

Health care disparities: interview case study

[Business](#)



Recently, while the American College of Obstetrics and Gynecologist (ACOG) have shown support to these accredited rating centers, they still show resistance to programs, such as these, that veer away from organized medicine. These facilities are being threatened by lack of funding and lack of providers available to fill the roles that many Individuals require. This paper will explore an interview with maternal health expert and health model pioneer Ruth Watson Lubing, Deed, CNN, which outline the disparities faced by these Institutions.

Feasible strategies to expand the role and opportunity for nurses to address the primary care supply and demand gap will also be reviewed. Finally, the role that nurses take in advocacy for much needed health care policy and reform to address these disparities will also be discussed, in order to promote becoming more visible and influential within this infrastructure.

In ten article outlining ten Interview AT Rut Watson Luda, CNN, race, Income, and education are some of many of the disparities discussed that her patients are faced when receiving maternal healthcare in a hospital setting.

This interview discusses how these issues are bridged and reduced in the new models of care offered by her childbearing centers, whose goals are to provide high quality, safer, tenant and family centered care to every individual, regardless of their ethnicity, income, or insurance carrier.

Common disparities are not determining factors for care at these clinics. The model of care designed for these centers is good for any family. Focus is not on the individual's financial status.

For example, instead of just focusing on low income minority groups, Dry.

<https://assignbuster.com/health-care-disparities-interview-case-study/>

Lubing realizes that the need for personalized, supportive, empowering maternity services is just as great in the white, high income individual or family. By empowering the individual to be interactive in her care, and in control of her choices while giving birth, allowing for cultural influence, and to having family members included as well, these clinics have increased the interest in being involved in one's own care. By meeting patient needs on an individual level, the disparities associated with birth are reduced. For example, in the birth centers opened by Dry.

Lubing, the breastfeeding rate is 100% (Mason, Alleviate, & Chafe, 2012). In contrast, the overall breastfeeding rate in Washington D. C. is 73.7% (CDC, 2012). Additionally, the amount of babies who were born at these birth centers that needed neonatal intensive care unit (NICU) care, when compared to the number of births with area hospitals, was greatly reduced in the maternal birth centers.

Dry. Lubing's facilities bridge the disparity gap by offering equal access and treatment to all patients that is not dependent on race, age, income, or education level.

A growing problem that has threatened facilities such as these, are the lack of providers available to open more clinics, as well as lack of funding to keep these doors open. Medicaid and Medicare reimbursement is not as dependable in the birth centers as it is when billed by hospitals, even though such births in centers have been shown to save insurance companies 3-4 times the cost as a hospital birth % (Mason, Alleviate, & Chafe, 2012). Lack of providers for these patients, and lack of funding to keep these doors open,

are just the disparities that keep these patients from having access to safer and equal treatment.

To keep valuable clinics like these open, these child birthing centers need to maintain a framework to be included as part of the infrastructure of the federal health care system (Mason, Alleviate, & Chafe, 2012).

In order to do this, they require a sustainable facility fee. Federal and state insurance programs, such as Medicaid and Medicare are not always required by law to pay a facility fee to childbearing centers as they are mandated to pay hospitals (Mason, Alleviate, & Chafe, 2012).

Money is temporarily saved by these programs, but by pushing women into having hospital births; in the end, however, it costs these programs 3-4 times more than if the women had been cared for in the childbirth center (Mason, Alleviate, & Chafe, 2012). This is due to the centers ability to decrease implications, readmission, preterm births, low birth rate and the need for cesarean sections (Mason, Leave Policy needs to support Tuning Tortons model of care. Dry. Lubing notes that if all Medicaid supported births were managed in the model presented, they would save billions a year.

Ideally, the new policies instituted by the Affordable Care Act (ACA) will serve as a temporary fix to the financial barrier that these clinics face. After the Bush administration, Medicaid and Medicare was withdrawn from paying facility fees to private birth centers, even though the cost of the facility fee was roughly 25% of the facility fee that a hospital needs (Mason, Alleviate, & Chafe, 2012). By ensuring that every single person has access to affordable

<https://assignbuster.com/health-care-disparities-interview-case-study/>

healthcare, the AC intends to bridge the gaps that are still maintained by disparities.

The new law also seeks to strengthen the nation's primary care foundation through enhanced reimbursement rates for providers and the use of innovative delivery models such as these (Davis, Abram, & Stresses, 2011). The other growing problem, not only faced by these clinics, but nationwide, is the declining numbers of primary care providers to fulfill the supply and demand gap.

With the up and coming Affordable Care Act, an additional 32 million patients will have access to primary care (Phosphors, Lucerne, Reach, & Borrowing, 2012).

It is not likely that the already scarce supply of primary care providers will be able to meet this need. This is due to fewer medical residents choosing internal and family medicine as specialties. By 2020 it is forecasted that the United States will face a shortage of more than 45,000 primary care physicians (Kirsch, 2012). Without providers to deliver high quality, cost effective care, these clinics cannot stay open, and patients will be forced to receive treatment in hospital settings, which is neither cost effective nor optimal to deliver the quality, safe, patient centered care these patients are benefiting from.

One key message in the Institute of Medicine's (IOM) future of nursing report is that nurses should practice to the full extent of their education and training (2012). The IOM's recommends that we should double the amount of nurses with a doctorate by 2020 and remove scope of practice barriers.

<https://assignbuster.com/health-care-disparities-interview-case-study/>

The RAND Corporation estimates that the state of Massachusetts could save between \$4.2 and \$8.4 billion over ten years if Nurse Practitioners (NP) and Physician Assistants (PA) were permitted to practice primary care to the fullest extent of their training and education (RAND Health, 2009).

Studies have shown consistently that the quality care that Naps provide yields patient outcomes that are equivalent to those of physicians (Phosphors, Lucerne, Reach, & Borrowing, 2012).

Nurses are key players in advocacy, not only for the rights and wellbeing of individual patients, but by being on the front lines and seeing the direct exult from these disparities. Changes cannot happen without voices being heard. Voices cannot be heard if we do not speak. There is a plethora of directions a nursing career can take.

Nurse practitioners do not get the credit they deserve for their education and are not commonly recognized as equal healthcare partners who can deliver effective care to patients. Advance Practice Nurses (PAN) not only draw the knowledge from the biomedical and physical sciences, but also focus their delivery of care with social services and person-environment interactions in mind (Phosphors, Lucerne, Reach, & Borrowing, 2012).

There has been a 458% increase in the number of Naps in the District of Columbia over the past ten years, with more projected to continue to grow in the next decade.

With barriers on scope of practice lifted, these Naps can continue to fill the roles of primary care providers and can provide equal Ana detective care at

<https://assignbuster.com/health-care-disparities-interview-case-study/>

much name private Institutions sun as ten Telling care centers. Congress will not support this if we do not take responsibility and action. Nurses have a responsibility to make their voices heard, and heard loudly. We all see apses in health care, whether we are talking about policies on a national level, or at the bedside.

We all see them, we all complain about them, but nothing will change unless we do something about it.

All nurses share the responsibility, in the boardroom or at the bedside; the hierarchy does not leave those who think they are uninvolved less responsible. We are all responsible. Policies are not written in stone, they are something for us as nurses to shape and develop. According the Future of Nursing report a good nurse leader must translate new research findings to the reactive environment and into nursing education practice and policy.

By continuing our education and advocating for our roles we are paving roads to reaching our goal of becoming full partners, with physicians and other health professionals, in redesigning health care in the United States (Institute of Medicine, 2011). By making our voices heard, and working as full partners to redefine healthcare, nurses play a defining role in the major redesign our nation's health care is facing.

Patient and family centered clinics such as these can be monument in delivering high quality cost effective care if the proper policies and regulations are put into place to protect them.