Brief Contents

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TIMBY'S

INTRODUCTORY

Medical-Surgical Nursing

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The authors, editors, and publisher have exerted every effort to ensure that drug selection and dosage set forth in this text are in accordance with the current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert for each drug for any change in indications and dosage and for added warnings and precautions. This is particularly important when the recommended agent is a new or infrequently employed drug.

Some drugs and medical devices presented in this publication have Food and Drug Administration (FDA) clearance for limited use in restricted research settings. It is the responsibility of the health care provider to ascertain the FDA status of each drug or device planned for use in his or her clinical practice.

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This textbook is dedicated to all current and future nursing students in their quest to comprehend diseases and disorders that continue to plague the human body, and to learn how to care for them with understanding and compassion.

—LADM & BM

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Features and Learning Tools

The 13th edition includes updated features that long-time users of *Timby's Introductory Medical-Surgical Nursing* love:

A **user-friendly design** along with **figures** of diseases, procedures, signs, symptoms, and normal-versus-abnormal comparisons helps visual learners understand the whole picture.

NCLEX-STYLE REVIEW QUESTIONS

PrepU

1. A client with chronic illness always reports feeling great. What does this tell the nurse about the client?

1. The client is able to define health in a positive way.
2. The client is able to dismiss the chronic illness.
3. The client is able to engage in meaningful activities.
4. The client is able to put on a positive demeanor.

NCLEX-PN Review Questions found at the end of each chapter help the students understand how the National Council Licensure Examination for Practical Nurses (NCLEX-PN) examination relates to the chapter content they just read.

Words to Know listed at the beginning of each chapter along with the chapter **Learning Objectives** help focus student reading and identify important information to learn in each chapter.

Words To Know

capitation
client
diagnosis-related groups (DRGs)
disease
early detection
health
health care delivery system
health care team
health maintenance
health maintenance organization (HMO)
health promotion
holism
illness

Learning Objectives

On completion of this chapter, you will be able to:

1. Explain the concepts of health, holism, wellness, illness, disease, and the health–illness continuum.
2. Describe how clients with chronic illness may still be considered healthy.
3. Differentiate between health maintenance and health promotion.
4. Identify members of the health care team.
5. Describe three levels of care that the health care delivery system provides.
6. Describe problems related to access to health care.
7. Describe Medicare, Medicaid, and Medigap insurance.

KEY POINTS

- Definitions
  - *Health: state of complete physical, mental, and social well-being
  - Holism: viewing a person's health as a balance of body, mind, and spirit
  - Wellness: a constant and intentional effort to stay healthy
  - Illness: a state of being sick

New! Key Points were added at the end of each chapter. Important information is included in outline form to assist the reader with studying key information from each chapter.

Stop, Think, and Respond exercises encourage rapid recall and practical assimilation of contents. These questions are found in every chapter and require students to apply content as they read.

››› Stop, Think, and Respond 1-1

A homeless client who collapsed on the street is brought to the emergency room by the local police for treatment. Without knowing the actual diagnosis, what factors related to health and illness concepts may have contributed to this client's poor health?

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Concept Mastery Alerts highlight and clarify fundamental nursing concepts to improve understanding of difficult topics that are identified by Misconception Alerts in Lippincott's Adaptive Learning Powered by PrepU, an adaptive quizzing platform. Data from hundreds of actual students using this program in medical-surgical courses across the United States identified common misconceptions for the authors to clarify in this feature.

Concept Mastery Alert

Prevention QIs have to do with avoidable hospitalizations. Client safety QIs reflect quality of care within the hospital, including safety issues.

Clinical Scenarios, related to Nursing Care Plans and Nursing Process sections, introduce the reader to a client's problem and include a critical thinking question to help students begin to think through each situation.

Clinical Scenario An older client seeks medical attention, complaining of nausea and vomiting that has persisted for more than 24 hours. The client states that family members had similar symptoms several days ago. What issues are of concern for the nurse? (See the following Nursing Process section for dealing with clients experiencing nausea and vomiting.)

Nursing Care Plans provide an overview of nursing care (with rationales) for clients experiencing common conditions. Each Nursing Care Plan relates to the client introduced in the Clinical Scenario. (See Quick Reference to Nursing Care Plans on p. xviii.)

NURSING CARE PLAN 66-1 The Client With Burns

Assessment

- Assess vital signs.
- Look for evidence of inhalation injury.
- Determine the oxygen saturation and respiratory effort.
- Evaluate pain intensity.
- Determine the volume and characteristics of urine.
- Note the percentage and depth of burn.
- Auscultate bowel sounds.
- Assess for concurrent medical problems, and review the results of laboratory tests.

Depending on the extent and degree of burns, some or all of the following nursing diagnoses may apply. Diagnoses change as the client progresses through treatment and the stages of healing.

Nursing Diagnoses. **Ineffective Airway Clearance Risk** related to increased airway secretions; **Impaired Gas Exchange** related to edema of airway and inhalation of carbon

Expected Outcomes. (1) The airway will be patent. (2) Gas exchange will be adequate as evidenced by clear lung sounds, blood oxygen saturation (SpO_2) greater than 90%, and arterial oxygen pressure (PaO_2) greater than 80 mm Hg.

Interventions	Rationales
Monitor characteristics of respirations and lung sounds frequently.	*Frequent focused assessments of respiratory function facilitate early detection of compromised ventilation.*
Check respiratory rate before and after administering an opioid analgesic.	*Narcotic analgesics depress the respiratory center in the brain.*
Measure SpO_2 with a pulse oximeter or analyze arterial blood gas (ABG) results.	*The PaO_2 can be determined deductively from the SpO_2; an SpO_2 of 90% or greater suggests that the PaO_2 is at least 80 mm Hg. ABGs provide objective measurements of serum O_2, CO_2, and bicarbonate levels.*
Administer oxygen as prescribed.	*Supplemental oxygen increases the percentage of inhaled oxygen above that in room air.*
Suction the airway cautiously if edema is present.	*Suctioning removes accumulated secretions, but the trauma of catheter insertion can worsen edema.*
Facilitate ventilation with artificial airways, such as with an endotracheal tube and ventilator.	*An artificial airway and ventilator facilitate the maintenance of adequate gas exchange.*
Be prepared to assist with an escharotomy if there is a circumferential burn of the chest.	*An escharotomy releases constriction and allows greater chest expansion.*
Evaluation of Expected Outcome	
Client breathes effortlessly and is well oxygenated.	

Nursing Diagnosis: Hypovolemia related to volume loss

Expected Outcome. Nurse will monitor to detect, manage, and minimize hypovolemia.

Interventions	Rationales
Monitor vital signs every 15 minutes.	*Hypotension and tachycardia suggest impending shock.*
Measure intake and output hourly.	*Hourly measurements facilitate early detection of mismatches between fluid intake and output.*
Weigh the client daily at the same time with similar dressings.	*A loss of 2 lb in 24 hours suggests a 1-L deficit in fluid.*
Administer fluids according to the fluid resuscitation formula.	*A large volume of fluid is necessary to prevent hypovolemic shock.*
Report urine output of <50 mL/hour.	*Urine output <50 mL/hour suggests inadequate renal perfusion due to hypovolemia or other causes.*
Evaluation of Expected Outcome	
Client does not experience hypovolemic shock.	

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NURSING PROCESS FOR THE CLIENT WITH NAUSEA AND VOMITING

Assessment

Obtain a complete medical, dietary, drug, and allergy history. In addition, compile a list of symptoms that occurred before and along with nausea and vomiting; how long the problem has existed; and the frequency, color, and amount of vomited material. List the foods and where the client has eaten in the past 24 hours. In addition, assess the general appearance, weight, and vital signs. Documenting intake and output and monitoring for signs of fluid volume deficit are additional essential assessment requirements (see Chapter 16).

Diagnosis, Planning, and Interventions

Hypovolemia: Related to prolonged vomiting and decreased intake of oral fluids
Expected Outcome: Fluid balance will be restored as evidenced by intake of 1500 to 3000 mL/day with similar fluid loss.

- Offer clear fluids in small amounts. *Slow introduction of fluids allows the client to develop tolerance and determine if they can advance the diet.*
- Recommend commercial over-the-counter beverages such as Gatorade. *Gatorade replaces fluids and electrolytes.*
- Inform the primary provider if urine output is below 500 mL/day or serum electrolyte levels are abnormal. *Such findings indicate severe dehydration and the need for IV replacement fluids.*
- Monitor weight daily. *Daily monitoring helps to determine trends in weight loss or gain.*
- Assess skin turgor and mucous membranes. *Decreased skin turgor and dry mucous membranes indicate dehydration.*

Malnutrition Risk: Related to nausea and vomiting
Expected Outcome: The client's nutritional status will be adequate as evidenced by maintenance of weight and normal electrolyte and blood values.

- When the client tolerates clear fluids, advance diet to full liquids, then to soft, bland foods, such as creamed soups, crackers, or toast. *Advancing diet slowly helps the client develop tolerance for fluids and food.*
- Collaborate with the dietitian to provide nutritional foods. *The dietitian can help create a plan that assists the client to increase caloric intake with foods that they can tolerate.*
- Discourage caffeinated or carbonated beverages. *Such drinks may decrease appetite and lead to early satiety.*

Evaluation of Expected Outcomes

The client has an oral intake of 2500 mL and an output of 2600 mL. Weight is maintained or restored to preillness level. Serum electrolyte levels and other laboratory test results are within normal limits.

Cancer of the Oral Cavity and Pharynx

Cancer cells undergo changes in structure and appearance. They multiply, eventually forming a colony of abnormal and dysfunctional cells (see Chapter 18). When cancer affects the oral cavity, cells in the lips, mouth, or pharynx undergo malignant changes. When cancers of the oral cavity are detected early, the rate of cure is fairly good.

Pathophysiology and Etiology

Development of oral cancers is linked to smoking (includes cigarettes, cigars, and pipes), smokeless tobacco, drinking alcohol in excess, and human papillomavirus (HPV). Lip cancer is associated with pipe smoking and prolonged exposure to wind and sun. Tobacco, in particular, increases the risk of oral cancer, but clients who use both tobacco and alcohol have an extreme risk of developing oral cancer. It is hypothesized that tobacco and alcohol have a synergistic effect, in that they increase the others' carcinogenic effect. It is believed that alcohol dehydrates the cell walls on the oral mucosa, increasing the ability of tobacco carcinogens to permeate these cells. Research on this phenomenon is ongoing (The Oral Cancer Foundation, 2020).

Nursing Process sections also relate to a specific client introduced in the Clinical Scenario. These sections emphasize a nursing process approach to care and provide rationales in italics for all interventions.

Evidence-Based Practice 1-1

Nursing Care, Health Care Management, and Hospital Reimbursement

Clinical Question

How will nursing care in the future affect health care management and hospital reimbursement?

Evidence

The ACA established the "Hospital-Acquired Condition (HAC) Reduction Program." This program guides the secretary of Health and Human Services on the amount of reimbursement health care facilities receive based on quality measures. The amount of reduction in payment will depend on their ranking in the performance quartile. The HAC program scores on Research and Quality, Patient Safety Indicators, Central Line Infections, Surgical Site Infections, and Urinary Tract Infections. The health care facility scores are also published and become public record through the ACA (Quality Net, n.d.).

Nursing Implications

Employers will work within their health care facilities to improve in all categories through education and training. Nurses play a part in each of the quality measures listed above. Proper training, orientation, continuing education, providing quality care, and following policies and guidelines are part of the professional responsibility of the nurse. As part of the health care team, nurses have a large impact on the health care facility's success in this reduction program. Aiming the focus on evidence-based practice and nursing outcomes may greatly affect the outcomes of these reimbursements.

Evidence-Based Practice boxes include a Clinical Question, Evidence, and Nursing Implications to help students understand how research relates to current nursing practice.

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DRUG THERAPY TABLE 45-1 Antiemetic Medications

Category and Common Generic (Brand) Drugs	Intended Use	Common Side Effects	Safety Warnings for Nurses
Serotonin (5-HT3) Receptor antagonist Ondansetron (Zofran) Palonosetron (Aloxi) granisetron	Chemotherapy-induced nausea, post-op vomiting, hyperemesis in pregnancy; works by blocking neural receptors for 5HT3	Headache, dizziness (low blood pressure), myalgia (muscle aches and pains), malaise, fatigue, drowsiness	Do not use if the client has heart block or prolonged QT interval Increased sedation if used with opiates Emphasize prevention, must take consistently to prevent nausea and vomiting
Antidopaminergic Prochlorperazine	Control of nausea and vomiting, intractable hiccoughs by inhibiting the CTZ	Drowsiness, hypotension, dry mouth, nasal congestion	Dehydration greater when used in older adults Monitor for EPS
Cholinergic blocking drug Trimethobenzamide (Tigan)	Control of nausea and vomiting at CTZ	Hypotension (IM use), drowsiness, dizziness	Monitor for EPS, blurred vision
Antivertigo Dimenhydrinate (Dramamine)	Inhibits vestibular stimulation in the ear, thereby relieving motion sickness	Drowsiness, nervousness, restlessness, headache, dizziness	Must be started before travel to be effective Can cause difficulty in voiding for men with enlarged prostate

Updated Drug Therapy tables provide an overview of the major categories of drugs used for common conditions ensuring safe, effective practice.

NURSING GUIDELINES 45-1

Managing the Care of Clients With Anorexia

- Provide foods that the client likes during meals.
- Offer nourishing beverages (eggnog, milk shakes, and commercial concentrates such as *Ensure* or *Instant Breakfast*) as between-meal snacks.
- If the client is hospitalized or in another health care facility, encourage family members to bring favorite foods that can be refrigerated or reheated.
- Conduct a daily caloric count if necessary to determine total proteins and carbohydrates in the client's diet.
- Keep serving sizes and containers small to avoid overwhelming the client.
- Serve and keep hot foods hot and cold foods cold.
- Encourage eating in the company of others.
- Formulate a nutritional plan with the client and dietitian that promotes weight gain (approximately 600 calories per meal).
- If necessary, arrange for supplementation based on documented deficiencies in the client's intake.
- Consult the primary provider and dietitian in cases of prolonged anorexia.

Nursing Guidelines present essential information nurses need to perform specific nursing skills or to manage care for a client with a particular disorder.

Client and Family Teaching boxes present instructions and information the nurse can give to the client and family to help improve client outcomes.

Client and Family Teaching 27-1
Hypertension

The nurse instructs as follows:

- Adhere to the treatment regimen even if you have few, if any, symptoms and feel well. Hypertension is a chronic condition requiring lifelong management and treatment.
- Learn to regularly monitor BP using a home sphygmomanometer or arrange for monitoring by a community agency that provides this service at no or low cost.
- Keep a log of BP measurements for follow-up visits.
- Comply with the treatment regimen involving diet, exercise, and drug therapy.
- Consult cookbooks published or endorsed by the American Heart Association, American Diabetes Association, or other reliable sources for "heart smart" recipes.
- Follow directions for medications; never increase, decrease, or omit a prescribed drug unless first conferring with the primary care provider.
- Report adverse effects from medications to the prescribing provider. Get medical approval before taking nonprescription drugs. Inform all primary providers and dentists of medications that you are taking.
- Avoid tobacco and beverages containing caffeine or alcohol unless permitted by the provider.

Gerontologic Considerations

- The components of blood change only slightly with age. RBCs become slightly less flexible and fewer in number. Lymphocytes also decrease in number, causing a decreased resistance to infection.
- Decreased renal perfusion can result in inadequate erythropoietin production, resulting in decreased RBC production.
- Cellular and humoral immunity are affected by age-related changes in the lymphatic system, including decreases in primary antibody, T-Cell and B-cell responses, and antibody production. This results in an increased susceptibility of older adults to infections and malignancies, and indication for recommended adult immunizations.
- The Schilling test may pose a problem in older adults if proper collection of the 24-hour specimen is not possible as a result of cognitive problems or urinary incontinence. Recent research indicates that gastric pH levels vary in older adults, requiring individual consideration of appropriateness of the Schilling test to detect B12 deficiencies for older adults. However, the full Schilling test is indicated if other causes are suspected.

Gerontologic Considerations are now located at the beginning of each chapter so that the student can incorporate these considerations into their thinking as they read the chapter. Students can reflect on current research and theory as they read and think about how pathophysiology, signs and symptoms, or nursing care differ for the older population.

Pharmacologic Considerations

- Consult the primary provider for changes in drug orders if a client cannot retain a medication orally.

Pharmacologic Considerations highlight special considerations nurses need to remember when administering or caring for clients receiving specific drugs.

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Nutrition Notes

The Client With Nausea

- The client should eat small meals and eat and drink slowly.
- Dry, salty foods, such as crackers and pretzels, may relieve nausea.
- Fried food, spicy food, and foods with strong odors should be avoided.
- Cold foods may be preferable to hot foods.

Nutrition Notes pinpoint key nutrition information for clients with certain types of conditions.

CRITICAL THINKING EXERCISES

1. Interview older clients to explore their understanding of the health care coverage including access to prescription drugs. Compare their knowledge with information available from the Medicare & You website at www.medicare.gov/publications.
2. Ask the nurse manager on your assigned clinical unit about the QIs the unit must provide data on and what impact they have had on client care.

Critical Thinking Exercises, at the end of each chapter, challenge students to apply the content they have read.

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Preface

In today's changing health care environment, nurses continue to face many challenges and opportunities. *Timby's Introductory Medical-Surgical Nursing* provides the necessary information to help nurses meet these challenges and embrace expanding opportunities. The textbook addresses common adult disorders that are treated medically and surgically and also covers basic concepts student nurses need to know to care for clients with these disorders. Written at a level appropriate for the practical/vocational nursing student, this textbook provides comprehensive information about medical-surgical nursing that is easy to understand.

For the 13th edition, the textbook was revised and updated to reflect current medical and nursing practice. New to this edition are **Key Points** found at the end of each chapter. These important learning points from the chapter are presented in an outline of bulleted points that highlight important concepts for students to master. This edition continues to include methodology for planning nursing care. Each of the **Nursing Process** sections, **Nursing Care Plans**, is preceded by a **Client Scenario** to assist students in relating the plan of care to a specific client. Other highlights of this edition include **Evidence-Based Practice** boxes. Also updated in this edition are **Concept Mastery Alerts**, which clarify fundamental nursing concepts to improve the reader's understanding of potentially confusing topics, as identified by Misconception Alerts in Lippincott's Adaptive Learning Powered by PrepU. Data from thousands of actual students using this program in courses across the United States identified common misconceptions to be clarified in this new feature.

Information in this text is updated to include and discuss new goals for Healthy People 2030. Cultural awareness is brought to the forefront throughout the text, as well as specifics as discussed in Chapter 8. The worldwide pandemic related to Covid-19 is addressed in several areas, as it does affect nursing care throughout the world.

CLINICAL JUDGMENT

Clinical judgment is an important part of the nursing process. Clinical judgment allows an individual to think like a nurse in preparation for becoming a nurse. To achieve clinical judgment, the nurse must first obtain the knowledge, analyze the data provided, prioritize the information, determine which action should be taken first, take the needed actions, and then evaluate the outcomes and determine if the process needs to start again.

Clinical judgment is supported in this textbook in multiple areas, such as the Case Studies, Evidence-Based Practice, and the Stop, Think, and Respond sections. Reviewing, processing, and mastering this information will help one become more confident with clinical judgment skills.

ORGANIZATION OF THE TEXT

The 13th edition of *Timby's Introductory Medical-Surgical Nursing* continues to provide readability and clarity. Information is presented in a logical and informative manner with 72 chapters organized into 17 units.

- ***Unit 1*, Nursing Roles and Responsibilities,** includes foundational chapters covering concepts and trends in health care, nursing roles and settings, the nursing process (including mention of concept care mapping), interviewing and physical assessment, legal and ethical issues, and leadership and management.
- ***Unit 2*, Client Care Concerns,** explores areas in which nurses interact and work with clients to manage their health. Topics include nurse–client relationships, culture, complementary and alternative therapies, and end-of-life care.
- ***Unit 3*, Foundations of Medical-Surgical Nursing,** includes chapters on frequent and regular topics in medical-surgical nursing care. These include pain, infection, intravenous therapy, perioperative care, and disasters.
- ***Unit 4*, Caring for Clients With Multisystem Disorders,** includes chapters on fluid, electrolyte, and acid–base imbalances; shock; and cancer.
- ***Units 5 through 16*** present information on disorders according to body systems. Each unit begins with an introductory chapter that includes a general review of anatomy and physiology, a discussion of client assessment, and common diagnostic and laboratory tests that pertain to particular disorders.
- ***Unit 17*, Caring for Clients With Psychobiologic Disorders,** contains chapters on frequently encountered emotional and behavioral issues: anxiety disorders, mood disorders, eating disorders, chemical dependency, and dementia and thought disorders.

At the end of the textbook, Appendix A lists commonly used abbreviations and acronyms. A glossary provides a quick reference to definitions for Words to Know that appear throughout the textbook. Additional resources available on

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thePoint® include Appendix B that provides a convenient reference for laboratory values. You will also find a comprehensive listing of references and suggested readings, including general recommendations as well as unit-specific citations, that provide a streamlined guide to current literature about topics discussed in the textbook.

TEACHING AND LEARNING RESOURCES

The 13th edition of *Timby's Introductory Medical-Surgical Nursing* features a compelling and comprehensive complement of additional resources to help instructors teach and students learn.

Resources for Instructors on thePoint®

Tools to assist you with teaching your course are available upon adoption of this textbook at https://thePoint.lww.com/TimbyMS13e.

- **Test Generator**, completely revised for this edition by expert NCLEX-PN test writers, contains thousands of questions to help you in assessing your students' understanding of the material.
- **PowerPoint Presentations** provide an easy way for you to integrate the textbook with your students' classroom experience, either via slide shows or through handouts. Multiple-choice and true/false questions are integrated into the presentations to promote class participation and allow you to use i-clicker technology.
- An **Image Bank** lets you use the photographs and illustrations from this textbook in your PowerPoint slides or as you see fit in your course.
- **Pre-Lecture Quizzes** (and answers) are quick, knowledge-based assessments that allow you to check student reading.
- **Guided Lecture Notes** walk you through the chapters, objective by objective, and provide you with corresponding PowerPoint slide numbers.
- **Discussion Topics** (and suggested answers) can be used as conversation starters or in online discussion boards.
- **Assignments** (and suggested answers) include group, written, clinical, and web assignments.
- **Case Studies** with related questions (and suggested answers) give students an opportunity to apply their knowledge to a client case similar to one they might encounter in practice.
- **Answers to Questions in the Book** (Stop, Think, and Respond Exercises; Critical Thinking Exercises; and NCLEX-style Review Questions) are provided for each chapter. Instructors are free to share these with their students to enhance student self-learning.
- A **Sample Syllabus** provides guidance for structuring your medical-surgical nursing course.
- **Lesson Plans** provide you with a lesson outline that links key concepts back to PowerPoint slides; figures, tables, and features; and lists resources for in- and out-of-class activities.
- **Quality and Safety Education for Nurses (QSEN) map** links key competency knowledge, skills, and abilities (KSAs) to the textbook to ensure quality assurance.
- **Answer Key for the Workbook** supplies answers to the questions appearing in *Workbook for Timby's Introductory Medical-Surgical Nursing*, 13th edition, the accompanying for-sale workbook.

RESOURCES FOR STUDENTS ON thePoint®

Free resources are available on thePoint® to help students review material and become even more familiar with vital concepts. Students can access all these resources on using the codes printed in the front of their textbooks. Resources include:

- **Appendix B** from the textbook provides a convenient reference for laboratory values.
- **References and Suggested Readings**, including general recommendations as well as unit-specific citations, provide a streamlined guide to current literature about topics discussed in the textbook.
- **NCLEX-Style Chapter Review Questions**, now including more than 1400 questions, help students review important concepts and practice for NCLEX-PN examination.
- **Concepts in Action animations** bring physiologic and pathophysiologic concepts to life and enhance student learning.
- **Watch and Learn video clips** demonstrate specific skills to enhance student understanding of key nursing techniques.
- **Heart and breath sounds** demonstrate key differences in the sounds that nurses need to identify when examining patients.
- A **Spanish–English audio glossary** provides helpful terms and phrases for communicating with clients who speak Spanish.

STUDENT WORKBOOK

The *Workbook for Timby's Introductory Medical-Surgical Nursing*, 13th edition, complements the textbook and reinforces information students need to learn and is available for purchase. **Case Studies with critical thinking questions** are included in every unit that offer a unique way for students to relate to a particular client situation and think about the type of care needed. Other key activities in the workbook include **review exercises**, **application activities**, **NCLEX-style practice questions**, and images from the textbook for **labeling activities**. Answers to the workbook questions are provided to instructors on thePoint®.

LIPPINCOTT ® COURSEPOINT

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We hope that *Timby's Introductory Medical-Surgical Nursing*, 13th edition, provides the readers with the practical knowledge and skills to manage the nursing care of clients in today's changing health care environments. We also hope that our contributions provide students with similar joys and rewards that we have experienced in our nursing careers.

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Quick Reference to Nursing Care Plans

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UNIT 1
Nursing Roles and Responsibilities

1

Concepts and Trends in Health Care

Words To Know

capitation
client
diagnosis-related groups (DRGs)
disease
early detection
health
health care delivery system
health care team
health maintenance
health maintenance organization (HMO)
health promotion
holism
illness
illness prevention
integrated delivery systems (IDSs)
managed care organizations (MCOs)
Medigap insurance
morbidity
mortality
physician hospital organizations (PHOs)
point-of-service (POS)
preferred provider organization (PPO)
primary care
prospective payment system (PPS)
secondary care
tertiary care
unlicensed assistive personnel (UAP)
wellness

Learning Objectives

On completion of this chapter, you will be able to:

1. Explain the concepts of health, holism, wellness, illness, disease, and the health–illness continuum.
2. Describe how clients with chronic illness may still be considered healthy.
3. Differentiate between health maintenance and health promotion.
4. Identify members of the health care team.
5. Describe three levels of care that the health care delivery system provides.
6. Describe problems related to access to health care.
7. Describe Medicare, Medicaid, and Medigap insurance.
8. Explain how a prospective payment system (PPS) works.
9. Explain how the different types of managed care organizations (MCOs) work.
10. Discuss the difference between capitation and fee-for-service insurance.
11. Discuss the effects of cost-driven changes on health care.
12. Discuss methods for monitoring quality of care.
13. Describe national and worldwide health care campaigns designed to improve health care and health care outcomes.
14. Identify trends that influence future health care policy.

The roles of nurses in the health care delivery system are multiple and complex. Nurses collect data, diagnose human responses to health problems, plan and provide care, and evaluate outcomes of care. They work in various settings, adhering to facility policies and state nurse practice acts. Nurses educate clients, families, and staff. They manage resources and act as advocates for clients. In addition, they participate in disease prevention and health promotion activities for clients, families, and communities.

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CONCEPTS RELATED TO HEALTH

Health and Wellness

The constitution of the World Health Organization (WHO, n.d., para. 1) defines **health** as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Although this definition of health is useful, it presents health and illness in absolute terms. If a person is not functioning optimally in every way, they are not healthy. It also implies that an infirmity negates the possibility of health. Nurses practice from the perspective of holism. **Holism** means viewing a person's health as a balance of body, mind, and spirit. Treating only the body will not necessarily restore optimal health. In addition to physical needs, nurses must also consider the client's psychological, sociocultural, developmental, and spiritual needs.

Wellness describes a state of being. It is a constant and intentional effort to stay healthy and achieve the highest potential for total well-being. It requires lifestyle choices that assist individuals to strive for and maintain a balance in their physical, occupational/leisure, environmental, intellectual, spiritual, and emotional/social domains. Activities and choices should help individuals to promote good physical self-care, prevent illness and injury, use their full intellectual potential, express appropriate emotions in response to changes and the behavior of others, manage stress, and maintain positive interpersonal relationships. As with health and illness, one's determination of a state of wellness is highly individual.

Illness and Disease

Theoretically, **illness** refers to a state of being sick. Illness may be viewed as catastrophic (sudden, traumatic), acute, chronic, or terminal. **Disease** refers to a pathologic condition of the body that presents with clinical signs and symptoms and changes in laboratory values. The term *disease* has related terminology and concepts. Table 1-1 provides a list of these terms with brief definitions.

The major difference between illness and disease is that illness is highly individual and personal, whereas disease is something more definitive and measurable. For example, a client with arthritis presents with distinct pathologic changes associated with the disease. A person, however, may or may not be ill with arthritis. The degrees of pain, suffering, and immobility vary with each person.

The Health–Illness Continuum

In contrast to definitions of health and illness, the health–illness continuum considers level of health, which continually changes for each person. The health–illness continuum illustrates this process of change, in which individuals face various states of health and illness, ranging from extremely good health to death (Fig. 1-1). Within this continuum, clients adapt physically, emotionally, and socially, enabling maintenance of comfort, stability, and self-expression. Therefore, clients with chronic illness can achieve a high

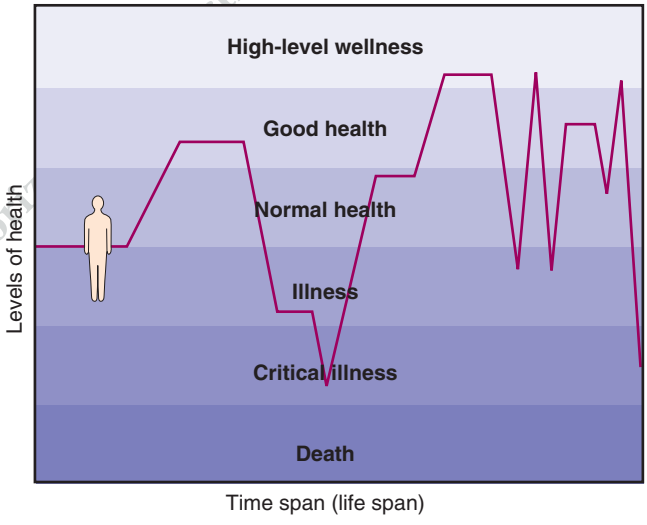

Figure 1-1 The health–illness continuum.

TABLE 1-1 Disease-Related Terminology

TERM	DEFINITION
Etiology	The cause of a disease
Incidence	The frequency of a particular disease in a specific population during a specific period
Morbidity	The number of sick persons with a particular disease in a specific population
Mortality	The death rate or the ratio of the number of deaths for a specific population
Pathophysiology	Study of how disease alters normal physiologic processes
Prevalence	The number of cases of a disease in a specific population during a specific period
Primary prevention	Prevention of the development of disease in a susceptible or potentially susceptible population; includes health promotion and immunization
Secondary prevention	Early diagnosis and treatment to shorten duration and severity of an illness, reduce contagion, and limit complications
Sign	Objective manifestation of a disease; can be seen, heard, measured, or felt
Symptom	Subjective manifestation of a disease or illness; what the client relates is happening
Tertiary prevention	Health care to limit the degree of disability or promote rehabilitation in chronic, irreversible diseases

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level of wellness if they can experience a high quality of life within the limits of that illness. For example, physically disabled people are considered healthy if they are physiologically stable and engaged in personal and social activities that they find meaningful.

Health Maintenance and Promotion

Many people now believe they have control over their well-being and are taking more responsibility for their health status. **Health maintenance** refers to protecting one's current level of health by preventing illness or deterioration, such as by complying with medication regimens, being screened for diseases such as breast and colon cancers, or practicing safe sex. **Health promotion** refers to engaging in strategies to enhance health. Such strategies include eating a diet rich in fiber, complex carbohydrates, low in fat, and high in fruits and vegetables; exercising regularly; balancing work with leisure activities; and practicing stress-reduction techniques. **Illness prevention** involves identifying risk factors such as a family history of hypertension or diabetes and reducing the effects of risk factors on one's health. In addition, **early detection**, such as mammographies and colonoscopies, uses screening diagnostic tests and procedures to identify a disease process earlier, so that treatment may be initiated earlier and be more effective.

A **client** is an active partner in nursing care. Thus, the person receiving health care services no longer plays a passive, ill role but is an active purchaser of health care services. The use of the term *client* in this textbook reflects the attitude of personal responsibility for health. Clients may or may not be ill, but they take great responsibility for meeting their health maintenance and promotion needs and actively participate in treatment decisions regarding health restoration.

HEALTH CARE

Just as the concept of health has changed in recent decades, so, too, has the health care industry. Rapid advances in science and technology have contributed to the development of highly sophisticated methods for diagnosing and treating disease. At the same time, escalating health care costs have created difficult economic conditions and disparity in access to care and have led to shorter lengths of stays in hospitals. The health care system has grown to include multiple outpatient, short-term, and long-term care facilities, with care given by various providers.

Health Care Providers

The **health care team** consists of specially trained providers who work together to help clients meet their health care needs. The team includes primary providers, nurses, psychologists, pharmacists, dietitians, social workers, respiratory and physical therapists, occupational therapists, nursing assistants, technicians, and insurance company staff (Fig. 1-2). All members of this team collaborate on client issues (medical, social, and financial) to achieve the best possible outcomes.

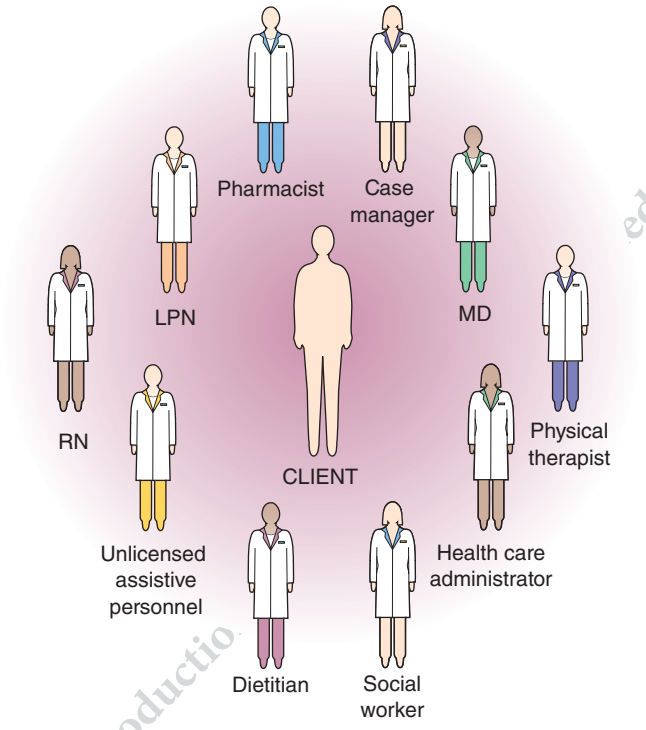

Figure 1-2 Members of the health care team.

»» *Stop, Think, and Respond 1-1*

A homeless client who collapsed on the street is brought to the emergency room by the local police for treatment. Without knowing the actual diagnosis, what factors related to health and illness concepts may have contributed to this client's poor health?

The Health Care Delivery System

The **health care delivery system** refers to the full range of services available to people seeking prevention, identification, treatment, or rehabilitation of health problems. The first resource person or agency that clients contact about a health need provides **primary care**. This initial contact is often with a family health care provider, internist, or nurse practitioner. Emphasis is on health promotion, preventive care, health education, early detection, and treatment. **Secondary care** includes referrals to facilities for additional testing such as cardiac catheterization, consultation, and diagnosis as well as emergency and acute care interventions. **Tertiary care** focuses more on complex medical and surgical interventions, cancer care, rehabilitative services, long-term care such as burn care, and palliative and hospice care.

In addition to their roles at the settings already mentioned, nurses provide care in a variety of other settings. Skilled nursing care occurs in facilities or units that offer

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prolonged health maintenance or rehabilitative services, such as long-term care or extended care facilities. Examples include nursing homes, skilled nursing facilities, rehabilitation centers, and subacute care units. Home care is an important adjunct to inpatient care; visiting nurses and home health aides make earlier discharge to home possible by providing services formerly done in hospitals or long-term care facilities. Hospices and home hospice care are resources for terminally ill clients and their families.

»» Stop, Think, and Respond 1-2

A client in an acute tertiary care setting is ready for discharge. This client will require follow-up for wound care. Discuss two possibilities for how this can be managed.

Access to Care

The Patient Protection and Affordable Care Act (PPACA; often shortened to the Affordable Care Act [ACA]) was passed in 2010. Also known as Health Care Reform or Obamacare, it is designed to provide affordable health care to U.S. citizens who previously had no access to health insurance. Prior to its passage, approximately 48.6 million Americans had no access to health care (15.7% of the population). The number of uninsured dropped to 10.9% in 2016, but as of 2019 it is 13.7% (Obamacare Facts, 2019). The overall goal of health care reform is to provide affordable health care to more U.S. citizens. Other goals are to reduce insurance company control of health care and to provide more assistance to senior citizens on fixed incomes. The controversy surrounding the PPACA has been overwhelming, and its future remains dependent on the current elected officials. Box 1-1 provides an overview of the PPACA.

FINANCING THE COSTS OF HEALTH CARE

Historically, private insurance, self-insurance systems, and Medicare paid for health care. Hospitals and approved providers received payment for what they charged; more charges meant more revenues. Thus, these plans had no incentives to control costs. Not only did charges escalate at an alarming rate, but abuse and fraudulent billing escalated as well. Disparities in access to health care coupled with its high costs prompted evaluation of spending in the entire health care industry. The 1990s was a decade of streamlining governmental payment systems and finding innovative approaches from private insurers and corporate health plans.

The 21st century has brought more reform and innovation in an attempt to trim health care costs. Currently, the United States ranks second globally (below Switzerland) in health care spending per capita. Despite higher health care spending, America's health outcomes are not any better than

BOX 1-1 Summary of the Patient Protection and Affordable Care Act (PPACA)

The PPACA ensures that all U.S. citizens and legal residents have access to quality, affordable health care. The PPACA contains nine titles, each addressing an essential component of reform:

- *Quality, affordable health care for all Americans*—include shared responsibility for health care (e.g., requirements for preventive care and immunizations), eliminate discriminatory practices (e.g., denial of coverage related to preexisting conditions), and increase dependent health care coverage up to 26 years of age
- *The role of public programs*—expand Medicaid eligibility, simplify enrollment methods, and establish a Federal Coordinated Health Care Office to integrate care under Medicare and Medicaid
- *Improving the quality and efficiency of health care*—link payment to quality outcomes in Medicare, encourage development of new client care models, and make improvements to Medicare programs
- *Prevention of chronic disease and improving public health*—implement methods to prevent chronic diseases and improve public health, increase access to clinical preventive services, and support innovative programs for public health
- *Health care workforce*—review and project future health care workforce needs, support workforce training needs, and support the current health care workforce to increase and enhance their training and education
- *Transparency and program integrity*—implement new requirements to provide information to the public on the health system and promote a newly invigorated set of requirements to combat fraud and abuse in public and private programs
- *Improve access to innovative medical therapies*—through the expansion of biologics price competition and innovation, it will make more affordable medicines for children and underserved communities
- *Community living assistance services and supports*—establish a new, voluntary, self-funded long-term care insurance program
- *Revenue provisions*—levy excise tax on high-cost employer-sponsored health coverage; increase transparency in employer reporting of value of health benefits; impose a manufacturer's fee on pharmaceutical, medical devices companies, and health insurance providers; and other provisions

Reauthorization of the Indian Health Care Improvement Act reauthorizes the provision and modernization of the Indian Health Care system for American Indians and Alaskan Natives

Adapted from Obamacare Facts. (2014, August 8). *Summary of provisions in the Patient Protection and Affordable Care Act*. http://obamacarefacts.com /summary-of-provisions-patient-protection-and-affordable-care-act/

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those in other developed countries (Peter G. Peterson, Foundation, 2020). Financing health care remains a challenge as policy-makers attempt to reduce costs and yet provide quality care and prevent Americans from being devastated by overwhelming health care expenses. Many of the systems implemented in earlier decades remain. Health care reform has focused on extending current insurance programs while improving efficiency and expanding health promotion and illness prevention programs.

Government-Funded Health Care

In 1965, federal legislation created Medicare and Medicaid.

Medicare

Medicare is a federally run program financed primarily through employee payroll taxes. It covers individuals who are 65 years of age or older, permanently disabled workers of any age with specific disabilities, and persons with end-stage renal disease. According to the Centers for Medicare & Medicaid Services in 2019, Medicare has several parts:

- *Part A*—covers hospital care, skilled care, nursing home (if services other than custodial or long-term care are required), hospice, and home health services; may require participants to pay a monthly fee for this coverage if they did not pay Medicare taxes when they were working. All participants may have to pay copayments, coinsurance, and deductibles.
- *Part B*—covers medically necessary services such as physician services, outpatient care, home health services, and other selected services not covered under Part A, including preventive services; requires an annual deductible, and after the deductible is met, the participant pays 20% of the Medicare-approved amount of the service or a monthly premium unless the participant has other insurance.
- *Part C (Medicare Advantage Plan)*—includes Parts A (hospital insurance) and B (medical insurance) and sometimes Part D as well. Private insurance companies approved by Medicare manage these plans and may implement different premiums, copays, coinsurance, or deductibles.
- *Part D (Medicare Prescription Drug Coverage)*—helps to cover and possibly reduce prescription drug costs and protect against catastrophic drug expenses. Premiums vary depending on the plan manager and a person's income.

Clients on Social Security automatically participate in Part A, whereas the other parts are optional. Although Medicare is primarily for older Americans, it does not cover custodial or long-term care and limits coverage for health promotion and illness prevention. The increased costs of Medicare coupled with decreases in benefits make the program prohibitively expensive for many older adults. Those people with adequate resources may purchase private **Medigap insurance** policies to cover other expenditures such as copayments and deductibles. Box 1-2 highlights information that clients need regarding Medicare prescription drug plans.

BOX 1-2 Medicare Prescription Drug Coverage, 2020

Who is eligible for a Medicare prescription drug plan (PDP)?

Everyone can enroll in Medicare.

When does a client join?

The client must join when first eligible for Medicare or wait for the enrollment period and pay a late penalty fee. If a client is unable to do this themselves, Medicare will enroll that person.

What types of PDP plans are there?

- *Medicare PDP*
- Original Medicare PDP
- *Medicare Advantage Plan:* a plan for clients with Medicare Parts A, B, and D that includes prescription drug care; sometimes called MA-PDs

What needs to be considered when selecting a plan?

- Does the plan include the client's prescription drugs?
- What are the costs, such as premiums, deductibles, or copayments?
- Does the client's preferred pharmacy accept the plan?

From Medicare & You. (n.d.). https://www.medicare.gov/sites/default/files/2020-12/10050-Medicare-and-You_0.pdf

Medicaid

Medicaid programs are administered by each state in accordance with federal requirements and funded jointly by state and federal governments. Medicaid provides health coverage for individuals and families with limited incomes and resources. Mandatory benefits include:

- Inpatient and outpatient hospital services
- Screening, diagnostic, and treatment services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

There are optional benefits that vary from state to state, and they may include services such as clinic care; physical and occupational therapy; speech therapy; respiratory, podiatry, optometry, and dental care; and other such services.

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The ACA created a national Medicaid minimum eligibility level of 133% of the federal poverty level ($26,200 for a family of four in 2020) for nearly all Americans under age 65. This part of the Medicaid eligibility expansion went into effect in 2014. As of January 2019, 37 states have expanded Medicaid coverage with federal support any time before this date (Medicare.gov, 2020).

Prospective Payment Systems

In 1983, Medicare implemented a **prospective payment system (PPS)** in an attempt to control costs. A PPS is a method of reimbursement in which health care providers receive payment for services based on a predetermined, fixed rate. The payment amount for a particular service is derived from the classification system of that service. One classification system for inpatient hospital services uses 467 **diagnosis-related groups (DRGs)** to group services for clients with similar diagnoses. For example, all clients receiving a hip, knee, or shoulder replacement fall into DRG, total joint replacement, and their surgeries are reimbursed at basically the same rate. Other classification systems may be used for other health care services. Private insurers may use DRGs or other classification systems for reimbursement.

PPSs are largely responsible for the marked decreases in hospital lengths of stay since the early 1980s. Possible premature discharge of clients and increased responsibility for family members who may be unable to provide adequate care has created much criticism of PPSs. These systems have also caused shifts in costs from clients with Medicare to those who have private insurance. Providers charge privately insured clients inflated amounts to make up for losses in Medicare revenues. In response to this cost shifting and other economic forces, insurers have challenged hospital charges aggressively, refused payment when hospital level of care is not provided, and shifted their clients into cost-containment reimbursement systems known as *managed care*.

Managed Care

Managed care organizations (MCOs) are insurers who carefully plan and closely supervise the distribution of health care services. Although it is a business venture that emphasizes costs of services and economic use of resources, managed care focuses on prevention as the best way to manage health care costs (Box 1-3). The two most common types of managed care systems are health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Two other models—point-of-service (POS) plans and physician hospital organizations (PHOs)—are becoming more prominent.

BOX 1-3 Goals of Managed Care

- Use health care resources efficiently.
- Deliver high-quality care at a reasonable cost.
- Measure, monitor, and manage fiscal and client outcomes.
- Prevent illness through screening and health promotion activities.
- Provide client education to decrease risk of disease.
- Case manage clients with chronic illness to minimize number of hospitalizations.

Health Maintenance Organizations

A **health maintenance organization (HMO)** is a group insurance plan in which participants pay a preset, fixed fee in exchange for health care services. The fee is not based on the number of services provided but rather is projected to the number of participants and expected services. This type of financial management is referred to as **capitation**, which refers to the actual head or person count. Primary providers have an incentive to keep costs low because the fee paid to the primary providers remains the same regardless of the actual services or frequency of care provided. The financial stability of HMOs is based on their ability to keep members healthy and out of the hospital through periodic screening, health education, and preventive services. Participant fees cover all medical costs incurred and are paid regardless of whether members require health care services. If they do not require much high-cost care, providers make money; if members use many high-cost resources, providers lose money. This method of financing provides the strongest incentives for limiting use of expensive services and focusing health care on health maintenance and health promotion.

HMOs provide ambulatory, hospitalization, and home care services. Some HMOs have their own facilities; others use community agencies for services. Members of an HMO must receive authorization (referral) for secondary care, such as second opinions from specialists or diagnostic testing. If members obtain unauthorized care, they are responsible for the entire bill. In this way, HMOs serve as gatekeepers for health care services.

»» Stop, Think, and Respond 1-3

An older client tells you that they receive Social Security benefits but is not clear about their Medicare benefits. What information would you provide to this client?

Preferred Provider Organizations

A **preferred provider organization (PPO)** operates on the principle that competition can control costs. Acting as agents for health insurance companies, PPOs create a community network of providers who are willing to discount their fees for service in exchange for a steady stream of referred customers. Consumers can lower their health care costs if they receive care from the preferred providers. If they select providers outside the network, they pay a higher percentage of the costs.

Point-of-Service Plans

Point-of-service (POS) allows clients the flexibility of using services out of network. Clients select a primary care physician within the group who then serves as the gatekeeper

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for other health care services. Clients can use health care providers in or out of the provider group; if they stay in the network they will get a higher benefit, if they choose to go out of network for services, they would be covered, but at a lower rate. The client also has the option to go to a specialized provider without a referral.

Physician Hospital Organizations

In **physician hospital organizations (PHOs)** the participating providers and the hospital develop contract terms and reimbursement levels and use those terms to negotiate with MCOs. The goals are to maintain high-quality service and contain costs while fostering group contracts, collaboration, and capitation.

CHANGES AND TRENDS IN HEALTH CARE

Effects of Cost-Driven Changes

Changes in reimbursement structures and practices have created a shift in economic and decision-making power from hospitals, nurses, and primary providers to insurers. Much concern and criticism accompany this shift as primary providers, nurses, other providers, and consumers find themselves unable to obtain or provide care free from the insurer's economic pressures. As a result of managed care's influence, hospitals have downsized, restructured, or sometimes closed. Consequently, many regions are left with fewer hospitals, higher nurse–client ratios, and higher client acuity levels on general medical–surgical units, skilled nursing facilities, long-term care facilities, and home health settings. Thus, many claim that profits posted by large insurance companies come at the expense of quality care and jobs of health care providers.

Changes in the health care industry have also affected employment for health care workers. Hospitals employ **unlicensed assistive personnel (UAP)** to perform some duties that practical and registered nurses once provided. Many are concerned that the use of UAPs will jeopardize quality of care. In addition, primary provider's income has decreased in recent years. This trend will most likely continue, partly because of the growth of nurse practitioners and physician assistants. The predicted decrease in income may lead to fewer men and women entering the medical profession. Rural areas already suffering with inadequate numbers of primary providers will not see an improvement in this situation.

These changes also may affect the client's experience and satisfaction with health care. A single episode of illness can involve negotiating for a referral, receiving testing at a site other than the hospital, staying a shorter time in the hospital, transferring to a skilled nursing facility, and obtaining outpatient rehabilitation and home health services. Although much effort is made to coordinate care, particularly by nurse case managers (see Chapter 2), this fragmentation forces clients to repeatedly build therapeutic relationships and may leave them unsure of who is in charge.

Cost-driven changes have had positive effects as well. In an attempt to reduce redundancy of health care services and increase economic leverage, hospitals and other health care facilities are forming networks known as **integrated delivery systems** (**IDSs**; Box 1-4). IDSs provide a full range of health care services with a goal of achieving highly coordinated and cost-effective care. Mandated shorter hospital stays may result in fewer nosocomial (acquired in the hospital) complications and a quicker return to self-care. Nurses have a greater ability to take an active role in advocating for high-quality, nurse-provided care. Nurses work in new and expanded positions in the health care industry (see Chapter 2). There is also increased attention to monitoring quality and best practices in health care.

BOX 1-4 Integrated Delivery Systems

Fully integrated health care delivery systems will provide the following:

- Wellness programs
- Preventive care
- Ambulatory care
- Outpatient diagnostic and laboratory services
- Emergency care
- General and tertiary hospital services
- Rehabilitation
- Long-term care
- Assisted living facilities
- Psychiatric care
- Home health care services
- Hospice care
- Outpatient pharmacies

Implementation of health care reform has many benefits but also raises many concerns. Paying for the reform is complicated and controversial. Tax credits for small businesses, increased health insurance premiums, high deductibles, and the requirement for most Americans to buy health insurance or face penalties will provide some of the revenues to pay for health care. Individuals and families may more easily qualify for subsidies and sliding scale tax breaks. Insurers will be monitored more closely and will no longer be able to impose inequities and disparities in health care coverage. Health care reform continues to be a major challenge for legislators, consumers, and taxpayers.

Measures of Quality of Care

Demand for evidence that hospitals and practitioners provide high-quality, cost-effective care comes from insurers, regulatory bodies such as The Joint Commission, and consumers. To meet this demand, hospitals form performance improvement committees. These groups or hospital departments also may be called *quality improvement* or *outcomes management committees*. These committees use standardized indicators to measure health care quality.

One example of standardized indicators is the quality indicators (QIs) provided by the Agency for Healthcare Research and Quality (AHRQ). These QIs can be used to measure health care quality at the federal, state, and local levels.

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Although specifically for use by hospitals, similar tools for other health care organizations are used or are in process. The AHRQ uses hospital administrative data to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time. As of 2020, the AHRQ QIs consist of the following four modules:

- Prevention QIs are measures used with hospital inpatient discharge data to identify hospital admissions that could be avoided through high-quality outpatient care.
- Inpatient QIs, which reflect quality of care inside hospitals, include inpatient mortality for medical conditions and surgical procedures.
- Client safety QIs also reflect quality of care within hospitals, but focus on potentially avoidable complications and adverse events.
- Pediatric QIs are measures used with hospital inpatient data to determine quality of care inside hospitals and identify potentially avoidable hospitalizations among children.

Concept Mastery Alert

Prevention QIs have to do with avoidable hospitalizations. Client safety QIs reflect quality of care within the hospital, including safety issues.

In 2002, The Joint Commission established National Patient Safety Goals, which are updated annually. The goals were established in order for accredited organizations to address areas of concern related to client safety. The 2016 hospital safety goals are focused on the following:

- Identify clients correctly.
- Improve staff communication.
- Use medicines safely.
- Use alarms safely.
- Prevent infection.
- Identify client safety risks.
- Prevent mistakes in surgery.

The goals established by The Joint Commission form the foundation for an evaluation process so that health care organizations can measure, assess, and improve performance (The Joint Commission, 2020).

Other methods exist for determining quality of care. Client satisfaction surveys, quality-of-life questionnaires, functional assessment tools, number of hospital admissions per year for clients with chronic illnesses, and **morbidity** (complications) and **mortality** (deaths) rates are a few important measures assessed when examining quality (Evidence-Based Practice 1-1).

Evidence-Based Practice 1-1

Nursing Care, Health Care Management, and Hospital Reimbursement

Clinical Question

How will nursing care in the future affect health care management and hospital reimbursement?

Evidence

The ACA established the "Hospital-Acquired Condition (HAC) Reduction Program." This program guides the secretary of Health and Human Services on the amount of reimbursement health care facilities receive based on quality measures. The amount of reduction in payment will depend on their ranking in the performance quartile. The HAC program scores on Research and Quality, Patient Safety Indicators, Central Line Infections, Surgical Site Infections, and Urinary Tract Infections. The health care facility scores are also published and become public record through the ACA (Quality Net, n.d.).

Nursing Implications

Employers will work within their health care facilities to improve in all categories through education and training. Nurses play a part in each of the quality measures listed above. Proper training, orientation, continuing education, providing quality care, and following policies and guidelines are part of the professional responsibility of the nurse. As part of the health care team, nurses have a large impact on the health care facility's success in this reduction program. Aiming the focus on evidence-based practice and nursing outcomes may greatly affect the outcomes of these reimbursements.

Reference
Quality Net. (n.d.). *Hospital-acquired condition (HAC) reduction program* (cms.gov). https://qualitynet.cms.gov/inpatient/hac/payment

Future Trends and Goals for Health Care

The health care system will continue to respond to changes in the demographics and cultural diversity as well as to technological innovations and the impact of the shortage of nurses. In the United States, the number of people over 65 years of age is projected to be 78 million by 2030 (AARP, 2020). It is also predicted that 40% of the population in 2030 will belong to ethnic minority groups. Concern remains regarding the health of all Americans. Several initiatives are directed at promoting health and monitoring progress toward health goals and prevention of treatable problems as well as actual treatment of illness without complications. The Healthy People 2030 campaign provides an overall action plan to improve the health and quality of life for people living in the United States. The U.S. Department of Health and Human Services (2020) identified five overarching health goals, which include the following:

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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TABLE 1-2 Healthy People 2030 Goals

OVERARCHING GOALS OF HEALTHY PEOPLE 2030	FOUNDATION MEASURES CATEGORY	MEASURES OF PROGRESS
Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury, and premature death.	General Health Status	• Life expectancy • Healthy life expectancy • Physical and mental unhealthy days • Self-assessed health status • Limitation of activity • Chronic disease prevalence • International comparisons (*where available*)
Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.	Disparities and Inequity	Disparities/inequity to be assessed by: • Race/ethnicity • Gender • Socioeconomic status • Disability status • Lesbian, gay, bisexual, and transgender status • Geography
Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.	Social Determinants of Health	Determinants can include: • Social and economic factors • Natural and built environments • Policies and programs
Promote healthy development, healthy behaviors, and well-being across all life stages.	Health-Related Quality of Life and Well-Being	• Well-being/satisfaction • Physical, mental, and social health-related quality of life • Participation in common activities
Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.	Government Leadership—Actions and Policies	Government lead programs encouraged to provide easier access to healthier foods and healthy activities

From Healthy People 2030 Framework. (2020, October 8). *What is the Healthy People 2030 framework?* https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework

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Table 1-2 provides a comprehensive methodology used to assess progress toward achievement of the five overarching health goals of Healthy People 2030.

U.S. Nutritional Strategies

Healthy People 2030 is a national effort to improve the health of Americans by providing recommendations to enhance nutrition and weight status. Other nutritional strategies include using the U.S. Department of Agriculture's MyPlate, referring to the nutrition labels on processed and packaged foods, and understanding standard definitions for the terms used on food labels.

Healthier Food Access

Healthy People 2030 aims to have an increased number of healthy food outlets, like farmer's markets, and displays of healthier foods by food retailers. Another objective is to promote availability and accessibility for people to use food as an incentive program for a healthier diet, including whole grains and fruits and vegetables.

Availability of Recreational Facilities

Where we live affects our health in multiple ways. Poor health measures are focused in neighborhoods that are most disadvantaged by society's social, economic, and housing inequities, which leads to a higher problem of chronic diseases.

Studies show that people who live close to recreational areas experience better mental health, *and* that frequency of exercise by adults and children and having fresh produce available are associated with healthier lifestyles.

Each of the indicators is tracked, measured, and reported on in a timely and regular basis. Data are provided from health care agencies at all levels to the National Center for Health Statistics. Progress reports are available quarterly and annually. A final report will be released in 2020 (Office of Disease Prevention and Health Promotion, 2016). As the 21st century progresses, economics, consumer satisfaction, effectiveness of traditional medical care, alternative medicine, disease prevalence, global emergence of drug-resistant organisms, and cultural diversity are forces that will influence the direction of worldwide health care. The continued effects of infectious diseases on global health, particularly in developing nations, and epidemics of cancer and other chronic diseases remain likely.

The United Nations Sustainable Developmental Goals build on the WHO's Millennium Developmental Goals (MDGs). The U.N. members want to achieve these goals by 2030 (Box 1-5).

In the midst of these dramatic changes and challenges, nurses must continue to provide safe, high-quality, cost-effective care to individuals, families, and communities. It is also imperative that nurses distinguish and communicate to clients the various choices that the clients may make about their health care.

BOX 1-5 United Nations Sustainable Development Goals

Goal 1: End poverty in all its forms everywhere.

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

Goal 3: Ensure healthy lives and promote well-being for all at all ages.

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Goal 5: Achieve gender equality and empower all women and girls.

Goal 6: Ensure availability and sustainable management of water and sanitation for all.

Goal 7: Ensure access to affordable, reliable, sustainable, and modern energy for all.

Goal 8: Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all.

Goal 9: Build resilient infrastructure, promote sustainable industrialization, and foster innovation.

Goal 10: Reduce inequality within and among countries.

Goal 11: Make cities and human settlements inclusive, safe, resilient, and sustainable.

Goal 12: Ensure sustainable consumption and production patterns.

Goal 13: Take urgent action to combat climate change and its impacts.

Goal 14: Conserve and sustainably use the oceans, seas, and marine resources.

Goal 15: Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation, and halt biodiversity loss.

Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels.

Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development.

From United Nations. (2015). *Sustainable Development Goals*. Copyright © 2015 United Nations. Reprinted with the permission of the United Nations. https://www.un.org/sustainabledevelopment/sustainable-development-goals/

KEY POINTS

- Definitions
  - *Health: state of complete physical, mental, and social well-being
  - Holism: viewing a person's health as a balance of body, mind, and spirit
  - Wellness: a constant and intentional effort to stay healthy
  - Illness: a state of being sick
  - Disease: refers to a pathologic condition of the body that presents with clinical signs and symptoms and changes in laboratory values
  - Health–illness continuum: level of health, which continually changes for each person
  - Health maintenance: refers to protecting one's current level of health by preventing illness or deterioration
  - Health promotion: refers to engaging in strategies to enhance health
- The health care team
  - Primary providers
  - Nurses
  - Psychologists
  - Pharmacists
  - Dietitians
  - Social workers
  - Respiratory therapists
  - Physical therapists
  - Occupational therapists
  - Nursing assistants
  - Technicians
  - Insurance company staff
- Three levels of care
  - Primary: person or agency that the clients contact about a health need
  - Secondary: referrals to facilities for additional testing such as cardiac catheterization, consultation, and diagnosis as well as emergency and acute care intervention
  - Tertiary: focuses more on complex medical and surgical interventions, and specialized services such as cancer care and rehabilitative services
- The PPACA (often shortened to the ACA) was passed in 2010. Also known as Health Care Reform or Obamacare, it is designed to provide affordable health care to U.S. citizens who previously had no access to health insurance.
- Medicare: a federally run program financed primarily through employee payroll taxes. It covers individuals who are 65 years of age or older, permanently disabled workers of any age with specific disabilities, and persons with end-stage renal disease.
- Medicaid: programs are administered by each state in accordance with federal requirements and funded jointly by state and federal governments. Medicaid provides health coverage for individuals and families with limited incomes and resources.
- Prospective payment system: a method of reimbursement in which health care providers receive payment for services based on a predetermined, fixed rate
- Managed care organizations:
  - HMO is a group insurance plan in which participants pay a preset, fixed fee in exchange for health care services.

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  - PPO operates on the principle that competition can control costs, consumers can lower their health care costs if they receive care from their preferred providers.
  - POS organizations involve a network of providers, allow clients the flexibility of using services out of network.
  - PHOs: the participating providers and the hospital develop contract terms and reimbursement levels and use those terms to negotiate with MCOs.
- AHRQ: These QIs can be used to measure health care quality at the federal, state, and local levels. The AHRQ uses hospital administrative data to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.
- Healthy People 2030: campaign that provides an overall action plan to improve the health and quality of life for people living in the United States
- MDGs: developed by the WHO, consist of eight goals with measurable targets and clear deadlines to improving the lives of the world's poorest people
- Sustainable Developmental Goals: developed by the United Nations to address a better and more sustainable future for all

CRITICAL THINKING EXERCISES

1. Interview older clients to explore their understanding of the health care coverage including access to prescription drugs. Compare their knowledge with information available from the Medicare & You website at www.medicare.gov/publications.
2. Ask the nurse manager on your assigned clinical unit about the QIs the unit must provide data on and what impact they have had on client care.

NCLEX-STYLE REVIEW QUESTIONS PrepU

1. A client with chronic illness always reports feeling great. What does this tell the nurse about the client?
   1. The client is able to define health in a positive way.
   2. The client is able to dismiss the chronic illness.
   3. The client is able to engage in meaningful activities.
   4. The client is able to put on a positive demeanor.
2. The nurse is meeting with a group of clients to discuss health promotion activities in an effort to target poor lifestyle habits. Which of the following activities promotes health? Select all that apply.
   1. Engage in activities to manage stress.
   2. Exercise for 30 to 40 minutes five times a week.
   3. Increase fiber in the diet.
   4. Reduce caloric intake.
   5. Sleep at least 6 hours a night.
3. After a client has a physical examination, the health care provider orders blood tests and a consult with a neurologist. In a review of the client's new insurance plan, what type of service does a consultation fall under?
   1. Acute care
   2. Primary care
   3. Secondary care
   4. Tertiary care
4. A nurse is working with an adult client who is scheduled for an annual physical examination. The nurse explains that some screening diagnostic tests may be done, such as blood pressure, blood cholesterol, and an electrocardiogram. What comment by the client indicates an understanding of the purpose of screening tests?
   1. "I may need more tests depending on the results of the screening tests."
   2. "The doctor can prescribe medications based on these tests."
   3. "The tests determine if I have a serious illness."
   4. "You will be checking my blood pressure and taking blood."
5. Nurses provide care in a variety of settings. Which of the following is an example of a nurse providing care in a primary care setting?
   1. The nurse explains the need for follow-up postoperative physical therapy.
   2. The nurse gives a tetanus booster to a healthy 40-year-old.
   3. The nurse prepares a client for a colonoscopy procedure.
   4. The nurse teaches a client about the effects of anesthesia.
6. A licensed practical nurse (LPN) is employed at a primary provider's office that is part of an organization that provides client referrals to this practice. In exchange, the primary provider's office offers services at a reduced cost. What is this practice a part of?
   1. An HMO—health maintenance organization
   2. A PHO—physician hospital organization
   3. A PPO—preferred provider organization
   4. A PPS—prospective payment system
7. A group of nurses discussing the changes in the health care system agree that future changes will be most greatly influenced by some key factors. What do these include? Select all that apply.
   1. Advances in medical technology
   2. Aging of the population
   3. Increase in chronic health problems
   4. Level of education of clients
   5. Workforce shortages

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8. An LPN is assigned to serve on their unit's quality improvement committee. Which of the following statements by the nurse manager is correct in explaining the primary purpose of this committee?

1. The purpose of the quality improvement committee is to audit client care based on standard measures.
2. The purpose of the quality improvement committee is to determine safe nurse–client ratios.
3. The purpose of the quality improvement committee is to develop systems to improve client care.
4. The purpose of the quality improvement committee is to establish standards of care.

WANT TO KNOW MORE? There are a wide variety of online resources available on thePoint to enhance learning and understanding of this chapter.

Go to **thePoint.lww.com/activate** and use the activation code found in the front of this text to unlock these online resources.

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