NPs and Current Health Policy: Opportunities and Challenges

National Organization of Nurse Practitioner Faculty

41st Annual Meeting
Baltimore, MD

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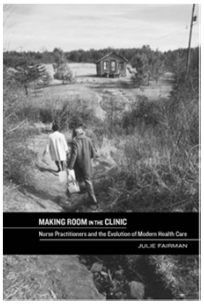
University of Pennsylvania
School of Nursing



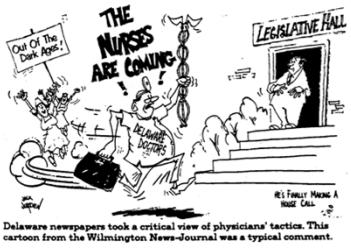
- How I became interested
- Framework
- Serendipity
- Intersections

- Huge topic!!
  - Scope of Practice
  - Payment
  - Workforce issues
  - etc

f1

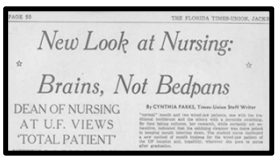
- Clinically significant questions focused on health policy issues :

How do we decide who provides particular types of care at particular times and places?



Delaware newspapers took a critical view of physicians' tactics. This cartoon from the Wilmington News-Journal was a typical comment.

What education, knowledge and skills are necessary for providers? How do we know this?

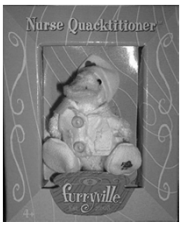


New Look at Nursing:

Brains, Not Bedpans

DEAN OF NURSING AT U.F. VIEWS 'TOTAL PATIENT'

– How do clinicians—physicians and nurses in particular —negotiate among themselves, with patients, and with public and private interests to define the borders of responsibility and authority for clinical care?



Slide 4

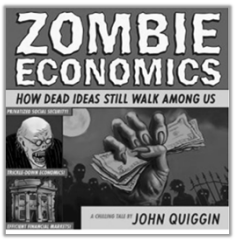
jf1 direct growth of the NLM, NEH and URF grants
Julie fairman, 11/24/2008

Intersection

- All 3 questions intersect in the area of:

- Competition!!!!

https://www.google.com/search?site=&tbm=isch&source=hp&biw

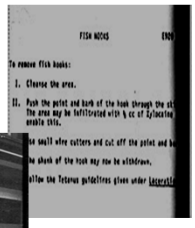


"A proposition that has been thoroughly refuted by analysis and evidence, and should be dead — but won't stay dead because it serves a political purpose, appeals to prejudices, or both……." (Krugman)

What I will discuss today

- Competition as an umbrella for health policy decisions
- Discuss ways that competition or anti-competition measures have been identified and addressed by the FTC,
- Discuss the intersection of medicine's use of education as a proxy for anti-competitive efforts over time
- Link prescription, education and anti-competitive efforts
- Tie competition to current health policy considerations: challenges and opportunities

Nurses and Physicians: History of Collaboration and Competition



196; Group Sessions – L-R Audrey Dahler, Heather Walters H
Maddie Nichols, Sue Stearly, Henry Silver, Nancy Brown, Mac
Rode, Loretta Ford. 1966

Practice protocols, Alaska Health and Social Services, 1972, Univ. of VA, CHIN.

- How does competition work?

  - Licensure and Scope of Practice
    - Restricts entry (or ongoing participation)
    - Describes bounds of licensure—what a given profession can or cannot do (or prohibits others from doing it)—costs and benefits of a particular SOP.
  - Licensure as a response to types of market failure
    - Information asymmetries and information costly
    - When professionals play dual role of diagnostician and treatment provider
    - Health and safety concerns
  - Result: Lack of competition offers no clear guidelines for consumers to make choices that are informed and do not incur substantial cost or safety issues

Scope of Practice

- Consumer protection rationale
  - At reasonable cost
  - Evidence of/or lack of harm

What are the likely effects on competition *and health care consumers* of particular potential changes to those rules, via expansion or contraction of the scope of professional practice?

Anti-competition

- SOP used to protect market share
- Restrict services beyond patient protection
  - Who can engage the pubic as providers
  - Institutional privileges
  - Payment mechanisms
  - Regulatory channels
- NC Dental Baord vs FTC

Restrict other professions from providing a full range of patient care services to the public, even when there is no evidence that the services provided by these practitioners "harm the public or provide benefits that off-set potential costs."

Competition and collaboration:

Collaborative agreements

*Should be voluntary
*can exist together
*should be market-based

Issue: Required Collaborative Agreements

Competition as a Health Policy Issue

- IOM Future of Nursing report recommendations:

"Nurses should practice to the full extent of their education and training"

- Regulatory SOP can be narrower than prudent—becomes a substantial health policy problem
- Alerted federal anti-trust agencies

Early FTC Actions

DC Council

- **FTC Staff Comment Before the Council of the District of Columbia Concerning Proposed Bill 6-317 to Create Specific Licensing Requirements for Expanded Role Nurses** (Nov. 1985) (P864613), *available at* http://www.ftc.gov/be/healthcare/docs/AF%2058.PDF.

State Volunteer Mutual Insurance

- Brief of the Federal Trade Commission as Amicus Curiae on Appeal from United States District Court, Nurse Midwifery Associates v. Hibbett, 918 F.2d 605 (6th Cir. 1990), appealing 689 F. Supp. 799 (M.D. Tenn. 1988)

Federal Trade Commission

Protecting America's Consumers

"when countervailing consumer protection benefits are nil, non-trivial competitive costs are not justified; and highly speculative (or poorly demonstrated) countervailing consumer protection benefits are, at best, highly speculative (or poorly demonstrated) justifications."

FTC Advocacies and Actions

APRN

- Massachusetts 2014
- Connecticut 2013
- W. VA 2012
- Louisiana 2012
- Kentucky 2012
- Texas 2011
- Florida 2011
- DC 1985
- Tennessee (Hibbett) 1988 (amicus brief)

Related

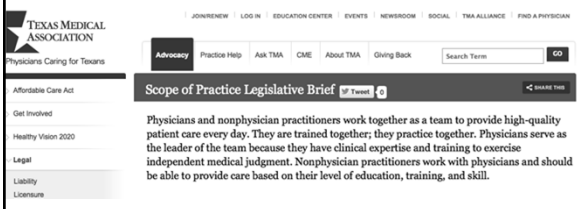
- Related: retail clinics
  - Kentucky 2010
  - Illinois 2008
  - Massachusetts 2007
- Related: Nurse Anesthetists
  - Massachusetts 2009
  - Illinois 2013
  - Missouri 2012
  - Tennessee 2011
  - Alabama 2010

http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

IV. CONCLUSION

HB951 would remove the requirement that certain APRNs who practice in medically underserved areas or treat medically underserved populations have formal written collaborative practice agreements with physicians in order to fully employ their education and experience in serving Louisiana health care consumers. Removing this requirement has the potential to benefit consumers by expanding choices for patients, containing costs, and improving access. Accordingly, we encourage legislators to consider whether the requirement is necessary to assure patient safety in light of your own regulatory experience and the expert findings of the IOM. Maintaining an unnecessary and burdensome requirement is likely to deprive consumers of the benefits that increased competition can provide. Therefore, the Louisiana legislature should carefully consider the safety record of APRNs in Louisiana. Absent countervailing safety concerns regarding APRN practice, HB951 appears to be a procompetitive improvement in the law that would benefit Louisiana health care consumers.

http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-likely-competitive-impact-louisiana-house-bill-951/120425louisianastaffcomment.pdf



http://www.texmed.org/Template.aspx?id=19666

The new law gives the physician the authority to decide what acts to delegate to an APRN or PA for a reason. "Due to the limited training and experience required in the abbreviated programs leading to licensure of APRNs (as compared to the required education and training of licensed physicians), it is the delegated physician who must assess the education, training, experience, and competence of each APRN to determine the appropriate amount and type of delegation of medical services,…."

"This is just one more example of **nurse practitioners** trying to obtain through rulemaking what they were unable to get from the Texas Legislature, and it goes well beyond the bill they agreed to," said TMA General Counsel Donald P. "Rocky" Wilcox. "We remain vigilant to protect the safety of Texas patients." (2014)

Texas Medical Association
Physicians Caring for Texans

The Board's opinion is not and cannot be altered by representations that a particular CRNA [Certified Registered Nurse Anesthetist] has received postdoctoral training in such areas or has performed such activities in this or another state. A non-physician may have education, training, and, indeed, expertise in such an area but expertise cannot, in and of itself, supply authority under law to practice medicine (emphasis added).

Louisiana State Board of Medicine, 2012 as cited by Barbara J. Safriet, *Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care*, in IOM FUTURE OF NURSING REPORT,

"Physicians receive far more education, clinical training, and continuing medical education to ensure they are well equipped to diagnose and manage patient care. For example, a primary care physician gains 21,700 hours of clinical education and training, compared to an average of 5,350 hours of clinical education and training for APRNs. This difference in education and training matters."

AMA 2008, Testimony, West Virginia

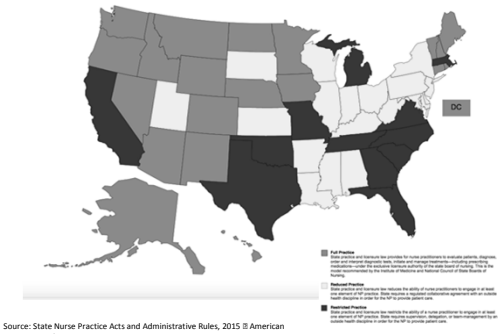
"Nurses are critical to the health care team, but there is no substitute for education and training. Physicians have seven or more years of postgraduate education and more than 10,000 hours of clinical experience, most nurse practitioners have just two-to-three years of postgraduate education and less clinical experience than is obtained in the first year of a three year medical residency.

AMA response to IOM report, 2010
http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page

Policy Question:

Why "this difference" for this policy choice—the codification of skills and knowledge, and the use of hours in training as proxy for safety and quality with its assumptions of holding the "right" knowledge and skills? And what happens when knowledge and skills are codified in the favor of one profession over the other.

- Training hours differential may not matter
- Nation's health needs not well-matched to medical school curriculums
- Teams



Source: State Nurse Practice Acts and Administrative Rules, 2015 © American Association of Nurse Practitioners, 2015

U.S. Judge Finds Medical Group Conspired Against Chiropractors

AP
Published: August 29, 1987

The American Medical Association led an effort to destroy the chiropractic profession by depriving its practitioners of association with medical doctors and by calling them "unscientific cultists" or worse, a Federal district judge has ruled.

Judge Susan Getzendanner described the conspiracy as "systematic, long-term wrongdoing and the long-term intent to destroy a licensed profession" in a ruling late Thursday in an antitrust lawsuit filed in 1976.

The decision said the nation's largest physicians' group led a boycott by doctors intended "to contain and eliminate the chiropractic profession."

Dr. Alan Nelson, chairman of the A.M.A. board of trustees, said in a telephone interview today from Salt Lake City, "we don't think there was ever a boycott or a conspiracy."

http://www.nytimes.com/1987/08/29/us/us-judge-finds-medical-group-conspired-against-chiropractors.html

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

November 3, 2010

Patricia E. Shaner, Office of General Counsel
Alabama State Board of Medical Examiners
Post Office Box 946
848 Washington Avenue (36104)
Montgomery, Alabama 36101-0946

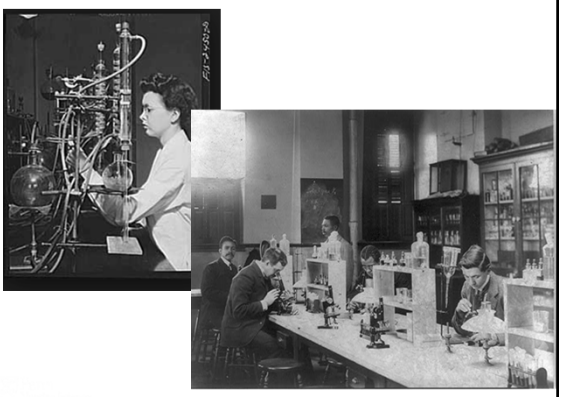
Dear Ms. Shaner:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] appreciate this opportunity to comment on the proposed regulation of interventional pain management services (Proposed Rule) issued by the Alabama State Board of Medical Examiners.[2] The Proposed Rule restricts the "interventional treatment of pain" to "qualified, licensed medical doctors and doctors of osteopathy,"[3] who "may not delegate to non-physician personnel the authority to utilize such procedures to diagnosis [sic], manage or treat chronic pain patients."[4] The rule appears to prohibit certified registered nurse anesthetists (CRNAs) from performing, under the supervision of a physician, pain management procedures that the Board of Nursing considers within the scope of CRNA practice.[5] Absent evidence that the proposed restrictions are necessary to protect the public, there appears to be no reason to sacrifice the benefits of CRNA pain management services as currently available under Alabama law.

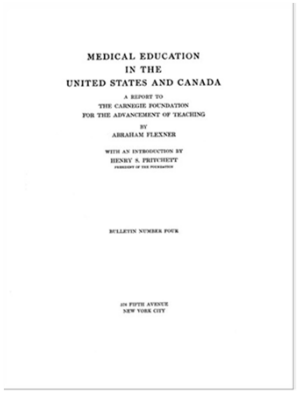
Unnecessary restrictions on the ability of physicians to provide pain management services in collaboration with CRNAs are likely to reduce the availability, and raise the prices, of pain management services in Alabama. In particular, the Proposed Rule may burden cancer

http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-board-medical-examiners-concerning-proposed-regulation/101109alabamabrdme.pdf

How then should meaningful and policy making responses be developed?



http://www.howard.edu/explore/paris/images/11paris.jpg


MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA
A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING
BY
ABRAHAM FLEXNER
WITH AN INTRODUCTION BY
HENRY S. PRITCHETT
BULLETIN NUMBER FOUR
576 FIFTH AVENUE
NEW YORK CITY

http://history.library.ucsf.edu/theme_photo5.html

- Medical education entrepreneurial
- Schools for profit
- Lacked qualified professors, laboratories
- Movement towards standards, science-based curriculum
- Subsequent exclusion of other types of providers

http://www.nlm.nih.gov/hmd/sowhatsnew/images/2a1-a.jpg

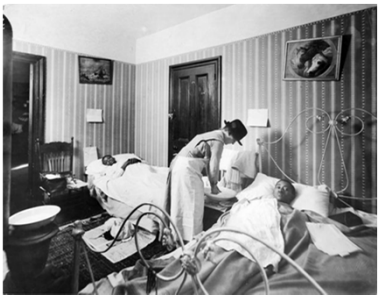
Nursing Education

- Began to integrate science
- Higher education
- Regulations not always following changes
- Medical education moved toward specialization and away from
  - Health promotion
  - Disease prevention
  - Public health
- Regulations did not follow

Chestnut Hill, PA circa 1950 BBCSHN

Harrison Narcotic Act, 1914

http://paranoiastrikesdeep.blogspot.com



Barbara Bates Center for the Study of the History of Nursing, VNA Collection

Visiting nurse entering a row home surrounded by children and adults, Visiting Nurse Society of Philadelphia, c. 1890

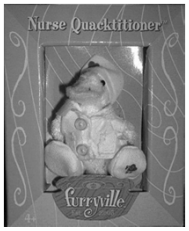
NY VNA, circa 1900, VNA Coll.

CHIN, UVA

Loretta Ford, circa 1980s

Child Health Station, Colorado, circa 1960s, Ford Collection

Go to Medical School!!



Policy Implications

- Competition is good!
  - Message the mantra
    - Choice
    - Cost implications
- FTC should evaluate the effectiveness of their advocacy work
  - Hard to do
  - Mixed success

Policy implications

- Develop delivery models organized around the care needed rather than around the type of practitioner who will deliver it—CMS, Insurers, Companies
  - Message should be on patients rather than the prerogatives or education of providers
  - How NPs provide access to high value, cost effective and safe care that meets the needs of the population?

Policy Implications

- Need for evidence at state level
  - Effect of strict regulations on workforce
    - Access to care
    - Costs to providers
    - Costs to patients
  - Effect of strict regulations on wages and compensation
  - Do certain licensure or SOP policies have measurable effect on outcomes or quality measures
    - E.g. utilization of prenatal care, immunizations, diabetes management guidelines, hospital readmissions

Policy Implications

- What is the effect of strict SOP on consumers?
- Capture power of consumers
  - AARP state branches
- Be alert for the reorganization of professional/occupational boards
- Public outreach via media
  - Some of most effective articles in recent popular press on what NPs do.
  - Keep positive message
  - Ahead of the game: Same old message by organized medicine

"A lot of it boils down to providing background for discussions and helping policy makers figure out whether past cases fit the present situation. It is not…writing a memorandum that lands on the president's desk and forever changes policy."

quote by Michael C. Horowitz, assoc. profess of political science, Penn

CHE p. A4 May 9 2014.

"There is a fine line between vision and hallucination" (anon)

Policy implication of most impact—

All states embrace NCSBN Model Practice Act

Or

CMS adopts a national SOP standard that meet NCSBN standards