

Research Paper

African American Nurse Leaders and the American Public: Do We Really Understand the Healthcare Law?

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ABSTRACT

Nurses make significant contributions to the American healthcare system and should have knowledge of major healthcare policies such as the Patient Protection and Affordable Care Act (PPACA), particularly those nurses in leadership. More nurse leaders of African descent need an understanding of PPACA to advocate for the policy provisions in the law as it relates to social determinants of health (SDH). This paper illustrates a need for a better understanding of PPACA among nurses of African descent to promote health equity.

Keywords: Patient protection and affordable care act; Social determinants of health; African American nurse leaders; Health equity; Health disparities

Introduction

Nurses are the most trusted healthcare providers[1] and are ideally positioned to play an integral role in moving the U.S. healthcare system forward. With the passage into law, the Patient Protection and Affordable Care Act (PPACA) has provided opportunities that may help achieve health equity. Communicating aspects of the law with patients, families, and communities is a major objective of nursing leaders[2]. Fellows of the Leadership Institute for Black Nurses (LIBN) have a duty, as healthcare providers, to be equipped with the tools that promote health equity. LIBN Fellows were immersed in healthcare both professionally and educationally, and it was expected that they would have more knowledge of PPACA than those of the general public who were surveyed by Kaiser[3] in 2010. Understanding provisions in the law is fundamental to healthcare leadership, and nurse leaders have a mandate to remain current in policy and practice[2].

Kaiser[4] reported that by the end of 2015, the number of uninsured non-elderly adults had decreased by nearly 13 million since 2013 due to PPACA. The decrease was due, in part, to the removal of barriers such as pre-existing conditions and healthcare insurance coverage for dependent children up to age 26. In addition, the Department of Health and Human Services[5] (DHHS) reported that PPACA has improved the quality of healthcare along with lowering the cost. For example, the cost of prescriptions for seniors has been reduced, and there are now tax credits for small business owners[5]. However, provisions in PPACA that improved access to care such as the health insurance exchanges remain a mystery to many. Moreover, awareness of the benefits of the law still eludes many currently including nurses and more importantly, those who it is intended to help the most. Therefore, this topic remains an issue and more education is needed among nurses as they advocate for healthcare consumers. Knowing fact from fiction is essential to effective leadership. It is necessary that nurses understand new and exciting programs in the U.S. healthcare system regardless of whether the nurse is:

- providing direct patient care as a staff nurse,
- directing patients' care as an Advance Practice Nurse (APN),
- overseeing a nursing department as a healthcare administrator,
- preparing future nurses as a nurse educator, or
- generating nursing science as a scholar.

Moreover, since many African American nurses work in urban settings and care for large minority populations, an understanding of PPACA is essential.

Purpose

The purpose of this paper is to (1) highlight policy provisions in PPACA; (2) discuss the link between social determinants of health (SDH) and PPACA; (3) compare knowledge levels of the American public in December, 2010 to nurses of African descent in December, 2013; and (4) recommend strategies to identify and improve areas of PPACA knowledge deficit.

Summary of PPACA

PPACA consists of two bills that were signed into law by President Barack Obama on March 23, 2010. The two bills consisted of the Patient Protection and Affordable Care Act (H.R. 3590) and Education Reconciliation Act of 2010 (H.R. 4872). Once signed by President Obama, the bills became Public Law 111-148[6] (Table 1) and Public Law 111-152[7], respectively (Table 2). Approximately two years later, on June 28, 2012, the Supreme Court rendered a

final decision to uphold the healthcare law[8]. However, there are still efforts to repeal and/or replace the law.

PPACA focuses on provisions to expand coverage, control healthcare costs, and improve the healthcare delivery system. One key provision of PPACA bans discrimination against preexisting conditions[9]. There are ten titles in the law[6] which address various areas in healthcare that contribute to the improvement of the U.S. healthcare delivery system (Table 1). The focus of the provisions of PPACA are quality of healthcare, affordable healthcare for all Americans, improved efficiency of healthcare, prevention of chronic disease, and improvement of public health. Title V of PPACA focuses on improving workforce training and development, and encompasses several areas targeting nursing education and training aimed at adequately preparing nurses at all levels to serve the population.

Public Law 111-152[7] adjusted revenue and financing schedules for private insurance coverage, Medicare, Medicaid; and reduced fraud, waste, and abuse in healthcare financing. In addition, key components of this law addressed investing in students and families through student loan reform, modifying financial assistance for higher education, and eligibility criteria for dependent children (Table 2). Together, Public Laws 111-148 and 111-152 are referred to as the Patient Protection and Affordable Care Act.

Table 1: Components of the ten titles of the Patient Protection and Affordable Care Act 111-148

I. Quality Affordable Health Care for All Americans
- a. Eliminates lifetime annual limits on benefits.
- b. Prohibits rescissions of health insurance policies.
- c. Provides assistance for those who are uninsured because of a pre-existing condition.
- d. Prohibits pre-existing condition exclusions for children.
- e. Provides coverage of preventative services and immunizations.
- f. Extends dependent coverage up to age 26.
- g. Develops uniform coverage documents to help consumers better compare policies.
- h. Limits insurance company non-medical administrative expenditures.
- i. Ensures consumers have access to an effective appeals process.
- j. Creates a temporary re-insurance program to support coverage for early retirees.
- k. Establishes an internet portal to assist in identifying coverage options.
- l. Facilitates administrative simplification to lower health system costs.

II. Role of Public Programs
- a. Expands Medicaid availability to consumers previously ineligible.
- b. Requires states to maintain eligibility levels for the Children's Health Insurance Program (CHIP) through September 2019.
- c. Simplifies enrollment through state-run Web sites.
- d. Creates the availability of the Community First Choice Option.
- e. Reduces states' Disproportionate Share Hospital Allotments (DSH).
- f. Improves federal and state coordination for individuals enrolled in Medicare and Medicaid.

III. Quality and Efficiency of Health Care
- a. Links payment to quality performance on common, high-cost conditions.
- b. Establishes national strategy to improve service delivery, patient outcomes, and population health.
- c. Encourages development of new patient care, payment, and delivery models.
- d. Ensures beneficiary access to physician care.
- e. Offers rural protections.
- f. Improves payment accuracy.
- g. Rearranges Medicare Advantage (Part C) payment schedules.
- h. Reduces Medicare Prescription Drug Plan (Part D) costs.
- i. Ensures Medicare sustainability.
- j. Improves quality of community health care.

IV. Chronic Disease and Public Health
- a. Modernizes disease prevention and public health systems.
- b. Increases access to clinical preventive services.
- c. Creates healthier communities.
- d. Offers supports for prevention and public health innovation.

V. Health Care Workforce
- a. Encourages innovative review of the workforce.
- b. Increases the supply of health care workers.
- c. Enhances health care workforce education and training.
- d. Supports the existing health care workforce.
- e. Strengthens primary care and other workforce improvements.
- f. Improves access to health care services.

VI. Transparency and Program Integrity
- a. Encourages physician ownership and transparency.
- b. Improves nursing home transparency.
- c. Targets enforcement.
- d. Improves staff training.
- e. Institutes nationwide program for background checks on direct patient access employees of long term care facilities and providers.
- f. Establishes patient-centered outcomes research.
- g. Establishes integrity provisions for Medicare, Medicaid, and CHIP.
- h. Enhances integrity provisions for Medicare and Medicaid.
- i. Encourages additional Medicaid program integrity provisions.
- j. Encourages additional program integrity provisions.
- k. Encourages enforcement of the Elder Justice Act.
- l. Expresses the sense of the Senate regarding medical malpractice.

VII. Access to Innovative Medical Therapies
- a. Establishes biologics price competition and innovation.
- b. Provides more affordable medicines for children and underserved communities.

VIII. Community Living Assistance Services and Supports
- a. Establishes national voluntary insurance program for purchasing Community Living Assistance Services and Support (CLASS).

IX. Revenue Provisions
- a. Levies excise tax on high cost employer-sponsored health coverage.
- b. Increases transparency in employer W-2 reporting of health benefits values.
- c. Supports distributions for medicine qualified *only* if for prescribed drugs or insulin.
- d. Increases additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses.
- e. Limits health-care related FSA contributions.
- f. Institutes requirement of corporate information reporting.
- g. Establishes new requirement for non-profit hospitals.
- h. Imposes a pharmaceutical manufacturer's fee.
- i. Imposes a medical device manufacturer's fee.
- j. Imposes an insurance provider fee.
- k. Instates requirement of Department of Veterans Affairs report.
- l. Eliminates the deduction for employer Part D subsidy.
- m. Modifies the threshold for claiming the itemized deduction for medical expenses.
- n. Limits executive compensation.
- o. Imposes additional hospital insurance tax for high-wage workers.
- p. Implements special deduction for Blue Cross Blue Shield (BCBS).
- q. Encourages attention to Indian Tribal Health Services.
- r. Simplifies cafeteria plans for small businesses.
- s. Implements credits to encourage investment in new therapies.

X. Quality Affordable Care
- a. Improves employer contributions pertaining to coverage.
- b. Introduces additional public programs improvements.
- c. Authorizes appropriations for the Indian Health Care Improvement Act.
- d. Improves Medicare beneficiary services.
- e. Improves reporting pertaining to public health programs.
- f. Focuses on strategies for workforce recruitment.
- g. Enhances transparency and program integrity.
- h. Suggests proposals to increase industry revenue.

Details and source: The Patient Protection and Affordable Care Act Detailed Summary (https://www.dpc.senate.gov/healthreformbill/healthbill52.pdf)

Summary of Health Disparities

In the U.S. similar to other developed nations, there are social determinants of health[10]. For America, the Healthy People 2020[11] document organized the social determinants into five key areas that contribute to health disparities. They are (1) economic stability, (2) education, (3) social and community context, (4) health and healthcare, along with (5) neighborhood and built environment. These determinants are unequally experienced and produce health disparities.

Similar to WHO, Schmidt, George and Bussey-Jones[12] made the point that non-biological determinants contribute to health disparities, and commented on the importance of teaching and learning strategies among healthcare providers that improve providers' attitudes towards underserved and medically indigent

Table 2: Highlights of Public Law 111-152 - Health Care and Education Reconciliation Act of 2010

Title I: Coverage, Medicare, Medicaid, and Revenues

1. Revised the formula for calculating the refundable tax credit.
2. Imposed penalties on individuals who decline to purchase health care coverage.
3. Imposed penalties on employers with 50 or more employees who decline to offer employees health care coverage.
4. Modified the definition of "modified adjusted gross income."
5. Appropriated to the Fund for the administrative costs of carrying out PPACA and this Act.

Subtitle B: Medicare

1. Provide a one-time $250 rebate in 2010 to all Medicare part D enrollees.
2. Analyze the differences in coding patterns between Medicare Advantage (MA) and the original Medicare fee-for-service.
3. Required MA plans whose medical loss ratios are not at least 0.85 to remit to the Secretary.
4. Specified reductions to Medicare to reflect lower uncompensated care costs.
5. Revised the hospital market basket reduction applicable to payments.
6. Postponed the date by which physician-owned hospitals may participate in Medicare.
7. Revised the special rule in the physician fee schedule for imaging services.
8. Modified the employee wage and rent portions.
9. Directs the Secretary to provide for a specified payment to qualifying hospitals.

Subtitle C: Medicaid

1. Amended SSA title XIX (Medicaid)
2. Repealed the permanent 100% federal matching rate.
3. Required that Medicaid payment rates be at least 100% of Medicare payment.
4. Lowered the reduction in federal Medicaid DSH payments.
5. Authorized to operate a Health Benefits Exchange Territories.
6. Postponed the effective date established for state Medicaid programs
7. Revised the definition of a new formulation of an existing drug, for applying rebate.

Subtitle D: Reducing Fraud, Waste, and Abuse

1. Revised the meaning of a community mental health center that provides Medicare partial hospitalization services.
2. Repealed Medicare prepayment medical review limitations.
3. Made additional appropriations to the Health Care Fraud and Abuse Control Account.
4. Revised enrollment process requirements for Medicare service providers and suppliers.

Subtitle E: Provisions Relating to Revenue

1. Delayed the excise tax on high cost employer-sponsored health coverage plans.
2. Included net investment income in the Medicare taxable base and imposes a tax.
3. Delayed limitation on annual salary contributions by an employee to a health flexible spending.
4. Delayed until 2011 the fee on sales of branded prescription drugs.
5. Imposed a tax on sales after 2012 of any taxable medical device
6. Delayed until 2014 the annual fee on the net premium income of health insurance providers.
7. Delayed until 2013 the elimination of the tax deduction for expenses allocable to the Medicare Part D subsidy.
8. Revised the definition of "cellulosic biofuel."
9. Set forth rules for the application of the economic substance doctrine to transactions affecting taxpayer liability.
10. Increased the estimated tax payment of corporations with assets of $1 billion or more.

Subtitle F: Other Provisions

1. Amended the Trade Act of 1974 to make appropriations for the community college and career training grant program.

Title II: Education and Health

1. Amended the Higher Education Act of 1965 to authorize, appropriate,and fully fund maximum Pell Grant amounts.
2. Authorized and appropriated funds for the College Access Challenge Grant program.
3. Extended funding for grants to historically Black colleges and universities and other minority-serving institutions.

Part II: Student Loan Reform

1. Prohibited any new loans from being made or insured under the Federal Family Education Loan (FFEL) program.
2. Allowed borrowers who have loans under both the Direct Loan (DL) and FFEL programs.
3. Terminated unsubsidized Stafford Loans for middle-income borrowers and special allowances.
4. Required DLs for students and the parents of students attending institutions of higher education outside of the United States.
5. Directed the Secretary to award DL servicing contracts to nonprofit servicers that meet certain federal standards.

Subtitle B: Health

1. Grandfathered health plans provisions that prohibit a health plan from applying any waiting period for coverage that exceeds 90 days.
2. Repealed the requirement that an adult child be unmarried in order to qualify for dependent coverage until age 26.
3. Limited the drug discount program to outpatient's drugs and excluded certain drugs.
4. Provide enhanced funding for the community health center program.

Details and source: https://www.congress.gov/bill/111th-congress/house-bill/4872

populations. They contend that provider learning experiences that include social determinants of health improve cultural competency thereby producing a better understanding of the community served. When providers understand the community, Schmidt, George and Bussey-Jones[12] contend they are empowered to give patient-centered care.

The 2012 National Healthcare Disparities Report (NHDR)[13] noted that some Americans receive worse care than others. These disparities were due, in part, to (1) provider biases, (2) differences in access to care, (3) poor provider-patient communication, and (4) patients with poor health literacy[13]. The US Congress mandated a report highlighting disparities in healthcare as it related to racial and socioeconomic factors. Unfortunately, one of the three major themes from these data showed that disparities are not changing[13]. Moreover, the report showed that people of African descent received worse care compared to Whites; and people of Hispanic descent received worse care than Whites of non-Hispanic descent in 40% of the quality and access measures. While the report indicated that overall quality is improving, access for minority and low income groups appeared to be getting worse, and disparities were not improving in 2012. Similarly, the Centers for Disease Control's 2013 Health Disparities and Inequalities Report - United States[14], indicated that people of African descent have the highest rates of death from coronary heart disease and infant mortality compared to other racial and ethnic groups.

Wilensky and Satcher[15] acknowledge that social determinants such as the effect of poverty, education, treatment of women, employment opportunities, and limited access to medical care contribute to health disparities. They explain that by focusing on the social determinants of health, as a means of reducing disparities in health outcomes, attention is given to the overall environment where people live and work. Moreover, Wilensky and Satcher[15] postulate how social and economic policy impact health outcomes. As such, it is important that nurses of African descent understand PPACA and its effects on disparities.

PPACA's Effect on Disparities

Noting that PPACA has numerous provisions that address SDH, LaVeist and Pierre[16] advocate for a diverse healthcare workforce. They discussed how racial/ethnic minority groups are faced with disproportionately poorer environmental conditions, segregation, discrimination, and physician bias in medical treatment when compared to Whites. While there are expectations that PPACA will help establish health equity, data reports such as the 2014 National Healthcare Quality and Disparities Report, have not provided evidence supporting those expectations[17]. However, LaVeist and Pierre's[16] conceptual framework which integrates SDH, health disparities, and workforce diversity may help explain the persistence of health disparities.

Further, LaVeist and Pierre[16] suggest that the lived experience of understanding how and why cultural factors affect illness and treatment adherence means that a diverse workforce will be able to better translate and modify these factors to improve patient care. In fact, they go so far as to suggest that the lack of a diverse workforce has the potential to foster cultural differences and biases that lead to barriers in access to quality care for racial/ethnic minority groups. Title V of PPACA also attempts to address this issue. As such, LIBN Fellows may be positioned to lead health equity initiatives since they may have personal experience with discrimination, biases, and poor health outcomes while their knowledge of PPACA may help to overcome these problems. LaVeist and Pierre[16] base their conceptual framework on growing evidence that a diverse workforce improves access, increases patient satisfaction, and ensures culturally competent care by addressing SDH.

LIBN Fellows and PPACA

Most of the Fellows (70%) reported the reason they applied to the Institute was to expand networking and career opportunities, and improve nursing leadership and patient outcomes. As shown in Table 3, 97% of the Fellows were female and in their mid-forties; 76% had a Master's degree and had an average income of $96,000.

Table 3: Demographics of the LIBN Fellows (n=100)

Demographics of the LIBN Fellows (n=100)	
Gender	97% Female
Age	46 (SD=8.7)
Income	$96K (SD=18)
Education	76% Master's Degree
Time in present position	4.51 years (SD=5.25)

The Fellows were asked to complete the Motivation to Lead (MTL) scale[18]. LIBN Fellows were highly motivated to lead based on scores from the above-mentioned scale. In addition to completing MTL, they were asked to complete the Leadership Efficacy (LE) scale[19] which measured 15 dimensions of leadership. Fellows with increased scores on the MTL also reported increased scores on the LE. This provided support for MTL results and further suggested that the Fellows were highly motivated to lead.

Prepared and motivated to lead, LIBN Fellows were asked to complete ten questions published by Kaiser[3] public opinion survey. Since Chan and Drasgow's theory[18] of leader development suggested that leaders must have social knowledge and skills; therefore, the expectation was that LIBN Fellows would have as much knowledge of PPACA as those surveyed by Kaiser[3] in the general public. Whether collective or individual, Chan and Drasgow posited that a leader's knowledge of and/or skills with social issues are important when developing new leaders[18].

Much of the nursing literature describes PPACA, and notes that it enhanced opportunities for nurses to lead the way in providing preventive and wellness services [American Nurses Association (ANA) President Karen Daley, 2012] [20]. According to ANA, care coordination for individuals as well as their families will help manage and prevent costly complications due to late entry into the healthcare system. Furthermore, PPACA is expected to utilize nurse practitioners and nurse midwives to their fullest extent, as the law increased patient-centered, team-based models of care such as medical homes. In addition, ANA suggested that advanced practice registered nurses (APRNs) were exploring opportunities under the new insurance marketplaces provided in PPACA.

Opportunities to address long-standing barriers to APRN practice such as getting credentialed and reimbursed by third party payers are essential to career options for nurses. Nurses are advocating for state insurance policymakers to embrace the value of APRNs as healthcare providers. LIBN Fellows pursuing leadership and career opportunities must provide guidance when implementing PPACA.

LIBN Fellows and PPACA Questions

A 10-question public poll created by the Kaiser Family Foundation Health Reform was utilized to assess knowledge of PPACA[3]. The general public was surveyed in 2010 and LIBN Fellows in 2013. Sixty-five of the 100 Fellows completed the online survey between April and November 2013. Results from the Kaiser survey of 1,207 adults indicated that, on average, Fellows barely outperformed those surveyed by Kaiser in December 2010. Moreover, in a smaller percentage of Fellows answered two of the questions correctly when compared to the Kaiser sample (Table 4). In other words, the Fellows did not outperform the general public on two of the questions three years later. Specifically, only 34% of Fellows answered the question regarding undocumented immigrants correctly compared to 42% of the Kaiser sample got the answer correct. The question regarding new government run insurance plans was answered correctly by only 25% of the Fellows compared to 27% of Kaiser's sample. The low percentage of respondents, who correctly answered some of the questions, may be due, in part, to the numerous provisions within PPACA and general confusion regarding PPACA.

Some provisions in PPACA may reduce health disparities through increased workforce diversity[16]. Similar to Ewoldt[21], LeVeist and Pierre highlight provisions, such as loan forgiveness

Table 4: True/false statements about Obama Care.

True/false statements about Obama Care	Answers	%Correct LIBN (Kaiser)
1. Provides subsidies to low and moderate income Americans.	True	87.3% (72%)
2. Prohibits insurers from denying coverage because of health status.	True	95.3% (67%)
3. Provides tax credits to small businesses that offer coverage to their employees.	True	88.9% (65%)
4. Contains individual mandates.	True	66.7% (64%)
5. Expands the existing Medicaid program to cover low-income uninsured adults regardless of whether they have children.	True	79.7% (62%)
6. Allows a government panel to make decisions about end-of-life care for people on Medicare.	False	62.3% (45%)
7. Allows undocumented immigrants to receive financial help from the government to buy health insurance.	False	33.9% (42%)
8. Cuts benefits that were previously provided to all people on Medicare.	False	83.9% (40%)
9. Creates a new government run insurance plan to be offered along with private plans.	False	24.6% (27%)
10. Requires all businesses, even the smallest ones to provide health insurance for their employees.	False	24.6% (25%)

for nurses and grant opportunities for nursing students and faculty. However, the Kaiser[3] survey did not include items such as loan forgiveness and grant opportunities, but asked questions to see how well Americans understood what the new law entailed. Kaiser[3] provided five items that were part of the law and five items that were not.

Compared to the items that were true, the false items presented more of a problem for the respondents. As noted in Table 4, the false items were answered incorrectly more often than the true items. (Table 4) As such, the question is raised whether the items accurately measured the respondents' knowledge, given both the nurses and general publics' poor response to the false items. The items answered incorrectly most often focused on myths about end-of-life care, death panels; and undocumented immigrants receiving government support.

Impact of PPACA on Nurses

According to the 2012 National Healthcare Disparities Report[13] released May 2013 by The Agency of Healthcare Research and Quality, access to healthcare had not improved from 2002-2008 for minorities and people of racial ethnic backgrounds. This, in part, led to the enactment of PPACA. This law provided quality and affordable healthcare for all Americans. It also promoted prevention and wellness. It increased access to affordable health insurance coverage and supported improvement in primary care.

Nurses are at the forefront of public health and community outreach; and they can provide health education, implement prevention and promote wellness in the community. As educators, advocates, and healthcare providers, nurses are gatekeepers. It is through education and preventive care measures that nurses' play a major role in affecting changes in the community according to ANA[20]. Whether by way of new programs piloting innovative healthcare or funding that supports nursing workforce development, ANA notes that PPACA has had a major impact on nurses and the profession.

This legislation helps nurses lead changes in healthcare that affect not only patients, but also the general public. For example, nurses can also make a huge impact in the community by establishing nurse-run managed care centers, which according to PPACA focus on preventive care.

Recommendations

PPACA has opened doors for nurses to practice to the full extent of their education[22]. Whether nurse managed care centers or increased nursing faculty, PPACA has an impact on nurses and nursing. Therefore, it is recommended that nurses take full advantage of education and career opportunities posed by PPACA.

LIBN Fellows, motivated and interested in leadership, barely outperformed the Kaiser[3] respondents on PPACA questions. Moreover, the Fellows failed to reach the benchmark of 80% on 5 of the 10 questions. Given the time lapse from 2010 to 2013, it was expected that the Fellows would have had significantly more knowledge of PPACA compared to the general public. Based on these findings, it is recommended that leadership programs for nurses especially those addressing racial/ethnic minority groups include PPACA provisions in their syllabi. Professional nursing associations and trade-journals would be of service to their membership by highlighting provisions in PPACA. If nurses of African descent are to play an essential role in establishing health equity, knowledge of PPACA is imperative.

Expectations are high that PPACA will continue to have an impact on health equity. Quality and disparity measures need continued monitoring and the dissemination of findings are vital to increase awareness. It is recommended that nurses of African descent, motivated to lead, remain vigilant for new evidence based approaches that address SDH among marginalized populations.

With expanded health insurance coverage, offered through PPACA, marginalized populations have increased access to healthcare. However, it should be noted that increased access does not limit the need for better lifestyle choices regarding exercise, eating, and smoking cessation. It is recommended that nurse leaders gain detailed understanding of new health plans that cover preventive services such as blood pressure and cholesterol screenings that focus on minimizing cardiovascular disease.

Lessons Learned

LIBN Fellows did not have a strong understanding of PPACA in 2013. Specifically, they were weak in the areas of individual mandates, government run insurance plans, and requirements on small businesses. In fact, when compared with Kaiser's 2010 general public, the Fellows scored lower on some questions. Given the scores, it could still be questioned whether these groups of nurses of African descent who are highly motivated to lead are sufficiently prepared to advocate for provisions in PPACA.

The impact of PPACA is related to the ten titles (Table 1). Millions of Americans gained health insurance due to PPACA. Care for these patients was accomplished through increasing the healthcare workforce and expanding their scope of practice. They were encouraged to be innovative in training, recruitment, and retention. Specifically, enhancements in the healthcare workforce included education and training that targeted advanced nursing education and community health with nurse-managed health centers.

Nursing is an essential profession that can move America's healthcare system forward, and those interested in leadership require current knowledge of policies that affect practice. If health disparities are to be abated, more healthcare providers of African descent must understand SDH and help close the gap by using all aspects of PPACA. However, efforts to repeal PPACA may have contributed to knowledge deficit by both the general public and the nurses. If PPACA is repealed, will there be high-quality healthcare for all? Will nursing continue to use innovative approaches for recruitment, retention, and education? And finally, will there be ongoing efforts to minimize and/or eliminate health disparities?

References

1. Saad L (2015) Nurses retain top spot as the most highly rated profession. Gallup Social Issues. http://www.gallup.

com/poll/187874/americans-faith-honesty-ethics-police rebounds.aspx?g_source=nurses&g_medium=search&g_campaign=tiles.

2. Miller TW, Maloney P, Maloney RJ (2012) Politics and Consumer Partnerships. In: Kelly P 3rd edition, Nursing Leadership and Management, Clifton Park: 223-240.
3. Kaiser Public Opinion (2011) Pop quiz: Assessing Americans' familiarity with the health care law Data Note. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8148.pdf
4. Kaiser Family Foundation (2016) Key facts about the uninsured population. http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population
5. Department of Health and Human Services (2016) Testimony from Richard Frank, PhD on impact of the ACA on small business http://www.hhs.gov/about/agencies/asl/testimony/2016-10/impact-aca-small-businesses/index.html
6. https://www.dpc.senate.gov/healthreformbill/healthbill52.pdf
7. https://www.congress.gov/bill/111th-congress/house-bill/4872
8. http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html
9. Lee M (2011) Trends in the Law: The patient protection and affordable care act. *Yale J Health Pol'y L. & Ethics*. 1: 1-7.
10. World Health Organization (2016) Social determinants of health. http://www.who.int/social_determinants/en/
11. Healthy People 2020 Social determinants of health. http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health
12. Schmidt S, George M, Bussey-Jones J (2016) Welcome to the neighborhood: Service learning to understand of social determinants of health and promote local advocacy. *Diversity and Equality in Health and Care.* 13: 389-390.
13. National Healthcare Disparities Report (2013) Rockville, MD: Agency for Healthcare Research and Quality. AHRQ Pub. No. 13-0003. http://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/index.html
14. Centers for Disease Control and Prevention (2013) Health Disparities and Inequalities Report - United States. MMWR. 62: 157-185.
15. Wilensky G, Satcher D (2009) Don't forget about the social determinants of health. *National Library of Medicine*. 28: 194-198.
16. LaVeist TA, Pierre G (2014) Integrating the 3Ds-social determinants, health disparities, and health-care workforce diversity. *Public Health Reports*. 129: 9-14.
17. National Healthcare Quality and Disparities Report (2015) Rockville, MD: Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
18. Chan KY, Drasgow F (2001) Toward a theory of individual differences and leadership: Understanding the motivation to lead. *Journal of Applied Psychology*. 86: 481-498.
19. Chemers MM, Watson CB, May S (2000) Dispositional affect and leadership effectiveness: A comparison of self-esteem, optimism, and efficacy. *Personality and Social Psychology Bulletin.* 26: 267-277.
20. American Nurses Association (2012) Affordable Care Act is still the law. *The American Nurse*. http://www.theamericannurse.org/index.php/2012/08/06/affordable-care-act-is-still-the-law/
21. Ewoldt LL (2014) Healthcare reform: Resolve to increase your knowledge in 2014. *American Nurse Today.* 9: 8-12.
22. Institute of Medicine (2011) The Future of Nursing: Leading Change, Advancing Health. Washington, DC: The National Academies Press.

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