Realizing the full potential of combining EHR and analytics will depend on integrated and compatible EHRs across an entire health system, which is a strong incentive for a change that some health systems may be reluctant to make. Clinicians also would benefit from additional training to ensure effective use of the system's data sets (Hoppszallern et al., 2016).

The rising interconnectivity of health care is also challenging facilities to think about how their data can be advantageous outside of their system. The Mayo Clinic, for example, has developed an *AskMayoExpert* tool that allows external clinicians to ask the Mayo staff questions, provides e-consultations with Mayo physicians, and accesses Mayo treatment guidelines (Hoppszallern et al., 2016).

This paradigm shift creates a new level of patient centeredness—connecting and coordinating care teams not physically located together. For example, one team member can capture data such as medical histories for use by the entire health team across multiple care settings (Graver, 2016). Other health systems use integrated, cloud-based EHRs to identify patients with gaps in care such as those who have gone too long without a test or screening (Karash, 2016). The adoption and growing capability of health informatics and EHRs are one reason the health workforce can meet the burgeoning health demands of an ever-growing population and are also one catalyst for the evolution of health care worker roles.

At the facility level, the shift to EHRs has been a major driver of change in staffing arrangements. Facilities using EHRs tend to have different staffing patterns and greater flexibility in staffing than those who do not (Frogner, Park, & Pittman, 2017), and nurse staffing flexibility was found to be statistically significantly associated with positive patient experience (Oppel & Young, 2017).

Taken all together, the potential implications of widespread EHR adoption and its effects on treatment, processes, staff deployment, and connectivity may benefit patient outcomes in many ways in the coming years.

Team-Based Care

Since CNPs and physician assistants now comprise over 40% of the primary care workforce, and as the number of primary care physicians continues to decline, a reorganization of health systems and care may be the solution to the impending primary care shortage (Streeter et al., 2017). Health care needs are already beginning to surpass the system's scope (Poghosyan, Liu, Shang, & D'Aunno, 2017). In the move toward precision medicine, interdisciplinary teams composed of an array of health professional experts take on more active roles in patient care. Rather than merely serving as support for the physician, other interdisciplinary team members use their individual specialized skills to focus on managing certain aspects of a patient's care. Organizing care with interdisciplinary teams shows promising data, not only with the comprehensiveness of care and patient satisfaction, but also with provider self-confidence and primary care team satisfaction. Studies have demonstrated that interdisciplinary teams are a worthwhile alternative to our current health care structure (Purcell, Zamora, Tighe, Li, Douraghi, & Seal, 2017).

In fact, studies suggest that transitioning to an interdisciplinary team in a health care setting can result in comprehensive care and reduced health care costs (O'Reilly, Lee, O'Sullivan, Cullen, Kennedy, & MacFarlane, 2017).

Several studies have demonstrated interdisciplinary team care, used in conjunction with palliative care, can improve oncologic results (Bakitas, El-Jawahri, Farquhar, Ferrell, Grudzen, & Higginson, 2017). Trials involving care for patients with advanced cancers by interdisciplinary teams demonstrated positive outcomes, such as improved quality of life, reduced anxiety, decreased caregiver distress, and, in several cases, reduced costs (Bakitas et al., 2017). Additionally, a study that investigated the use of interdisciplinary bedside rounds at a U.S. academic medical center found communication and coordination of care were optimized when an interdisciplinary model of care (IMOC) involving daily rounds between the interdisciplinary team and their patients and their families was used (Malec, Mork, Hoffman, & Carlson, 2017). Before the medical center began an IMOC, nurse participation in the daily rounds and use of best practices fluctuated (Malec et al., 2017). Outcomes after implementing an IMOC included increased nurse participation, a more patient-centered method of care, and improved staff cooperation and collaboration (Malec et al., 2017). Despite promising IMOC results, evidence suggests this model is being underutilized or seeing different levels of use across health care, such as in heart failure patients (Kavalieratos et al., 2017). Perhaps it can achieve greater outcomes if optimally used and widely adopted.

The emphasis on team-based care leads to questions about team-based regulation. Which board is responsible when an interdisciplinary team is involved in a complaint? Will the boards communicate to find out more facts and arrive at a fair resolution for all, or will each board handle their own licensee negating the fact that an entire team was involved in the incident? To take the first steps towards a more collegial role and to establish a foundation for team-based regulation, in 2018, regulators from health care disciplines will work together to align their codes for reporting violations to the National Practitioner Databank. This collaborative step is important for aligning procedures and processes.

Federal Legislation Impacting the Nursing Workforce

The 21st Century Cures Act

President Obama's signing of the 21st Century Cures Act (The Cures Act) (2016) in December 2016 began a new era heralding the modernization of medical science. This landmark legislation provides a trajectory for new discoveries and innovations in health care

by funding precision medicine, the Cancer Moonshot, and the BRAIN Initiative, which address devastating diseases, mental health issues, and the opioid crisis and offer new promise and hope for millions. The Cures Act also calls for FDA drug and device approval reform. It impacts hospitals and other institutions by promoting the interoperability of EHR and the use of telehealth and social media tools for preventing, monitoring, and treating illnesses (Landi, 2016). The Cures Act is accelerating EHR adoption and places special requirements on its capability and application. For example, it promotes the interoperability of everyone's medical record to allow for "complete access, exchange, use, and secure transfer of all electronically accessible information under applicable federal or state law" (Johnson, Thaul, & Bagalman, 2015).

Although the benefits may seem distant, the Cures Act authorizes $4.8 billion total to the NIH through 2026 in hope of speeding results so those living today may benefit from the research (University of San Francisco Health, n.d.). Along with the possibilities it offers the future of health care, the Cures Act presents nursing with new challenges and opportunities inherent in precision medicine, EHR adoption, and use of telehealth and social media.

Deferred Action for Childhood Arrivals

The Trump administration stopped accepting renewal applications for the Deferred Action for Childhood Arrivals (DACA) program in September 2017. DACA was instituted in 2012 and allowed approximately 800,000 undocumented immigrants who came to the United States as children to legally live and work in the country. Unless addressed by Congressional legislation, DACA recipients will no longer be able to legally live and work in the United States once their current exemption expires. An estimated 20% of DACA recipients work in health care. Consequently, this policy change will impact a substantial number of nurses and nursing students (Heredia Rodriguez, 2017).

Telehealth

Numerous bills have been introduced in Congress to assist telehealth service implementation and address telehealth reimbursement through Medicare and Medicaid. Notably, the U.S. Senate passed The CHRONIC Care Act (2017), which incentivizes care coordination and updates Medicare telehealth payment policies for care delivered to patients managing chronic diseases. Other bills addressing Medicare telehealth payment policy that have received substantial attention in Congress include The CONNECT for Health Act (2017) and The FAST Act of 2017 (2017). CMS is considering changes that would allow for additional telehealth reimbursement. In the CMS CY 2018 Physician Fee Schedule final rule, the agency created a remote patient monitoring benefit that would pay caregivers who obtain digitally transmitted biometric data from patients (CMS, 2017a).

Veterans Affairs

The U.S. Department of Veterans Affairs (VA) continues to pursue changes to policies impacting veterans and the VA's health care workforce. The VA has issued a proposed rule that would allow VA-employed health care professionals to practice telehealth across state lines with only one license and would allow veterans to receive telehealth services outside of a federal facility. The proposed rule may be finalized in 2018 and is in line with The VETS Act of 2017 (2017), which would codify these changes in statute. The VA is also currently implementing full-practice authority for APRNs in the vast majority of their facilities nationwide.

Update on The Affordable Care Act

The ACA was passed by Congress and signed by President Obama in 2010. The ACA aimed to provide health care insurance to all U.S. residents by mandating insurance coverage via a federal government or state-based website, prohibiting insurance coverage denials based on pre-existing conditions, subsidizing insurance payments for residents who cannot pay premiums, and expanding Medicaid (ACA, 2010).

The ACA has been resilient in the face of multiple repeal attempts in 2017. In May, the House passed H.R. 1628 (the American Health Care Act), a repeal bill that would have eliminated tax penalties for those without health insurance, allowed higher premiums for some pre-existing conditions, and rolled back the state expansion of Medicaid (Kaplan & Pear, 2017; Levitt, Damico, Claxton, Cox, & Pollitz, 2017). The Congressional Budget Office and Joint Committee on Taxation estimated that enacting the American Health Care Act would reduce federal deficits by $119 billion from 2017 to 2026 and increase the number of uninsured by 23 million by 2026 (Congressional Budget Office, 2017a).

The Senate was unable to pass the American Health Care Act. Although most senators found the House bill to be flawed, consensus could not be reached on how to improve it (Cunningham, 2017b). A bill that would have eliminated the insurance mandate and removed subsidies while leaving the Medicaid expansion intact was narrowly defeated in July (Eilperin, Sullivan, & Snell, 2017). A proposal to end the insurance subsidies and coverage requirements and to replace the arrangement with block grants to individual states did not reach a vote. Analyses of the proposal showed that more than 30 states would have lost federal money for health coverage, with Medicaid expansion states being the hardest hit (Goldstein & Eilperin, 2017). The year ended with no indication that a repeal of the ACA was on the horizon (Cunningham, 2017c).