACOs), and they are monitored by Medicare (Gold, 2014). An ACO is a network of providers and hospitals that share medical and financial responsibility for providing coordinated care to patients and limiting the amount of unnecessary health care spending. According to the ACA, each ACO must manage the care of at least 5,000 Medicare beneficiaries for a minimum of three years (Gold, 2014). ACOs were included in the ACA law as a potential solution to the rising health care costs for the aging population with multiple health issues. ACOs are given financial incentives to cooperate and cut costs by avoiding unnecessary tests and procedures. Networks that save money and meet quality standards will be able to keep a percentage of the savings. In their first four years, ACOs are expected to save Medicare up to \$940 million (Gold, 2014).

#### Primary Care and Prevention

The ACA is promoting the use of primary care by offering physicians, nurse practitioners, and physician assistants a 10-percent bonus for treating Medicare patients. Additionally, in 2013 and 2014, primary care providers received higher reimbursement rates for Medicaid that were equal to Medicare rates (Davis, Abrams, & Stremikis, 2011).

Primary care providers are also receiving an incentive for preventative service with health care reform. The ACA created the Prevention and Public Health Fund, which is the nation's first mandatory funding organization dedicated to improving public health (American Public Health Association, 2013). The ACA provided this fund with \$18.75 billion for fiscal years 2010-2022 and \$2 billion per year thereafter (American Public

Health Association, 2013). However, in 2012 and 2013, severe cuts were made and only \$616.5 million was allocated to the fund in fiscal year (FY) 2013. Additionally, Congress passed, and the President signed, legislation that decreased the fund by \$6.25 billion over nine years (FYs 2013-2021). The cut was made to offset the increase in provider payments for Medicaid services (American Public Health Association, 2013). The fund currently supports prevention programs at the local, state, and federal levels that fight obesity and tobacco use and increase access to preventative care services. The fund also helps state and local governments to respond to public health outbreaks and threats (American Public Health Association, 2013).

#### Long-term Care

As the aging population increases, the need for long-term care grows. The ACA provides programs and funding to ensure access to long-term care in the home or community. The Home and Community-Based Services State Plan Option is described in section 2402 of the ACA. This program enables states to target home and community services to specific groups of people, provide accessible services to more individuals, and ensure quality services (Centers for Medicare and Medicaid Services, n.d.). Section 2401 of the ACA includes Community First Choice, which provides federal funding to states that provide person-centered home and community-based attendant services and support to increase the ability of people with disabilities to live in the community. The State Balancing Incentive Payments Program is detailed in section 10202 in the ACA. This program authorizes grants to states to increase access to non-institutional long-term services and support. Section 2403 includes Money Follows the Person (MFP), which is a program that provides individuals with long-term services and support to move out of

institutions and into their own homes or other community-based settings (Centers for Medicare and Medicaid Services).

### **Physician Shortages**

In 1970, there were a total of 334,028 physicians in the United States, and that number has greatly increased over the past four decades (Chang, Stukel, Flood, & Goodman, 2011). In 2010, according to the American Medical Association (AMA) Physician Masterfile, there were 985,375 physicians in the U.S. This is a 195% increase since 1970. The AMA also calculated the physician-to-population ratio and found an increase of 98% from 1970 to 2010. In 1970, there were approximately 161 physicians per 100,000 people in the U.S., and in 2010, the ratio increased to 319 physicians per 100,000 people (Heisler, 2013). However, even with the physician population growth, there remains a provider shortage, which will continue to grow due to the millions of people who will gain health care coverage through the Affordable Care Act.

In 2008, before the passing of the ACA, the Association of American Medical Colleges (AAMC) estimated that by the year 2025, there would be a shortage of 124,000 physicians (Dill & Salsberg, 2008). The AAMC revisited this estimation after the passage of the ACA, and the AAMC now predicts a shortage of 130,000 physicians by 2025 (Association of American Medical Colleges, 2010).

The provider shortage is felt throughout all health care domains, however, primary care is the worst off. In the mid-1990's, health maintenance organizations (HMOs) became popular and shifted the emphasis to primary care. During the 1990's, primary care physicians increased from 67 per 100,000 population to 90 per 100,000 population (Bodenheimer & Pham, 2010). In 1992, 15% of graduating U.S. medical

students were planning to enter primary care, and in 1997, the number increased to 40%. However, this increase was short-lived. By 1997, HMOs and primary care were declining. Primary care provider responsibilities grew while their pay declined. There was a wide and growing income gap between primary care physicians and specialists (Bodenheimer & Pham, 2010). In a 2007 survey of fourth-year medical students in 11 medical schools in the U.S., only 4.9% were planning a career in family medicine, or primary care (Hauer et al., 2008).

In 2008, according to the Medical Expenditure Panel Survey (MEPS), 977 million people made office visits to physicians (Pettersen et al., 2012). Of these office visits, 462 million were to primary care physicians. The National Ambulatory Medical Care Survey (NAMCS) has similar figures with 994 million office visits, in which 50% of those, or 497 million, were to primary care physicians. This data represents a mean of 1.6 primary care physician visits per person annually. The insured made more office visits than the uninsured, and the gap widens with the elderly (Pettersen et al., 2012). In 2008, the AMA Physician Masterfile indicates that there were 243,360 practicing primary care physicians (PCPs). After adjusting for retirement and physicians practicing in emergency departments or urgent care facilities, it is estimated that there were 206,369 physicians practicing in a primary care office setting in 2008. Therefore, assuming 462 million primary care office visits were made, each PCP had 2,237 visits per year. However, data estimates that the U.S. had only 1 practicing PCP for every 1,475 people. Since the passing of the ACA, it is projected that the total number of PCP office visits will increase from 462 million in 2008 to 565 million by 2025. Due to aging alone, PCP visits are expected to increase from 1.6 in 2008 to 1.66 in 2025 (Pettersen et al., 2012).

Assuming that each PCP sees 2,237 patient visits annually, the U.S. will need approximately 260,687 practicing PCPs by the year 2025 (Petterson et al., 2012). This is an increase of 51,880 PCPs from the current workforce. Much of the increased need is due to population growth, which will require 33,000 additional PCPs. Population aging will create a demand for an additional 10,000, and insurance expansion under the ACA will require about 8,000 additional PCPs (Petterson et al., 2012).

### **Role of the Nurse Practitioner**

The AHRQ reports that in the U.S. during the 1960's, nurse practitioners (NPs) and physician assistants (PAs) were created in response to uneven distribution and shortages of physicians (Agency for Healthcare Research and Quality, 2011). As of 2010, the Centers for Medicare and Medicaid Services reported a total of 106,073 NPs and 70,383 PAs practicing in the U.S. A little more than half, 55,625 or 52%, of NPs were practicing in primary care, while 30,402, or 43.4%, of PAs were in primary care (Agency for Healthcare Research and Quality, 2011). Even with the use of NPs and PAs in primary care, shortages are still inevitable.

All nurse practitioners are registered nurses with advanced degrees at the Master's or Doctorate level. The scope-of-practice for NPs varies by each state in the U.S. Some states require no physician oversight of NPs, while other states do not allow for as much autonomy. One study looked at six different states in the U.S. to determine their scope-of-practice laws for NPs. In Maryland and Arizona, NPs had full autonomy and did not require physician oversight (Yee, Boukus, Cross, & Samuel, 2013). In Michigan and Indiana, NPs had to have a collaborative agreement with physicians to prescribe. In Massachusetts and Arkansas, NPs had very little autonomy, in that they are required to

have collaborative agreements with physicians to diagnose, treat, and prescribe (Yee et al., 2013). Despite many states limiting NPs' autonomy, the study found that payer policies had more of an impact on how and where NPs practiced than the individual states' scope-of-practice regulations. Both private and public payers must adhere to each states' scope-of-practice laws, but they often add additional restrictions. For example, NPs are not recognized as primary care providers by Medicaid in Arkansas and Indiana. Additionally, the Medicaid program in Arkansas will not pay for influenza swabs or streptococcal screenings performed by NPs, which further limits the NPs ability to provide services. Due to these restrictions, many NP services are provided as "incident-to" the physician, which allows billing for NP services under the physician's name (Yee et al., 2013). These laws and restrictions make NP practice challenging, which is worsening the current provider shortage by limiting the care an NP is allowed to provide. Despite these setbacks, the number of practicing NPs is expected to double by 2025. The ACA supports every person practicing at the highest level of their scope-of-practice, and many suggestions are being made to expand the role of the NP (Yee et al., 2013).

As discussed previously, the number of physicians is inadequate, and the problem is even worse in the primary care sector. However, the growth of NPs is increasing and is expected to increase by 9% annually (Naylor & Kurtzman, 2010). Between 1995 and 2006, primary care medical residency programs declined by 3%, while NP primary care training programs grew by 61%. Unfortunately, due to faculty shortages and an inadequate supply of clinical preceptors and placements, more than 2,700 qualified applicants were denied admission to a master's degree program for NPs in 2008 (Naylor & Kurtzman, 2010).

There have been many research projects conducted regarding the quality of NPs' performance as compared to physicians'. A Canadian study found that NP care was equivalent to that of a physician in areas such as patient satisfaction, patient outcomes and mortality, and physical, social and emotional functioning (Naylor & Kurtzman, 2010). Additionally, a study performed by the congressional Office of Technology Assessment (OTA) found that NPs provided quality care that was equivalent to physicians. Recent systematic reviews found that patients receiving care from NPs were more satisfied and had longer consultations (Naylor & Kurtzman, 2010).

On April 16, 2015, President Obama signed into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015. The law replaces the Medicare Sustainable Growth Rate (SGR) formula for provider reimbursement with an improved payment system that rewards quality, efficiency, and innovation; including nurse practitioners, clinical nurse specialists (CNS), and certified registered nurse anesthetists in the new Merit-Based Incentive Payment System. Lastly, it removes the barrier to practice in Medicare, allowing APRNs to order durable medical equipment and document the required face to face encounter. Previously, NPs and CNSs were required to have a co-signature by a physician (American Nurses Association, 2015). The ANA President, Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, stated "The provisions affecting nursing in this bill recognize that nurses provide high-quality, efficient and cost-effective services that are valued and needed by Medicare patients, many of whom rely on APRNs for their primary care needs...Nurses are more than ready to meet the quality and accountability standards for reimbursement and will continue to improve the health care experience for some of the nation's most vulnerable citizens" (American Nurses Association, 2015).

### **Influx of Newly Insured into the Health Care System**

Before the enactment of the Affordable Care Act, there were approximately 57 million uninsured people in America, or 17% of the total U.S. population (Foster, 2010). It is estimated that by the year 2019, the number of uninsured will decrease to approximately 23 million, or 7% of the U.S. population. Therefore, by 2019, it is estimated that 34 million people will gain health care coverage. Of those 34 million people, about half, or 18 million, will be covered under Medicaid. In order to be eligible for Medicaid, a person must be under 133% of the federal poverty line. It is estimated that the majority of people, approximately 15 million, will gain health care coverage in the first year, 2014, and the remaining will gain coverage by 2016 (Foster, 2010).

There have been many coverage expansions made under the ACA. One major expansion was the requirement of all health insurance policies to cover dependents up to the age of 26 years old (Blumenthal & Collins, 2014). In 2013, the Commonwealth Fund performed a survey and found that 7.8 million adults between the ages of 19 and 25 years were enrolled in their parents' health insurance. They also found that most of these enrollees would not have been eligible to remain on their parents' insurance without passage of the ACA (Blumenthal & Collins, 2014). Therefore, without this law, those 7.8 million young adults may have been uninsured.

As of May 1, 2014, eight million people enrolled in health insurance plans through federal and state market places (Blumenthal & Collins, 2014). Federal market places enrolled 68% or 5.4 million people, and state market places enrolled 32% or 2.6 million. Many people are enrolling through federal market places, but some states are having higher success with their state market places. States that have successful systems

include California, Connecticut, Kentucky, New York, and Rhode Island. These states' systems have substantially contributed to the increase in new health insurance enrollees (Blumenthal & Collins, 2014). The Congressional Budget Office estimates that a total of 25 million people will gain insurance through these market places by the year 2017 (Blumenthal & Collins, 2014).

As discussed previously, America is already experiencing a shortage in health care providers. It is estimated that by 2025, the U.S. will need an additional 51,880 PCPs. New insurance enrollees will require 8,000 new PCPs alone (Petterson et al., 2012). With this new influx of patients into the health care system, it is unknown how people will be taken care of related to the shortages of providers, and if access to insurance coverage actually equates with access to care.

### **An Aging Population**

According to the U.S. Census Bureau, the U.S. population, as of New Year's Day 2014, was 317.3 million people and growing. This is a 2.2 million, or 0.7%, increase from New Year's Day 2013 (The United States Census Bureau, 2013). In 2000, there were 35 million Americans over the age of 65, accounting for 12% of the population. By 2030, it is estimated there will be over a 50% increase to 72 million Americans age 65 or older, which will account for 20% of the total U.S. population (Federal Interagency Forum on Aging-Related Statistics, 2012).

The ACA was passed in 2010. Three years later, in 2013, more than one in every eight Americans was over 65 years old (Maga & Lewis, 2014). That represents 13.3% of the population, or 41.4 million Americans. Over the past century, the number of new elders has drastically increased. In 1900, there were only 3.1 million people over age 65, which represented 4.1% of the U.S. population. It is predicted that by 2040, the elderly

population will double again. Due to increasing numbers alone, these older adults will be challenging to care for, as they require the most services and uses the most health care dollars (Maga & Lewis, 2014). As discussed previously, the rising elderly population alone will require an additional 10,000 PCPs by the year 2025 (Petterson et al., 2012).

Many elderly Americans have multiple chronic conditions and diseases. This population has difficulty paying for care and prescriptions, which often leads to non-adherence, and ultimately, poor health. In January 2006, Medicare Part D was implemented to address the issue of prescription affordability (Naci et al., 2014). Improvements in affordability of prescriptions occurred from 2007 to 2009, but then declined after 2009. In 2009, elderly beneficiaries with four or more chronic conditions had a 14.4% rate of cost-related nonadherence. This prevalence increased to 17% in 2011. In 2007, 8.7% of the sickest elderly were forgoing basic needs to pay for medications. This rate declined to 6.8% in 2009, but increased again to 10.2% in 2011 (Naci et al., 2014). The ACA was passed in 2010 with the goals of increasing quality and access to care while decreasing cost. However, affordability of medications for the elderly has become worse since the passage of the ACA, and this problem will undoubtedly lead to nonadherence and poor health outcomes for the elderly.

## Theoretical Framework

The theoretical framework that was used to describe the policy levels included in the complex ACA will be The Conceptual Model for Nursing and Health Policy Revisited, created by Gail E. Russell and Jacqueline Fawcett. The framework was first introduced as A Conceptual Model of Nursing and Health Policy in 2001 (Russell & Fawcett, 2001), and was revisited in 2005 (Russell & Fawcett, 2005). The model was created to develop knowledge of health policy within the discipline of nursing. The Conceptual Model for Nursing and Health Policy Revisited discusses four levels of nursing and health policy focus and outcomes, whereas the original model from 2001 had five levels. The levels are interacting and start out with a specific population and expand into a global perspective. Each level is further broken down into five categories: human beings, environment, health, nursing and health policy focus, and nursing and health policy outcomes (Russell & Fawcett, 2005).

The Conceptual Model for Nursing and Health Policy Revisited, which will herein be referred to as The Conceptual Model, was applied to selected provisions of the ACA. The initial three interacting levels were utilized to describe aspects of the Affordable Care Act that relate to the individual stakeholders and, more broadly, the healthcare system and nation as a whole.

Level 1 of The Conceptual Model emphasizes the quality and efficacy of nursing practice process on individuals, families, groups and communities. The health concerns in this level are the wellness and illness conditions of individuals, families, groups, and communities. The concerns extend into the environment of significant others, relevant inanimate surroundings, and the nursing practice delivery system. Nursing practice

processes of focus are assessment, labeling, planning, implementation, and evaluation (Russell & Fawcett, 2005).

A provision of the ACA that relates to Level 1 of the model is the Prevention and Public Health Fund, which was created in 2010. The fund was the first federal funding of public health and prevention (Trust for America's Health, 2015). This Fund supports health promotion and disease prevention to individuals, families, groups, and communities. In 2015, the Fund will invest \$1 billion in programs to promote health. Over the next 10 years (FY 2015-2024), the Fund will invest \$14.5 billion in prevention programs. The Fund supports new programs such as State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke and Tips from Former Smokers Campaign. The Fund also supports immunization services and interventions that reduce hospital acquired infections (Trust for America's Health, 2015). These programs represent Level 1 of The Conceptual Model by promoting wellness and prevention for individuals, families, groups, and communities.

Level 2 of the model emphasizes quality and cost as measures of the effectiveness of the nursing practice processes and the efficiency of health care delivery subsystems. The Conceptual Model's target population is a specific nursing practice or health care delivery system. The environment is a specific health care delivery system or all of the delivery systems. Health is determined by the functional condition of the nursing practice delivery subsystem or the specific health care delivery system. Nursing and health policy focuses on nursing practice delivery subsystem administrative practices or health care delivery subsystems, which include nursing integration and administrative

practices (Russell & Fawcett, 2005). The ACA represents level 2 of the model because one of the main goals of the ACA is to contain costs while improving quality of care.

Another provision of the ACA that relates to level 2 of The Conceptual Model is the Accountable Care Organizational model. Accountable Care Organizations (ACO's) are networks of providers and hospitals who are medically and financially responsible for providing quality care and limiting health care waste (Gold, 2014). These networks of providers and hospitals care for individuals, groups and communities. Their goal is to provide quality care and decrease health care expenditure by limiting waste, such as unnecessary tests and hospital readmissions. To achieve this goal, the ACO's are coordinating care with all in-network providers and hospitals. They ensure follow-up after discharge from the hospital, and they share information between primary providers, specialists, and hospitals. This sharing of information is expected to decrease the amount of unnecessary tests (Gold, 2014).

Level 3 emphasizes access. Outcomes are based upon the equity of access to effective and efficient nursing practice processes, practice delivery systems, and distribution of cost and burden of care delivery. The population focus is on health care systems in geopolitical communities, states, and nations. The specific environment is a geopolitical community, and the health status is determined by the functional condition of the health care system. The nursing and health policy focus is based on health care system administrative practices (Russell & Fawcett, 2005). An example of level 3 is the ACA's goal of providing access to care for all people in the U.S.

A concern related to this goal of the ACA is the shortage of primary care providers in America, which impedes access to care for millions of older adults. The

current PCP shortage greatly challenges access to care because not all people are able to find a PCP. It is estimated that by the year 2025, America will need 260,687 practicing PCPs to adequately care for all people in the U.S. (Pettersen et al., 2012). To reach that number, there will need to be an additional 51,880 PCPs added to the current workforce. Population aging alone will require an additional 10,000 PCPs, and insurance expansion under the ACA will require approximately 8,000 additional PCPs (Pettersen et al., 2012). A diversity of Americans will be in need of PCPs, including the elderly and immigrant populations. On March 3, 2015, The U.S. Census Bureau released a report stating that 52% of all children under 18 years are single-race non-Hispanic white (U.S. Department of Commerce, 2015). By 2060, it is projected that only 36% of all children will be single-race non-Hispanic white. In 2014, America's foreign-born population was 13% of the total population. By 2060, it is estimated that 19% of the total population will be foreign born (U.S. Department of Commerce, 2015). So, while a major goal of the ACA is to provide access to health care to all people in America, the current provider shortage defeats this goal.

Level 4 of The Conceptual Model emphasizes quality, cost, and access on a global scale. Outcomes are based on justice, which involves social changes and market interventions based on equity. The population is broadened to humankind in general, and the environment is the global community as a whole. The focus is on the health of global conditions and world health administrative practices (Russell & Fawcett, 2005). This fourth level of the model does not pertain to the ACA, as the law regulates health care in the U.S. only.

## **Policy Analysis**

### **Stages of the Process and Recommendations**

McLaughlin and McLaughlin created the Policy Analysis Process, which utilizes six stages in analyzing a health policy (McLaughlin & McLaughlin, 2007). These six stages will be used to guide a policy analysis of the ACA and recommend solutions to the current policy.

Stage 1 of the analysis is problem identification. As stated previously, a major problem with the implementation of the ACA is the shortage of providers in the health care work force, which is disabling access to care. Primary care faces the largest shortages, needing an additional 51,880 PCPs by the year 2025. Of those additional PCPs, 10,000 will be solely to accommodate the aging population (Pettersen et al., 2012).

Stage 2 of the analysis is process definition. A current challenge in our health care system is the provision of primary care to expanding populations of elders and immigrants. In 2000, the elder population accounted for 12% of the population, with 35 million Americans over the age of 65. It is estimated that by 2030, there will be over a 50% increase to 72 million Americans age 65 or older, which will account for 20% of the total U.S. population (Federal Interagency Forum on Aging-Related Statistics, 2012). In 2013, more than one in every eight Americans was over 65 years old, which represents 13.3% of the population, or 41.4 million Americans (Maga & Lewis, 2014). It is concerning to have a diverse, complex elder population, with multiple co-morbidities, while also being in the midst of a provider shortage. To address this situation, PCPs will receive a 10-percent bonus for treating Medicare patients, and in 2013 and 2014, PCPs received higher reimbursement rates for Medicaid that were equal to Medicare rates

(Davis et al., 2011). However, with continued spending cuts, reimbursement is likely to recede.

Stage 3 is the process analysis. In this stage, the impacts of the health policy are analyzed (McLaughlin & McLaughlin, 2007). This is difficult to assess related to the novelty of the ACA, however, by 2019, it is estimated that 34 million Americans will gain health care insurance, and half, or 18 million, will be covered under Medicaid (Foster, 2010). This new influx of patients into the health care system, combined with the aging population and shortage of PCPs, will undoubtedly create a crisis in access to care.

Stage 4 of the process includes qualitative analysis, which, for the purpose of this analysis, will focus on assessing the quality and distribution of health care (McLaughlin & McLaughlin, 2007). A goal of the ACA is to provide access to quality care to all Americans. As discussed earlier, Accountable Care Organizations (ACOs) are networks of providers and hospitals that share responsibility for coordinating care of their patients. This ACO model provides continuity of care to patients, which increases satisfaction and yields better outcomes. However, ACOs are not required under law; they are suggested as an incentive, so not all Americans have the opportunity to be included in an ACO.

Stage 5 of the policy analysis includes evaluating the qualitative and quantitative evidence (McLaughlin & McLaughlin, 2007). In order to evaluate the success of the ACA, the short-term outcomes will be compared to the two primary goals of the ACA: (a) make health care accessible to all people, and (b) improve health outcomes, increase quality of care, lower health care costs and improve the process of delivering care. The ACA attempts to achieve the first goal by providing health care insurance to all

Americans. Health insurance is not synonymous with access, however, as evidenced by the primary care workforce shortage. The ACA attempts to achieve the second goal by promoting the development of ACOs, creating wellness and prevention programs, and increasing reimbursement to primary care providers. The ACA is making strides in providing wellness and prevention programs through enhanced insurance plans that include reimbursement with limited cost sharing for wellness programs. Of concern, though, is that there are not enough health care workers or funds to develop and maintain these programs at a level that would benefit all Americans. Therefore, when comparing short-term outcomes with the ACA's main goals, it is apparent that there are not enough funds or providers to give adequate care to the American people. This will worsen in time because the population continues to expand and people are living with more comorbidities.

Stage 6 of the analysis process focuses on recommendations for policy change (McLaughlin & McLaughlin, 2007). Recommendations will be made relating to the two primary goals of the ACA: (a) make health care accessible to all people, and (b) improve health outcomes, increase quality of care, lower health care costs and improve the process of delivering care. Recommendations to achieve the first goal will focus on expanding the health care workforce, and the second goal will focus on coordination of care.

The overall, very ambitious goal of the ACA is to provide access to health care to all Americans. The ACA attempted to achieve this goal by providing health insurance eligibility to all Americans. However, as has been discussed, health care coverage does not equate to access to care. In order to provide access to care to all Americans, the health care workforce must expand. As stated previously, there would need to be an

additional 51,880 PCPs added to the workforce by 2025 to adequately care for all Americans (Pettersen et al., 2012). Most medical students are not interested in primary care related to lower incomes as compared to specialty practice (Hauer et al., 2008). With looming student loan debts, students are looking to make the most money in order to repay their debt and to have a gratifying income. To fill the PCP demand, primary care must look more appealing to new medical school graduates. There should be incentives to PCPs with higher reimbursements to increase salaries. ACOs are attempting to do this by providing increased reimbursements if target savings are met among the group network (Gold, 2014). Additionally, more professors must be added to the workforce. Physicians make more money practicing than teaching, and therefore, there is a shortage of medical professors. Not only must the physician population increase, but the nurse practitioner (NP) population should increase as well. Primary care accounts for 52% of NP practice as of 2010. Primary care has the greatest need for providers, and research shows that NPs can fill that role effectively and efficiently. NP school is two years less than medical school, and it does not require a residency program post-grad. Therefore, NP vacancies can be filled much faster than MD positions. In addition to expanding the number of NPs, the role of the NP must also expand. Currently, there is no federal scope-of-practice standard for NPs, and guidelines vary from state-to-state. The ACA must support NPs practicing at the top of their scope-of-practice, allowing all NPs to practice independently to alleviate primary care shortages.

To achieve the second goal of the ACA, coordination of care is a necessity. As previously discussed, ACOs are coordinating care between providers and hospitals. However, not all providers are in an ACO. A large disconnect continues to create

disparities among continuity and coordination of care. A system or programs must be created to coordinate care as patients navigate through the health care system. This could be achieved with federal grants that support the integration of care coordination across the continuum of care. This initial investment would save money in the long run by providing coordinated, quality care. This type of coordination of care could be achieved by having one national system that holds all patient health records. Each American would have their own code and their own record, which would contain all of their medical information from allergies to the most recent lab tests. Additionally, there must be programs and positions created to facilitate safe transitions in care, from inpatient to the community setting. This would include increasing the number of nurses and social workers who act as case managers and advocates to meet the complex physical, social, and emotional needs of diverse patient populations.

## **Methodology**

### **Problem Statement**

The Patient Protection and Affordable Care Act (ACA) is creating a new influx of patients into the healthcare system. The goals of the ACA are to increase quality of care and provide access to care for all Americans. America is already facing a problem of health care provider shortages, especially in the primary care setting. Currently, there are not enough primary care providers to care for the insured. It will be a more devastating problem as the population ages and more people are obtaining health insurance.

### **Purpose**

The purpose of this project was to perform a policy analysis of the provisions of the Patient Protection and Affordable Care Act (ACA) that relate to access to primary care by older adults and to examine if the primary care work force is adequate to meet the needs of an expanding elderly population.

### **Procedures**

First, the data and information were collected through sources such as CINAHL, Ovid, Google Scholar, MEDLINE, PubMed, medical, political and health journals, news articles, and government sponsored websites. A comprehensive literature review was created with sections focusing on and describing health care around the globe, the ACA, health care workforce shortages, role of the nurse practitioner in the ACA, influx of newly insured into the health care system, and an aging population. Then, data were analyzed guided by the problem statement, purpose, and Russell and Fawcett's The Conceptual Model for Nursing and Health Policy Revisited (Russell & Fawcett, 2005). After performing research, analyzing the policy, and attending meetings, suggestions for

policy changes to the ACA were made, with evidence from supporting data, to improve policy and health outcomes.

### **Measurements**

Outcome measurements of this project included: a detailed policy analysis of the Affordable Care Act, research to identify policy problems and challenges of the ACA with strong supporting evidence, and suggested changes for policy improvement.

Outcomes were evaluated by the strength of evidence used to suggest policy improvements based on identified problems related to the ACA.

### **Ethics**

No human participants were included in this project, and therefore IRB review was not necessary for this policy analysis.

### **Data Collection and Analysis**

Different types of information were collected such as scholarly articles, official legislation, and quantitative data. Specifically, data were collected relating to the ongoing effects of the ACA with an emphasis on primary care and the elderly population. Information was also collected related to possible solutions to key problems with the current policy. The time period of data collection was one year, from May 2014 to April 2015. Key informants were the stakeholders, who are the people effected by the provisions of the ACA that related to the focus of this project.

Both qualitative and quantitative data were analyzed. Examples of data included articles, interviews, conferences, and raw numbers. Data were analyzed carefully, checking multiple sources and verifying reliability and authenticity. Data were also analyzed with the guidance of Russell and Fawcett's The Conceptual Model for Nursing

and Health Policy Revisited (Russell & Fawcett, 2005). The analysis process and recommendations were guided by the use of McLaughlin and McLaughlin's Policy Analysis Process (McLaughlin & McLaughlin, 2007).

### **Plan for Dissemination**

The accumulated knowledge and policy suggestions have the ability to be shared in numerous domains and settings. This project was presented at the Rhode Island College Masters of Science in Nursing symposium in May 2015. It was also posted on the online data base Digital Commons. Other options for sharing this project include submitting a poster and presenting at a conference, sharing information at a health care policy meeting or conference, or converting the project to a manuscript for submission to a journal for publication.

## **Summary and Conclusions**

The ACA was signed into law in 2010 and provides access to health insurance coverage for all people in the United States, with predictions of approximately 34 million people gaining coverage (Foster, 2010). The legislation changes health care delivery from “treating illness” to “promoting health”, while it also creates a new payment reform, in which quality is valued over quantity (Wilson, 2014). The ACA was analyzed using the guidance of The Conceptual Model for Nursing and Health Policy Revisited (Russell & Fawcett, 2005) and the Policy Analysis Process (McLaughlin & McLaughlin, 2007). Overall, the ACA is the first step in changing a broken health care system. However, it is overly ambitious and underprepared to provide quality care to all Americans. Suggestions and recommendations were made with two main goals in mind: expanding the health care workforce and improving coordination of care.

### **Recommendations and Implications for Advanced Practice Nursing**

Advanced practice registered nurses (APRNs) play a vital role in health policy. APRNs are the leaders in nursing; impacting education, practice, and policy. As key educators, APRNs create curricula to develop the knowledge, skills, and attitudes of advanced practice nurses. They perform research and promote evidence-based best practices. Nurses and APRNs are educated in a holistic way, encompassing the bio-psycho-social aspects of the whole person. This is crucial in addressing the social determinants of health for today's diverse society, especially the growing immigrant and elder populations. APRNs are also knowledgeable in the area of ethics, playing key roles on ethics committees and advocating for ethical health care policies. Based on nursing experience, APRNs know the importance of collaboration and continuity of care, supporting these essential processes through policies and procedures. APRNs act as mentors and role models for nurses, thereby advancing professional practice. Additionally, they join credentialing committees to promote APRNs working within their full scope of practice.

Diversity is an important issue to APRNs who will care for diverse populations and value diversity in the nursing workforce. According to the U.S. Census Bureau in 2012, ethnic and racial minority groups accounted for more than one-third, or 37%, of the U.S. population (American Association of Colleges of Nursing, 2014). By 2043, it is projected that the minority populations will become the majority. It is imperative, therefore, that nursing represent the diverse society that it serves.

According to a 2013 survey by the National Council of State Boards of Nursing (NCSBN) and The Forum of State Nursing Workforce Centers, only 19% of the

registered nurse workforce is represented by a minority population. The American Association of Colleges of Nursing (AACN) issued the report 2012-2013 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing (American Association of Colleges of Nursing, 2014). According to the report, nursing students from minority backgrounds represented 28.3% of students in entry-level baccalaureate programs, 29.3% of master's students, and 27.7% of students in research-focused doctoral programs (American Association of Colleges of Nursing, 2014).

Another aspect of diversity is gender, and in terms of gender breakdown, men comprise only 11.0% of nursing students in baccalaureate programs, 10.0% of master's students, 7.9% of research-focused doctoral programs, and 10.0% of practice-focused doctoral students (American Association of Colleges of Nursing, 2014). Though nursing schools have made strides in recruiting and graduating nurses that reflect our society, APRNs must lead initiatives that result in equal representation in nursing.

Quality and safety are cornerstones of the APRN practice. According to the Institute of Medicine (IOM) October 2010 report, *The Future of Nursing: Focus on Scope of Practice*, there is no scientific evidence to suggest that APRNs deliver care that is less safe, effective, and efficient than physicians (Institute of Medicine, 2010). Additionally, no studies exist that show that health care outcomes better in states that restrict APRN scope-of-practice. Instead, research evidence shows that nurses provide quality care to patients including: reducing or eliminating infections, preventing medication errors, and easing the transition patients make from hospital to home. Unfortunately, though, many states continue to limit the scope-of-practice of APRNs (Institute of Medicine, 2010).

Many stakeholders are working to eliminate the restrictions on APRNs' scope-of-practice. In 2008, several nursing organizations developed the Consensus Model, which standardized the regulations for APRNs, including education, accreditation, certification, and licensure (Institute of Medicine, 2010). Despite this standardization of advanced practice, however, APRNs continue to have less recognition than physicians, and scope-of-practice continues to be inconsistent throughout each state. Advanced practice nurses must work with their legislators to change Nurse Practice Act language so that they can be employed as autonomous primary care providers.

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## Appendix A

## Approximate U.S. Health Care Waste in 2011

Category	Money Spent in Billions
Failures of Care Delivery	\$102 - \$154
Failures of Care Coordination	\$25 - \$45
Overtreatment	\$158 - \$226
Administrative Complexity	\$107 - \$389
Pricing Failures	\$84 - \$178
Fraud and Abuse	\$82 - \$272
<b>Total</b>	<b>\$558 billion - \$1.264 trillion</b>

(Beriwck &amp; Hackbarth, 2012)

## Appendix B

## The U.S. Compared to Other Countries: Diagnostic Tests and Surgeries

Diagnostic Test/ Surgery	United States	Rank compared with OECD countries	OECD average
MRI Units	31.6 per million population	2 <sup>nd</sup>	12.5 per million population
MRI exams	97.7 per 1,000 population	2 <sup>nd</sup>	46.3 per 1,000 population
CT scanners	40.7 per million population	3 <sup>rd</sup>	22.6 per million population
CT exams	265.0 per 1,000 population	3 <sup>rd</sup>	123.8 per 1,000 population
Tonsillectomy	254.4 per 100,000 population	1 <sup>st</sup>	130.1 per 100,000 population
Coronary bypass	79 per 100,000 population	3 <sup>rd</sup>	47.3 per 100,000 population
Knee replacements	226.0 per 100,000 population	1 <sup>st</sup>	121.6 per 100,000 population
Caesarean sections	32.9 per 100 live births	6 <sup>th</sup>	26.1 per 100 live births

This information was obtained from OECD data from 2012 (Kane, 2012, figure 4)

## Appendix C

## Fundamentals of Health Care Pre- and Post-ACA

Pre-ACA	Post-ACA
<ul style="list-style-type: none"> <li>• Treating sickness</li> </ul>	<ul style="list-style-type: none"> <li>• Promoting wellness and prevention</li> </ul>
<ul style="list-style-type: none"> <li>• Paying for volume; fee-for-service</li> </ul>	<ul style="list-style-type: none"> <li>• Paying for value; performance based</li> </ul>
<ul style="list-style-type: none"> <li>• Emphasizing acute care</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasizing primary or outpatient care</li> </ul>
<ul style="list-style-type: none"> <li>• Treating care in isolated episodes</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinating care across continuum and across disciplines</li> </ul>
<ul style="list-style-type: none"> <li>• Treating chronic disease in isolated individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Managing and treating care among populations</li> </ul>
<ul style="list-style-type: none"> <li>• Paper-based patient records</li> </ul>	<ul style="list-style-type: none"> <li>• Electronic health records</li> </ul>
<ul style="list-style-type: none"> <li>• Doctor and system-centered care</li> </ul>	<ul style="list-style-type: none"> <li>• Patient-centered care; decision making shared by patients, caregivers, and families</li> </ul>

(Wilson, 2014)