CHAPTER 2
Health-Care Delivery, Settings, and Economics

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KEY TERMS

Capitation (KAP-ih-TAY-shun)
Case management (KAYSS MAN-aj-ment)
Patient-centered care (PAY-shent SEN-terd KARE)
Diagnosis-related groups (DYE-ag-NOH-siss rih-LAY-ted GROOPS)
Health-care provider (HELLTH KARE proh-VYE-duhr)
Health maintenance organization (HELLTH MAYN-tuh-nanss OR-ga-nih-ZAY-shun)
Home health care (HOHM HELLTH KARE)
Hospice (HOS-pis)
Inpatient (IN-pay-shent)
Managed care (MAN-ajd KARE)
Medicaid (MED-ih-kayd)
Medicare (MED-ih-kare)
Outpatient (OWT-pay-shent)
Point-of-service plan (POYNT-uv-SER-viss PLAN)
Preferred provider organization (PPO) (prih-FERD pro-VYE-duhr OR-ga-nih-ZAY-shun)
Primary care nursing (PRY-mare-ee KARE NER-sing)
Primary care physician (PRY-mare-ee KARE fih-ZIH-shun)
Referral (rih-FER-uhl)
Rehabilitation (REE-ha-BIL-ih-TAY-shun)
Team nursing (TEEM NER-sing)
Third-party payer (THERD-PAR-tee PAY-uhr)

CHAPTER CONCEPTS

Caring
Collaboration
Evidence-Based Practice
Leadership and Management
Health Policy
Health-Care Systems

LEARNING OUTCOMES

1. Define various terms associated with health-care delivery and economics.
2. Discuss health-care collaboration and how it links to patient safety.
3. Identify the two most important factors in health-care delivery and economics.
4. Describe members of the health-care team and their functions.
5. Describe inpatient health-care settings and their services.
6. Describe outpatient health-care settings and their services.
7. Explain two types of rehabilitation services.
8. Distinguish between types of nursing care delivery systems.
9. Contrast Medicare and Medicaid.
10. Describe various types of private health insurance.
11. Discuss information found in the Connection features of the chapter.

CRITICAL THINKING CONNECTION

Clinical Assignment

You have been assigned to care for a 60-year-old female patient diagnosed with colon cancer. She underwent abdominal surgery to remove the tumor, and now she has an infected abdominal wound. Her care plan calls for dressing changes on the wound twice a day and IV antibiotics. She is very anxious to get home so that she can take care of her two young grandchildren, of whom she has primary custody. There are no other adults in the home to help care for her.

Critical Thinking Questions:

1. What concerns do you have regarding discharge of this patient?
2. What resources are available to help her?
3. How can the hospital staff help prepare her for discharge?

THE HEALTH-CARE TEAM

A patient in a health-care facility sees an amazing number of different workers, all of whom are members of the health-care team. These team members provide medical and mental health services to patients in various settings. They have a common goal of providing quality, cost-efficient care to all their patients in order to restore them to their optimal level of functioning and wellness.

While caring for patients on a busy day, the last thing on the minds of many nurses is who is paying for each patient's care. Yet some entity is responsible for payment. As a nurse, it is important for you to be conscious of cost, to conserve supplies when possible, and to avoid waste. In this chapter we will talk more about who pays for health care and how.

Collaboration of the Health-Care Team

You will work with a variety of team members with different types of training and areas of focus (Table 2.1). Please note that physicians, physician assistants, and nurse practitioners are referred to in this book as **health-care providers** (HCPs) because they all write orders for patient care. It is important that you realize the valuable input of each health-care team member. It takes all of us working together to deliver quality health care to our patients. Communication between members of the health-care team is also extremely important. This

Table 2.1
The Health-Care Team

Staff Member	*Description*
Health-Care Providers	
Medical Doctor (MD) Doctor of Osteopathy (DO)	Responsible for diagnosing and treating disease, illness, and injury; ordering diets, tests, medications, treatments, therapies, and procedures; and directing overall care of patients
Physician Assistant (PA)	Employed by a physician or hospital to work closely with the physician and assist in directing patient care
Nurse Practitioner (NP)	Masters-prepared registered nurse certified in a specific area of practice and identified with advanced practice license who diagnoses illnesses and prescribes medications and treatments
Nursing Staff	
Registered Nurse (RN)	Practices nursing within a defined scope under the direction of a physician; provides direct patient care, manages departments, and supervises other nurses and assistive personnel
Licensed Practical/Vocational Nurse (LPN/LVN)	Practices within a defined scope under the supervision of a physician, dentist, or RN; provides direct patient care and supervises assistive personnel
Unlicensed Assistive Personnel (UAP)	Performs more complicated tasks than the certified nursing assistant, including sterile procedures, in some states
Certified Nursing Assistant (CNA)	Performs patient care duties and assists nursing staff
Therapy Staff	
Respiratory Therapist (RT)	Evaluates, treats, and cares for patients with breathing problems due to heart and lung disease
Respiratory Therapy Technician (RTT)	RTT generally works under the supervision of an RT
Physical Therapist (PT)	Provides services to help improve or restore function and mobility, relieve pain, and prevent or limit permanent physical disabilities for patients suffering from injuries and disease
Physical Therapy Assistant (PTA)	PTA generally works under the supervision of a PT and carries out the PT's orders
Speech and Language Therapist (ST)	Assesses, diagnoses, treats, and helps to prevent disorders related to speech, language, voice, swallowing, and fluency

Continued

Table 2.1
The Health-Care Team—cont'd

Staff Member	*Description*
Occupational Therapist (OT) Certified Occupation Therapy Assistant (COTA)	Assists patients with disabilities to develop, recover, or maintain their skills for daily activities and work
Laboratory Staff	
Pathologist (MD)	Medical doctor who examines tissue and blood samples to determine the origin or existence of disease
Medical Laboratory Technologist (MLT) Medical Technician (MT)	Examines and analyzes body fluids and tissues, matches blood for transfusions, and tests for blood levels of medications
Phlebotomist	Draws blood specimens from patients for testing
Radiology Staff	
Radiologist (MD)	Medical doctor who specializes in procedures involving x-rays and radiation therapy; reads radiographs and other radiological films
Radiologic Technologist (Rad Tech)	Operates x-ray machines and other radiological equipment, such as computed tomography (CT) scanners, as well as magnetic resonance imaging (MRI) and ultrasound equipment; assists the radiologist by performing ordered tests to determine diagnoses and treat certain diseases
Ancillary Staff	
Pharmacist	Pharmacist distributes prescription medications and advises patients and prescribers on the selection
Pharmacy Technician	Pharmacy technician assists pharmacist by helping to prepare prescribed medications
Registered Dietitian (RD)	RD plans regular menus and develops special menus to meet the dietary needs of patients, works with health-care providers to meet special dietary needs, and instructs patients on special diets
Dietary Technician	Dietary Technician assists the RD by distributing and picking up selective menus and monitoring patient food intake
Medical Social Worker Public Health Social Worker	Provides psychosocial support to patients, families, or vulnerable populations; advises caregivers; counsels patients; plans for patients' needs after discharge; and arranges for needed care such as home health care
Chaplain	Provides spiritual care for patients in hospitals and hospice settings, meets the spiritual needs of families and patients when diagnosis is terminal or when death occurs, and provides spiritual care for hospital staff

is discussed further in Chapter 6. When health-care workers collaborate with one another, one of the most positive outcomes is improved patient safety. Poor quality care and higher rates of preventable errors occur when health-care personnel act alone, or in a "silo."

Advancements in health information technology (HIT) and the development of electronic health records (EHRs) contribute to team coordination and collaboration by allowing health-care teams to quickly receive and analyze more data about patient care and outcomes. This data technology is referred to as *big data*; it is used to assist the health-care team in improving patient safety, care quality, and nursing practices.

One program, called Team STEPPS, is available through the Agency for Healthcare Research and Quality (AHRQ). This program teaches evidence-based teamwork to improve communication and teamwork skills, which in turn helps raise quality and safety in health-care settings. More information

on this program is available at https://www.ahrq.gov/teamstepps/index.html.

Interprofessional collaboration allows health-care professionals and patients to access one another's knowledge, unique perspectives, and specialized skills to better address the needs of all patients and their families. No one can do this all alone. As a nurse, you have a critical role in collaborating with health-care professionals, patients, and patient families to ensure quality care.

Multidisciplinary Team Conferences

One way to help facilitate communication between professionals caring for the same patients is through multidisciplinary team conferences. These conferences bring together all of the disciplines involved in the patient's care. For example, a patient who has had a stroke and is paralyzed with difficulty swallowing and eating might have a multidisciplinary team that includes the health-care provider, the physical therapist, the occupational therapist, the speech therapist, the dietitian, and a representative from the nursing staff. Each discipline has input for the care of the patient to bring about the best outcomes.

DETERMINING THE DELIVERY OF EFFECTIVE CARE

When the economics of care is a foremost consideration, two factors help guide decisions about patient care: *medical necessity* and the *appropriate level of care.* These factors are important to ensure that patients get the care they need in the correct setting, while being cost-effective and promoting patient improvement. In order to make these decisions about care, *insurers* (the entity or entities that are responsible for paying part or all of the patient's care) use some form of managed care. **Managed care** has been defined as "any method of financing and organizing the delivery of health care in which costs are contained by controlling the provision of benefits and services."

Medical Necessity

Insurers determine medical necessity by comparing the patient's clinical/medical information against accepted medical review criteria. According to government funding sources, *medical necessity* is defined as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. This means that the services must seem reasonable and necessary to the entity paying for them.

Example of Reasonable and Necessary Services

If a person has health insurance and submits a claim for a face lift, the insurance company would not pay it because a facelift is not needed to diagnose or treat an illness or injury, nor does it improve the functioning of a malformed body part. However, another person could submit a claim for facial reconstruction surgery after a car accident, and that claim would be paid because it is reasonable and necessary to repair the person's facial structures after an injury.

Appropriate Level of Care

Another aspect of paying for health care requires determining an appropriate level of care to meet the patient's needs. In today's health-care environment, there is a continuum of care that the patient may travel in their efforts to reach an optimal level of health, function, and wellness. It is important that the patient is cared for at the most cost-effective, yet safe and effective, level. This may be either at an inpatient or outpatient level.

Inpatient Settings

Inpatients stay overnight or longer in a health-care facility. Inpatient care may be provided in an acute medical or mental health-care hospital, a skilled nursing facility located in a nursing home or hospital, a long-term acute care hospital, a long-term chronic care facility such as a nursing home or assisted living facility, or a rehabilitation facility.

ACUTE CARE HOSPITAL OR MEDICAL CENTER. An acute care hospital may be the only hospital in a region for many miles, or it may be one of several hospitals in a medical center complex where a number of different specialty hospitals are grouped together and share resources. Acute care hospitals provide emergency care, surgeries, inpatient care, diagnostic testing, and usually some types of outpatient care. Staff is composed of a variety of doctors, nurses, assistants, therapists, laboratory workers, and other medical personnel. Rural hospitals may be smaller, with fewer departments and less staff than their larger city counterparts. Regardless of size or location, when a person is ill or injured, they generally seek care at the closest hospital.

LONG-TERM ACUTE CARE HOSPITAL. A long-term acute care hospital (LTACH) provides a level of care similar to that of an acute care hospital. However, an LTACH focuses on patients with serious medical problems that require intense, special treatment for a long period of time, usually from 20 to 30 days. These patients often transfer from intensive care units in traditional hospitals. It would not be unusual for a patient in an LTACH to need a ventilator or other life support medical assistance.

The health-care team in an LTACH is composed of members similar to those in the acute care hospital. A health-care provider visit is required daily.

• WORD • BUILDING •

ventilator: ventilat – ventilate + or – a thing performing an action

Example of the Effective Use of This Level of Care

A patient is in intensive care on a ventilator after lung surgery and develops an infection in the chest cavity. The patient is stable on the ventilator and will have to remain on it until the infection is completely cleared, which could be up to a month. It would be extremely expensive for the patient to remain in an acute care hospital during that time. The patient is transferred to an LTACH for continued treatment of the lung infection and ventilator support.

SKILLED NURSING FACILITY. A skilled nursing facility (SNF) may be associated with a hospital or long-term care facility. The SNF provides a less intense level of care than that found in a traditional or long-term acute care hospital. It usually is a transitional care setting. Patients may stay in an SNF for a few days or as long as 100 days, but they eventually move to a rehabilitation, nursing home, or home-care setting.

SNF care consists of skilled nursing care and physical, occupational, and speech therapy as needed. Health-care providers usually do not visit daily and are more likely to see patients on a weekly basis. Laboratory, radiology, or surgical services usually are not available at an SNF. An SNF level of care usually is covered by Medicare and most private insurers, but there are certain requirements, such as:

- The patient must have been hospitalized for at least 3 days before admission.
- The patient must enter the nursing home within 30 days of a hospitalization.
- There is a 100-day stay maximum per year related to any one hospitalization and diagnosis.
- The patient must be making regular progress as documented by the medical professionals.

Example of the Effective Use of This Level of Care

An older man falls at home and suffers a fractured hip. While in the acute care hospital, he has surgery to repair the fracture but does not want to eat after surgery. Eventually a feeding tube is placed, and the patient is fed through the tube. He begins to eat a bit, but not enough to take out the tube. The surgery was successful, but the patient is not strong enough to return home. He is placed in an SNF unit for skilled nursing care. He continues to increase his oral intake and receives physical therapy support. He is discharged to his home in 40 days.

REHABILITATION FACILITY. **Rehabilitation,** often shortened to "rehab," is a level of care in which the patient can receive intense physical, occupational, and speech therapy services. The rehabilitation facility may be part of a hospital, or it may be a freestanding facility. A physician specialist in physical medicine and rehabilitation oversees the patient's care during their stay. Other health-care team members who may participate in patient care include nurses, therapists, therapist assistants, nursing assistants, and technicians. As a rule of thumb, the patient must be capable of participating in at least 3 hours of therapy a day to be admitted to a rehabilitation facility. If the patient becomes ill or has other medical problems while in rehabilitation, they may be transferred back to an acute care hospital.

Example of the Effective Use of This Level of Care

A female patient suffers a stroke and has weakness on the left side of her body. She is discharged from the hospital to a rehabilitation facility for 2 months of intensive therapy to regain as much strength and use as possible in her affected side. The therapy sessions are held every morning and afternoon. She is also expected to perform activities such as bathing and grooming with assistance. As her stay lengthens, she is expected to need less assistance.

Another type of rehabilitation facility focuses on treating patients with chemical dependency and mental health issues. Some of these facilities provide medical care in the form of *detoxification,* or the removal of drugs and alcohol from the person's body, which generally takes several days. If the rehabilitation facility does not provide this type of care, patients have to be admitted to an acute care hospital for the detoxification process because the process can lead to a medical emergency. After going through the detoxification process, patients can then be admitted to a rehabilitation facility designed to treat chemical dependency and mental health issues. Generally, the physician who oversees the patient's care is a psychiatrist who specializes in treating mental or behavioral disorders. The health-care team in this type of rehabilitation setting consists of nurses, nursing assistants, clinical social workers who usually function as therapists or counselors, and psychologists.

Example of the Effective Use of This Level of Care

A young male patient is addicted to the pain medication, extended-release oxycodone (OxyContin), prescribed for severe pain. He cannot begin treatment for addiction until the drug is completely out of his body and the withdrawal symptoms are past. While he is detoxifying, health-care staff monitors him closely for physical problems related to withdrawal, such as seizures, sweating, hallucinations, muscle pain, and nausea and vomiting. He then begins individual and group counseling sessions and group activities to deal with the issues that led to his addiction.

RESIDENTIAL CARE FACILITIES. The term *residential care* is used to describe care given in settings where the patients, or

• WORD • BUILDING •

detoxification: de – removal + toxi – poison + fication – make

residents, stay for long periods of time. Box 2.1 lists examples of residential care facilities and their functions.

KNOWLEDGE CONNECTION

Give an example of a procedure that would be considered medically necessary. List four settings for residential care. List four criteria that a patient must meet to be admitted to an SNF. What is the difference between an acute care hospital and an LTACH?

Outpatient Care

Outpatient care is provided in many settings. It is designed to meet the needs of the patient in 1 day (24 hours), after which the patient is allowed to return home. Care and services provided on an outpatient basis usually are less expensive than care provided on an inpatient basis. Outpatient care is preferred when possible to decrease costs while still providing quality care. A patient may require surgery that can be provided at an outpatient facility; however, if the patient has other health conditions that could compromise their recovery, then the appropriate level of care may require that the surgery be performed in an inpatient setting.

HOSPITAL OUTPATIENT DEPARTMENT. Hospitals offer a wide range of outpatient services. Most larger hospitals or medical centers provide outpatient surgery; cardiac, pulmonary, physical, occupational, and speech therapy/rehabilitation; laboratory, radiation, and diagnostic testing; and mental health services such as intensive outpatient or partial-day treatment. Sometimes a patient may only need observation or monitoring in the emergency department after treatments, procedures, or diagnostic tests. Observation stays generally last 24 to 72 hours and are considered outpatient services. Most hospitals also have an observation setting, such as a medical decision-making unit, in which patients can receive care and diagnostic testing to determine whether they need to be admitted.

Outpatient surgery is performed in a hospital setting, but the patient is allowed to return home on the same day that the surgical procedure is performed. Outpatient surgery is also referred to as *ambulatory surgery* or *same-day surgery.* It is suited best for healthy people undergoing minor or intermediate procedures. Some outpatient surgeries may require a 24-hour observation stay to make sure the patient does not have any immediate complications after surgery. More than 60% of elective surgical procedures in the United States are currently performed as outpatient surgeries. Health experts expect that this percentage will increase to nearly 75% over the next decade.

Ambulatory surgery centers (ASCs) are freestanding health-care facilities that provide outpatient surgery only. The type of surgeries performed at ASCs may be directed by state regulations.

Example of the Appropriate Use of This Level of Care

A patient has her gallbladder removed via a small abdominal incision called *laparoscopic surgery.* The patient is monitored after she awakens from the anesthetic. The nurse assesses the patient to ensure that she can tolerate liquids and can urinate after surgery. Then the patient is discharged with follow-up instructions.

OUTPATIENT MENTAL HEALTH SERVICES. Some hospital mental health outpatient services include intensive outpatient and partial-day treatment programs. Intensive outpatient programs generally provide group counseling and therapy sessions for mental health and chemical dependency illnesses; these sessions generally last 2 to 3 hours per day,

Box 2.1

Examples of Residential Care Facilities

A person may live in a variety of residential care settings. Each provides a different level of assistance.

- **Long-term care facilities:** Also called nursing homes or convalescent homes, these facilities are where residents often live for many years. Nursing care is provided around the clock for the residents in these facilities. The residents usually have chronic illnesses or disabilities. Long-term care facilities may also be affiliated with skilled nursing facilities. Therapies are available through the facility or through home health agencies. They are staffed by RNs, LPN/LVNs, and CNAs. In some states, medication aides help administer medications to these residents.
- **Assisted living facilities:** These facilities provide less nursing care than that found in long-term care facilities. They offer 24-hour protective oversight. Residents are assisted with medications and personal care such as bathing and dressing. Meals are provided, and a choice of activities may be available. Therapies and specific nursing care, such as dressing changes, are provided through home health agencies. These facilities are staffed with one or more RNs, one or more LPN/LVNs, and numerous CNAs.
- **Memory care facilities:** These are secure facilities for residents with cognitive issues who are likely to wander or to be unsafe unless they are in a protected environment. Twenty-four hour care is provided by CNAs with specialized training to work with cognitive-impaired patients. An RN or LPN/LVN is usually available on the unit during the daytime hours but may be only on-call in the evenings. In this environment, the residents are provided with personal care, meals, a safe environment, and appropriate activities.
- **Independent living facilities:** These facilities do not provide nursing care. They generally have staff available around the clock to respond to urgent situations by contacting emergency medical services for the residents. Meals usually are available, as well as transportation and activities.

• WORD • BUILDING •

ambulatory: ambulat – move about + ory – relating to

two to five times per week. Partial day treatment programs provide group and individual counseling and therapy sessions for mental health and chemical dependency illnesses, lasting approximately 7 to 8 hours per day during the week.

Example of the Appropriate Use of This Level of Care

As a continuation of the treatment for the patient addicted to oxycodone whom we discussed earlier, after detoxification and inpatient treatment, he transitions to partial-day treatment. He comes to the mental health facility every day for 8 hours. As the patient improves, he begins a job during the day. He then comes back to the facility 2 nights per week for group therapy sessions.

CARDIAC REHABILITATION. Cardiac rehabilitation programs help patients with cardiac disorders recover quickly and improve their overall physical, mental, and social functioning. The goal is to stabilize, slow, or even reverse the progression of cardiovascular disease. Cardiac rehabilitation programs include the following:

- Counseling that enables the patient to understand and manage the disease process
- Exercise programs
- Nutritional counseling
- Risk factor modification
- Counseling on the appropriate use of prescribed medications

The cardiac rehabilitation health-care team consists of cardiologists (physicians who specialize in the diseases and treatments of the heart), nurses, physical/exercise therapists and assistants, and dietitians. Cardiac rehabilitation is provided through an outpatient setting of a hospital or at a freestanding facility.

PULMONARY REHABILITATION. Pulmonary rehabilitation is a program of education and exercise classes that teaches patients about their lungs, how to exercise and perform activities with less shortness of breath, and how to live better with a lung condition. The health-care team for pulmonary rehabilitation includes a pulmonologist (physician who specializes in diseases and treatments of the lungs), nurses, respiratory therapists, and respiratory assistants. Pulmonary rehabilitation is provided through an outpatient setting of a hospital or at a freestanding facility.

AMBULATORY CARE CLINICS. Ambulatory care clinics operate much like a medical office and provide the same type of services. Some may specialize in one type of care, such as urgent care or occupational health care. Ambulatory care clinics may provide a variety of health- care services under one roof. These services may include medical, dental, laboratory, x-ray, psychological, and/or pharmaceutical care. They may also specialize in urgent care services such as pulmonary or orthopedic care.

HEALTH DEPARTMENTS. Health departments are public facilities that provide health-care services. These facilities are funded by county, city, state, and federal governments. Therefore, the cost of care at these facilities is lower than the cost of care at private clinics. In some cases, care is provided at no cost. The services provided are determined by the governing entity and may include immunizations; family planning; maternity education; well-baby clinics; child developmental services; Women, Infants, and Children (WIC) nutrition program; and environmental health.

Health departments are also responsible for the tracking and treatment of certain communicable diseases such as tuberculosis, sexually transmitted diseases, measles, mumps, rubella, hepatitis, flu, and certain viruses.

Example of the Use of This Level of Care

A young mother, pregnant with her second child, cares for her 18 month-old son and does not work. Her husband has been laid off from his construction job. She is seen at the health department for assistance with food and health care for herself and her child through the WIC health program. She is provided with vouchers to buy healthy food, and her pregnancy is monitored for problems. Her son is provided with the appropriate immunizations and is monitored for normal growth and development.

MEDICAL OFFICE. The medical office setting offers evaluation, assessment, treatment, simple diagnostic testing, and simple surgical treatment. The health-care provider and staff may specialize in one particular area of health care, seeing only patients with specific health conditions. The health-care team in a medical office usually consists of one or more physician, physician assistants and/or nurse practitioners (health-care providers), an office nurse or medical assistant, and medical office personnel. Administrative medical assistants are responsible for appointments, phone calls, collaboration with health insurance companies, billing, and other duties assigned by the health-care providers.

HOME HEALTH CARE. **Home health care** can be one or many types of health or medical services provided to patients in their homes because they are confined to their homes by an illness or disability. Home health agencies provide care in the form of skilled nursing visits with or without home health aide visits; physical, occupational, and speech therapy; medical social worker visits; infusion therapy; durable medical equipment; and hospice. Home health services must be ordered by a physician and be medically necessary in order to be covered by Medicare and private insurance plans.

Home health care allows people to stay in their homes rather than being forced by medical needs to live in a health-care facility. Home visits for skilled care are a cost-effective way to provide limited care.

Skilled services are those that require a license to be performed, and Medicare requires that a patient need skilled services in order to qualify for home health care. These

skilled services may come in the form of nursing, therapy, or social work. Skilled nursing visits include performing nursing assessment and evaluation, complicated dressing changes, and the administration of IV medications. Home health aides provide nonskilled services such as assisting with bathing and grooming, housekeeping, transportation, and food preparation and delivery.

Physical, occupational, and speech therapy services can be provided in the home by therapists who make home visits through a home health agency. The patient must be homebound to receive these services; otherwise, the patient would go to an outpatient therapy center for this type of care.

Medical social worker visits can be ordered to assist patients and families with psychosocial support to help them deal with chronic, acute, or terminal illnesses. Medical social workers can also help patients and their families with financial needs. They may arrange for community services such as Meals on Wheels, public transportation, medication assistance, and legal assistance.

Example of the Effective Use of This Level of Care

An older man whose wife died last year recently underwent abdominal surgery to repair a bowel perforation. His abdominal wound has not healed, and he requires dressing changes twice each day. A home health nurse comes each morning and evening to change the dressing, and a home health aide comes 2 days per week to help him take a sponge bath, change his sheets weekly, and prepare lunch for him. The social worker has arranged for meals to be delivered through a neighborhood Meals on Wheels program. The patient's wound gradually heals, and he gains strength. He no longer needs home health assistance and goes to the senior center for his lunch.

HOSPICE. Hospice is defined as an interdisciplinary program of palliative care and support services that addresses the physical, spiritual, social, and economic needs of terminally ill patients and their families (Taber's 24e). The appropriate time for hospice care is when the patient is no longer seeking treatment to arrest or cure the disease and is expected to live 6 months or less. The patient is treated with medications and other measures to relieve pain and remain comfortable. This treatment is usually in the home, but may also occur in a long-term care facility, a free-standing hospice building, or a hospice wing in a hospital. Hospice services include managing the patient's pain and symptoms, lending emotional support to the patient and family, administering medications, providing medical supplies and equipment, providing caregiver instructions and support, coordinating all health-care services, and providing grief support for surviving loved ones and friends.

The hospice team usually consists of home health aides, a hospice physician, nurses, social workers, a chaplain or clergy, and trained volunteers, and it may include the patient's personal health-care provider. For more information about hospice, see Chapter 10.

KNOWLEDGE CONNECTION

How are inpatient and outpatient settings different? What types of diseases are treated and tracked by health departments? How are home health care and hospice care similar? How are they different?

DELIVERY OF NURSING CARE

Whatever the setting or level of care, nurses provide quality care to patients. This requires organization, in-depth knowledge of patient care, and application of that knowledge in a variety of situations.

When you care for patients, you deliver nursing care. This may be accomplished in several different ways. It is important for you to be familiar with these delivery systems to understand your role in each of them. Some systems are well suited to specific settings but would not work as well in others. The most commonly used types of delivery for nursing care include team nursing, patient-centered care, primary care nursing, and case management.

Team Nursing

Team nursing uses a team consisting of nurses and certified nursing assistants (CNAs) or other assistive personnel to provide care for a group of patients. This type of delivery system for nursing care is often used in the acute care hospital, rehabilitation setting, and long-term care setting. In team nursing, each member of the team provides nursing care depending on their skills, education, and licensure. The team nursing model is a traditional model that has been used effectively for years and is very beneficial when there are not enough registered nurses (RNs) to cover patient loads.

For example, a nursing care team in the acute care hospital might consist of an RN, a licensed practical nurse (LPN), and other assistive personnel, all of whom are responsible for the care of 10 patients. The RN might be responsible for assessing patients, administering some or all of the IV medications, maintaining the IV sites, communicating with health-care providers and obtaining orders, and ensuring that other team members have performed and documented care appropriately. The LPN/LVN might be responsible for administering medications to all of the patients as well as performing any treatments (for example, dressing changes), assessing the patient for any changes from baseline, evaluating pain levels and medicating appropriately, and providing patient teaching. Assistive personnel might be responsible for helping each patient bathe and dress in a clean gown, changing sheets on the beds, assisting patients to the bathroom, and taking routine vital signs. The job duties are divided by the nursing team's level of knowledge and education. This is not to

say that *only* nursing assistants should help a patient to the bathroom. The needs of the patients must be the first priority of everyone on the team.

A disadvantage of team nursing is that, without excellent communication between team members, care may become fragmented.

Patient-Centered Care

Patient-centered care empowers the patient to take control of and manage their care. This type of system is often seen in a rehabilitation setting. It allows patients to achieve independence within the limits of their disability by permitting them to have a voice in their rehabilitation, schedule, goals, and method of attaining those goals.

Patient-centered care in the acute care hospital setting varies. In this setting, the goal is to decrease the number of people who give care to the patient so that there is less chance of miscommunication or error and to provide care as soon as it is needed instead of having to wait for people from different departments to arrive. Health-care workers are cross-trained to perform as many tasks as possible for each patient. For example, in some patient-centered care settings, the nurse not only performs the usual nursing care, but also obtains needed blood specimens, runs an *electrocardiogram* (ECG; a tracing of electrical heart activity) when indicated, and may even administer respiratory therapy treatments. In this situation, no phlebotomist comes in to draw blood, no ECG technician is requested if the patient is having chest pain, and no respiratory therapy technician is needed to give a breathing treatment. One disadvantage of this type of care in the acute care hospital is the time and education needed for each staff member to cross-train in all of these areas.

Primary Care Nursing

In **primary care nursing,** one nurse is responsible for all aspects of nursing care for their assigned patients. This means that there is no assistant to take vital signs, no other nurse to call the health-care provider or take orders, and no one else to bathe the patient or change the bed. In this type of nursing, the nurse carries a great deal of responsibility. A secondary nurse is assigned care for the patient when the primary nurse is off duty.

The primary care nursing model is often used in intensive care units (ICUs). An RN or LPN/LVN provides all aspects of nursing care to one or two critically ill patients. These nurses must be able to work quickly and efficiently in a crisis or under stress. In addition, they must be able to assess the patient carefully, noting any small change in the patient's condition and correctly interpreting its significance. A disadvantage of this type of nursing delivery is that it works best when the number of patients assigned to the nurse is very limited, so it does not work well outside critical care settings.

Evidence-Based Practice

Preventing Infection and Pressure Injuries During a Pandemic

Clinical Question

How do nurses prevent infection and pressure injuries in critically ill patients during a novel pandemic (such as COVID-19) when current evidence-based practices cannot be implemented?

Evidence

In 2020, nurses working the ICU at Rush Medical Center in Chicago, Illinois were flooded with a high number of patients with COVID-19. During this time, the nurses could not implement their usual performance improvement efforts to prevent hospital-acquired infections (HAIs). Patients were spending a lot of time in the prone position to facilitate lung expansion. This positioning made it difficult to perform the routine central line and catheter care needed to prevent infections related to the tubing in use. In addition, patients developed skin breakdown and pressure injuries in different places than when they were positioned on their backs and sides. These nurses collaborated to develop new approaches to prevent infection, including distributing a central line–associated bloodstream infection tip sheet and a prone positioning kit for hospital-acquired pulmonary infection prevention. The nurses also adapted team nursing to meet their needs. Acute care nurses from elsewhere in the hospital were reassigned to the ICU and teamed with ICU nurses Despite the challenges of COVID-19, these nurses prevented HAIs and gave quality patient care by working together.

Implications for Nursing Practice

Although preventing infections and pressure injuries are just part of what is needed to deliver quality nursing care, it is a huge part. During a pandemic involving high numbers of patients who are critically ill, nurses must work together to be open to and develop new approaches to fit the needs of patients when the standard approaches to care cannot be implemented.

Source: You can read more about this at https://journals.lww.com/jncq-journal/pages/articleviewer.aspx?year=2021&issue=01000&article=00001&type=Fulltext or in the *Journal of Nursing Care Quality,* Jan/Mar, 2021.

Case Management

The delivery of nursing care via a **case management** system is associated with a managed care strategy. The nurses providing case management services act simultaneously as

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electrocardiogram: electro – electricity + cardio – heart + gram – writing

coordinators, facilitators, impartial advocates, and educators. These case managers can be found in health insurance companies, hospitals, SNFs, LTACHs, rehabilitation facilities, and home health agencies. Case managers employed by workers' compensation insurance companies may also handle workers' compensation claims resulting from severe injury or disability. The process of case management involves seeing each patient as an individual and each situation as unique. The goal of case management is to assist patients who are vulnerable, at risk, or cost-intensive so that their care is coordinated, meets their specific needs, and is cost-effective while still bringing them to optimum health.

Case managers may supervise the care of a group of patients within one facility, such as an acute care hospital or home health agency. In that situation, the case manager ensures that each assigned patient is receiving cost-effective care while reaching the goals of a return to optimal health and function. Case managers may also supervise the care of patients in a wide geographical area who have been injured on the job. These case managers make sure that their patients make it to their scheduled health-care appointments and assist with arranging for retraining if the patient cannot return to their previous work situation.

Case managers in the health insurance setting coordinate the patient's needed services with their benefits and services within the patient's provider network. One challenge for case managers in this setting is that options may be limited depending on the patient's health-care benefit coverage and the availability of in-network facilities and providers necessary to provide the optimum level of care.

No matter what the setting is or the type of nursing delivery being used, the patient's *social determinants of health* must be considered in caring for any individual. The Centers for Disease Control and Prevention (CDC) says that social determinants of health are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. These conditions are shaped by the availability of such resources as money, power, and national, state, and local support. As a nurse, you have a responsibility to identify a patient's social determinants of health and to assist them in accessing resources such as transportation to appointments, medication assistance, and food delivery programs. Addressing these factors is part of providing quality, comprehensive health care and improving patient outcomes.

KNOWLEDGE CONNECTION

Give one advantage and one disadvantage for each type of nursing care delivery system. Which system seems the best for providing optimum patient care? Which system seems the most cost-effective?

Supervision/Delegation Connection

The Secret to Good Supervision

RNs and LPNs may function as managers or supervisors. It is important to remember that when you supervise other nurses, you are supervising health-care professionals. Avoid allowing a position of supervision to "go to your head." Put yourself in the place of the people you supervise. Always treat them with respect and avoid being overly critical. Everyone responds well to positive comments about their work. Find positives to praise, and if you must correct another nurse or nursing assistant, be as kind as possible.

HEALTH-CARE ECONOMICS

In health-care economics, we will discuss how health care is paid for and why that matters to you as a nurse. As this book is being written, our national health-care provisions are in a state of flux. Since 2010, the Affordable Care Act (ACA) has been the law regarding health care. It made some sweeping changes in attempting to provide health insurance or Medicaid for what was hoped would be all Americans.

The Affordable Care Act

The ACA works to address four major issues: cost containment, preexisting conditions, small business premiums, and lifetime benefit caps. Therefore, it can be helpful for people with preexisting conditions or high-risk medical conditions, those who have surpassed the lifetime benefit maximum with their current private insurance carrier, and those who are self-employed. Also, under the ACA benefit plans, some services are made available at no cost to the consumer. These include preventive care and vaccinations. In addition, the ACA allows young adults to stay on their parents' insurance policy until age 26 years (instead of 21 years) to help them pay for the cost of insurance.

At the launch of ACA, health-care exchanges were set up for people to purchase insurance if they did not have coverage through their employers. The coverage varied according to the plan they chose, and some people received tax subsidies to help them pay for the cost of their insurance premiums.

The ACA also required that everyone buy health insurance or else pay a special tax. (This penalty was later repealed.) Larger businesses who did not insure their workers were also required to pay a special tax.

However, many insurers are leaving the health-care exchanges or dropping some ACA plans they offer because of the lack of provider participation and higher than expected cost of care for those participating in the plans. This has caused premiums to increase greatly, making policies unaffordable for many.

There are many ideas about how to fix our nation's health-care cost and coverage issues, but none have yet been signed into law.

Payment of Health-Care Costs

Health-care costs are paid for in one of five ways:

1. Public health insurance (e.g., Medicare and Medicaid)
2. Private health insurance (e.g., Aetna, Blue Cross, United Healthcare, Prudential)
3. Insurance for special populations (e.g., CHAMPVA, TRICARE, Indian Health Service [IHS], Workers' Compensation, and disability insurance)
4. Charitable organizations (e.g., Shriners and the Kaiser family)
5. Self-pay (those who are uninsured)

Public Health Insurance

Public health insurance is funded by the government, either state or federal, or a combination of both. Medicare and Medicaid are forms of public health insurance, as is the IHS.

Medicare

Medicare is the federal government's health insurance program for people older than 65 years. It may be available to those younger than 65 years if they have end-stage renal disease, are mentally or physically disabled (or both), or have certain other debilitating illnesses. Often private insurers adopt the requirements and payment policies determined by Medicare. It includes four programs, which are described in Box 2.2.

Medicare uses a payment schedule based on **diagnosis-related groups** (DRGs). These classifications of illnesses and diseases are used to determine the amount of money paid by Medicare to the hospital for the care of a patient with that particular illness or disease. For example, a patient might be admitted to the hospital with diabetes. According to the DRGs, Medicare will pay the hospital a certain amount for the care of this patient, which includes all nursing care, tests, treatments, and teaching. If the patient stays in the hospital longer than the allowed time or it costs the hospital more than the set amount for the patient's care, the payment will still be the set amount of the DRG. If the patient has complicating factors that affect the hospital stay (for example, the patient gets an infection or develops a new problem in addition to diabetes), the hospital can submit bills for the additional problems under a different DRG.

Box 2.2

Medicare Programs

Medicare includes several types of programs. Parts A through D each provide a different aspect of care for eligible patients.

- **Part A:** Insurance for hospitalization, hospice, home health, and skilled nursing facility services
- **Part B:** Supplementary health insurance to help pay for outpatient services, such as health- care provider visits, laboratories, x-ray technicians, and home health nurses, and for durable medical equipment
- **Part C:** Also called Medicare Advantage Plans, which are HMO health insurance plans administered by private insurance companies in place of traditional Medicare
- **Part D:** Also known as Medicare Prescription Drug Coverage; provides payment for prescribed medications and is run by insurance companies or other private companies approved by Medicare

Medicaid

Medicaid is a federal-state program in which the federal government helps states pay for the health care of those with an income below the federal poverty threshold as well as certain other individuals, including pregnant women, children, and individuals with disabilities who meet income-level requirements. Because the state is required to set coverage policies and administer the program, the benefits are slightly different in each state.

Indian Health Service

The IHS provides government funding for health care for qualified Native American individuals. The IHS may fund hospitals, ambulatory medical and mental health-care clinics, and dental care facilities. It may contract with one or more of the federally recognized tribes to fund health-care services in that tribe's reservation territory. Individuals using these health-care services must meet criteria for a "certificate of degree of Indian blood" (CDIB) in order to be eligible to receive care. A CDIB card is issued when an individual meets the criteria set by the tribe. This card enables the individual to receive health-care services at tribal and IHS facilities.

Private Health Insurance

When a person uses private health insurance, that person, known as the beneficiary, pays premiums to the insurance company. If people do not have health insurance through their employer, they must purchase it through the Health Exchange. When the beneficiary is cared for by a health-care provider or hospital and the bill is sent to the insurance company, the insurance company is referred to as a third party or a **third-party payer.** Health insurance companies create provider networks by contracting with a variety of health-care providers to provide services contracted at government reimbursement rates. Blue Cross Blue Shield, Aetna, United Healthcare, and Prudential are a few of the largest private health insurance companies currently operating in the United States.

Private health insurance companies offer several types of health insurance plans and services. Box 2.3 provides a brief explanation of the most common types. The development of these plans came about as a strategy to help contain the cost of health care by developing networks of health-care providers and individual providers who have contracted to provide specific services at a negotiated price.

Box 2.3

Common Types of Health Insurance Programs

Health insurance programs fall under several main categories:

- **Health Maintenance Organization:** A cost-containment program featuring a primary care physician as the gatekeeper to eliminate unnecessary testing and procedures. This may be a capitated system that requires the insured person to remain within the designated provider network.
- **Preferred Provider Organization:** In this type of plan, a group of health-care providers contract with a health insurance company to provide services to a specific group of patients on a discounted basis.
- **Point-of-Service Plan:** This plan is similar to a Health Maintenance Organization in that a primary care physician still serves as a gatekeeper, but it is not capitated. Insured people can seek care from health-care providers who are both in and out of the network. The patient pays a part of the bill (usually 20%–30%), and the insurance company pays the remainder.

Capitation refers to the payment system used by **health maintenance organizations** (HMOs). In this system, **primary care physicians** (PCPs) are paid a set amount per member per month to manage the health care of those members. This PCP is considered the gatekeeper to health services for the individual enrolled in the HMO. For example, a PCP may have 200 patients assigned to them. Perhaps the set amount per member is $40. The PCP is then paid $8,000 per month to see all the patients who make appointments. If the PCP is unable to successfully treat the patient's condition, they make a **referral** to a specialist. The patient cannot self-refer, and the specialist cannot accept the patient without a referral. In this way, access to more costly care and potentially redundant testing is controlled.

Patient Teaching Connection

Teaching About Health Insurance Regulations

Teach patients that before any procedures, surgeries, and tests are performed, the patient or health-care provider's staff must confirm that the health-care provider is in their network of approved providers. If so, prior authorization must be obtained by contacting the insurance company and acquiring approval for the treatment. If this is not done, the insurance company may deny the claim.

Private health insurance is available in different venues. Individuals may participate in group health insurance plans provided by employers. With this type of health insurance, the employer pays a portion or all of the cost of the premium. The company may offer one type of health plan or may offer a variety of plans, and the individual can choose from several types of coverage for different prices. The employer decides what types of policies are available to the employee. The options available to the employer include HMOs, **preferred provider organizations** (PPOs), and **point-of-service plans** (POS plans).

The company may also define and fund its own benefits and have a health insurance company administer the benefits according to the employer's defined requirements. This is called an administrative services only (ASO), or *self-insured,* plan. The employer generally works with the health insurance company to develop the plan criteria (HMO, PPO, or POS) and to determine which type of network of providers will be used.

Underinsured patients are those who have purchased some form of medical insurance, but it pays only a portion of their medical expenses. Depending on the plan a person purchases, only 60% to 80% of their costs may be covered, and the plan may have a high deductible. For example, if a person had an acute and severe illness, such as an infection in the lining of the heart, they may be in an intensive care unit for a week or longer. With a deductible of $10,000 plus 40% of the total cost of the hospitalization, which could amount to $80,000 or more, the patient would owe around $42,000. This patient will likely have difficulty paying such a bill. In this case, the patient would have been underinsured for the situation.

Health Insurance Plans for Specific Populations

Some health insurance plans are designed to serve only a specific group of people. TRICARE is an insurance plan for active and retired military service members and their families, and CHAMPVA provides free health benefits for veterans of military service. Workers' compensation insurance provides for people who are injured on the job. It pays for medical costs and some living costs while the person is unable to work. Disability insurance is designed specifically for those who cannot work because of some type of temporary or permanent disability.

Charitable Organizations

There are also local, state, and national charitable organizations that provide free health-care services to individuals. These organizations may be funded by religious denominations, private individuals, or national or community organizations such as the Catholic and Jewish health systems, Shriners, the Kaiser family, and the Robert Wood Johnson Foundation, just to name a few.

Self-Pay (Uninsured Patients)

Although it has been the goal of the ACA that all people in the United States will have health insurance, many people remain uninsured and must pay for their health care on their own. Many health-care providers offer discounts to those who must pay for their own care, and most will require a payment plan to pay a monthly fixed amount on the bill.

Some physicians are opting for a self-pay option called *concierge medicine.* The patient pays a yearly fee, often $2,000 or $3,000, to have full access to their physician. In return for that fee, the physician is available by phone 24 hours per day, 7 days per week. The patient is seen quickly when the need arises. The patient also pays a visit fee to the physician, which varies according to what is done and may be covered by insurance. This type of care often can prevent the need for hospitalization by allowing early intervention in an acute illness or complication of a chronic illness.

KNOWLEDGE CONNECTION

What are the differences between Medicare and Medicaid? List three types of private health insurance plans. What populations are covered by TRICARE and CHAMPVA?

CRITICAL THINKING CONNECTION: POST CONFERENCE

During your post conference with your clinical group, a discussion about your patient's situation ensues. She wants to be home, yet she also needs IV antibiotics and dressing changes. Although everyone understands her desire to go home right away to care for her young grandchildren, they also know she must stay in the hospital if she is to fully recover. Although you do not know how to help her with this situation, you are learning from the RN in charge of her care. The RN has brought in the hospital social worker to help the patient apply for state help. The RN has also talked to her doctor about arranging for home health care to do the dressing changes, IV antibiotics, and assessments. The physician has agreed, and the RN has scheduled everything. The patient will therefore be discharged today, and the home health nurse will see her this evening.

Key Points

- The ACA was designed to eliminate many problems in the current health-care system. It does away with lifetime limits and the denial of coverage based on preexisting conditions. It allows young people to stay on their parents' policy until age 26 and provides some preventive care without cost to the consumer.
- One of the most positive outcomes of health-care workers collaborating with one another is improved patient safety. Team STEPPS is a program that uses evidence-based teamwork to improve communication and teamwork skills, which will, in turn, help to improve quality care and patient safety. Working in isolation rather than collaborating with other health-care team members increases the risk of preventable errors.
- The two most important factors in determining payment for health-care delivery are medical necessity and appropriate level of care.
- The health-care team is made up of a number of professionals and assistants, including medical, nursing, therapeutic, laboratory, radiology, and ancillary staff. It is impossible to provide thorough health care without the help of everyone on the team.
- A variety of inpatient and outpatient settings exist to provide health care. It is important for patients to obtain needed care in the most appropriate setting to deliver cost-effective health care.
- Nursing care is delivered in a variety of ways. Some commonly used delivery systems are team nursing, patient-centered care, primary care nursing, and case management.
- Health care is costly, and the costs may be paid in numerous ways. These include public and private health insurance, insurance for special populations, charitable organizations, and self-pay.
- Public health insurance is funded by the federal government, the state government, or a combination of both. It includes Medicare, Medicaid, and the IHS.
- Private health insurance companies, also known as third-party payers, include HMOs, PPOs, POS plans, and variations of these services.
- HMOs may pay PCPs by a capitation system. The PCP is the gatekeeper for referrals to other health-care professionals such as specialists and therapists.
- PPOs and POS plans rely on controlling costs by provider network contracts with previously negotiated discount agreements and providing utilization management services
- Many situations exist that prevent Americans from being able to afford health-care insurance, and this is of great concern to those both inside and outside the health-care system.

CRITICAL THINKING EXERCISES

Answers available online.

1. If a patient with insurance coverage that limits access to specialists wants to see a dermatologist for a skin condition, what must the patient do *first*?
2. Which type of nursing would you expect to see in each of the following settings?
   - Intensive Care Unit
   - Rehabilitation facility
   - Medical-surgical step-down unit
   - Complicated care such a severe injury requiring rehabilitation at an out-of-state facility

Additional Resources

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Study Guide