Future of Primary Care: The Changing Role of the Primary Care Provider

American Society of Law, Medicine & Ethics
Public Health Law Association
Network for Public Health Law
Public Health Law Research Program

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- Next webinar is Thursday, January 26th at 1:00 p.m. ET
- “Gun Violence, Mental Illness and Firearms Laws: Research Evidence and Questions for Science, Policy and Practice”
  - Jeffrey Swanson, Ph.D., Professor in Psychiatry and Behavioral Sciences, Duke University School of Medicine
  - Paul S. Appelbaum, M.D., Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law, and Director, Division of Law, Ethics and Psychiatry, Columbia University
  - Joshua Horwitz, J.D., Executive Director, Coalition to Stop Gun Violence
Public Health Law
WEBINAR SERIES

Nurse Practitioners and Primary Care: The Evidence

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Nurses and Primary Care

NYVNA, circa late 19th century
<table>
<thead>
<tr>
<th>Who Are They?</th>
<th>How Many in United States?</th>
<th>What Do They Do?</th>
</tr>
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<tbody>
<tr>
<td>Nurse Practitioners (NPs)</td>
<td>153,348</td>
<td>Take health histories and provide complete physical exams; diagnose and treat acute and chronic illnesses; provide immunizations; prescribe and manage medications and other therapies; order and interpret lab tests and x-rays; provide health teaching and supportive counseling.</td>
</tr>
<tr>
<td>Clinical Nurse Specialists (CNSs)</td>
<td>59,242*</td>
<td>Provide advanced nursing care in hospitals and other clinical sites; provide acute and chronic care management; develop quality improvement programs; serve as mentors, educators, researchers, and consultants.</td>
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<tr>
<td>Certified Registered Nurse Anesthetists (CRNAs)</td>
<td>34,821</td>
<td>Administer anesthesia and provide related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as pain management. Settings include operating rooms, outpatient surgical centers, and dental offices. CRNAs deliver more than 65% of all anesthetics to patients in the United States.</td>
</tr>
<tr>
<td>Certified Nurse Midwives (CNMs)</td>
<td>18,492</td>
<td>Provide primary care to women, including gynecological exams, family planning advice, prenatal care, management of low-risk labor and delivery, and neonatal care. Practice settings include hospitals, birthing centers, community clinics, and patient homes.</td>
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</table>

*APRNs are identified by their responses to the National Sample Survey of Registered Nurses, and this number may not reflect the true population of CNSs.

NPs by Specialty

http://www.ahrq.gov/research/pcwork2.htm
Who Is Getting Paid for Primary Care?

- % of allowable charges for primary care services

<table>
<thead>
<tr>
<th>Profession</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Physician</td>
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<tr>
<td>Geriatric medicine</td>
<td>65.0%</td>
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<td>Family medicine</td>
<td>62.5</td>
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<tr>
<td>Internal medicine</td>
<td>44.4</td>
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<tr>
<td>Pediatric medicine</td>
<td>36.5</td>
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<tr>
<td>Nurse practitioner</td>
<td>65.4</td>
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<tr>
<td>Physician assistant</td>
<td>34.8</td>
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<tr>
<td>All other</td>
<td>13.4</td>
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MedPac analysis of 2006 claims data,

http://www.medpac.gov/chapters/Jun08_Ch02.pdf
Scope of Practice Variability Across States
Evidence to Better Cost/Value

- Rand Health Foundation Survey: Massachusetts
  - Scope of Practice
- Cochrane Database Review (2004) (Laurant, Reeves et.al)
- Cost effectiveness of retail clinics
  - Rand
- Cost based on insurance claims
Colorado Health Charges, 2009

<table>
<thead>
<tr>
<th></th>
<th>Retail health clinics</th>
<th>Urgent-care centers</th>
<th>Physician’s office</th>
<th>Emergency room</th>
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<tr>
<td>Evaluation</td>
<td>$66</td>
<td>$103</td>
<td>$106</td>
<td>$358 (total)</td>
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<tr>
<td>Lab</td>
<td>$15</td>
<td>$27</td>
<td>$33</td>
<td>$113 (total)</td>
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RAND Corp. study examining costs at retail clinics for treating ear infections, sore throats and urinary tract infections. Graphic published by the Denver Post, September 30, 2009 (c)
Rx for Pennsylvania Example

- 51 retail clinics that use APRNs in urban, suburban and rural areas
- Provide care to 60 percent of the state’s uninsured
- Of 300,000 visits to such clinics, about half would have been ER visits, one of most expensive types of care
Nurse Managed Health Centers

- 250 NMHC/27 in PA
- Provide care at a 10 percent lower cost than other models—
  - 15 percent reduction in ER use
  - 25 percent reduction in prescription drug costs (NNCC)
    http://www.nncc.us/site/index.php/applied-research/nncc-research

- Examples:
  - LIFE/PACE
  - 11th Street Family Health and Counseling Center
NP and Patient Outcomes

- **Office of Technology Assessment (1986)**
  - Review and pilot of new analysis technique
  - “within their areas of competence, NPs, PAs and certified nurse-midwives provide care that is equivalent to that of care provided by physicians…” (p. 5)

- **British Medical Journal (2002) (Horrocks et.al)**
  - … No significant difference in numbers of prescriptions, return consultations and referrals… Patient outcomes similar… Patient satisfaction higher for NPs…”

- **Cochrane Database Review (2004) (Laurant, Reeves et.al)**
  - “appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients.”
NPs and Outcomes

- Indian Health Service
- IOM Future of Nursing: Leading Change Advancing Health
NPs and Outcomes

- Health Affairs 2010 (Naylor, Kurtzman, 29(5):893-895
- Medline/pubmed survey 2000-2002
- “…NPs provided care that was equivalent to the care provided by physicians and in some cases, more effective care among selected measures than that provided by physicians.”
  - Weight programs
  - Chronic illness management
    - Diabetes
    - Asthma
    - HIV
NPs and Outcomes

- 2011 Nursing Economic$ (Newhouse, et.al., October 29(5))
  https://www.nursingeconomics.net/ce/2013/article3001021.pdf

- High evidence levels for equivalent or better levels of:
  - self-reported patient perceptions of health
  - functional status outcomes
  - glucose control
  - lipid control (better)
  - BP control
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Today’s Presentation

- Focus on Nurse Practitioners (but Physician Assistants face similar challenges)
- Discuss Nurse Practitioners and the environments they provide care in
- Discuss why expanding the role of nurse practitioners is critical to the success of state workforce development and health care reform efforts
  - Massachusetts Case Study
  - Pennsylvania Case Study
There Is a Crisis of Access - Everywhere

- More than 50 million Americans are uninsured, including 1 in every 10 children.
- 70% of Americans report they can’t get same-day appointments with their PCP.
- 29% of Medicare recipients (11.6 million people) have a hard time finding a PCP who accepts their insurance.
- 30% of Americans lack a regular source of primary care.
- About half of all emergency room visits were non-emergent in nature or otherwise treatable in primary care settings.
Crisis of Access

- By 2020, there will be a shortage of as many as 45,000 primary care physicians.
- Between now and 2015, the shortage of doctors across all specialties will quadruple (with a shortage of 63,000 doctors in all specialties) and a worsening of shortages through 2025.*

*Source: American Association of Medical Colleges, 2010 (http://www.aamc.org/newsroom/pressrel/2010/100930.htm)
NPs and NMHCs Can Help Meet the Increased Demand for Care

- Approximately 100,000 nurse practitioners now provide primary care.

- Nurse practitioners are by far the fastest growing group of primary care professionals in the country (compared to physicians, dentists, and physician assistants).*

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NP Outcomes as Primary Care Providers

- There are no appreciable differences between physician and NP-provided primary care.*
- The health status and outcomes of the patients of primary care NPs are comparable to the status and outcomes of the patients of primary care physicians.
- This includes outcomes including health status; physiologic measures; satisfaction; and use of specialists, emergency room, or inpatient services.**

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What is a Nurse-Managed Health Clinic?

- A nurse managed health clinic is a nurse practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency. **Source: Affordable Care Act (ACA)**

**Characteristics:**
- NMHCs are accessible service sites that deliver community-based primary and/or wellness care regardless of a patient’s ability to pay.
- The majority of care is provided by nurses—a team of advanced practice nurses (Nurse Practitioners, Clinical Nurse Specialist, Nurse Midwives), RNs and other health professionals (e.g. Social Workers, Nutritionists) in collaboration with MDs in jurisdictions where required.
- Nurses control their own practice and provide the care.
Services Provided

- Primary Care
- Mental/Behavioral Health
- Family Planning
- Prenatal Services
- Disease Prevention
- Health Promotion
NMHCs in Primary Care

- **Centers report:**
  - High patient satisfaction
  - ER use 15% less than aggregate
  - Non-maternity hospital days 35-40% less
  - Specialty care cost 25% less than aggregate
  - Prescription cost 25% less than aggregate
  - NMHCs see their members an average of 1.8 times more than other providers
What is a Convenient Care Clinic?

Accessibility
- The majority are run by nurse practitioners.
- Located in high-traffic retail outlets.
- Extended weekday and weekend hours.
- No appointments necessary.
- Visits take 15-20 minutes.

Affordability
- Transparent pricing; prices are clearly posted.
- Services cost between $40 and $70.
- CCCs accept many insurance plans.
## Top Treatments at CCCs

1. Sore throat
2. Common Colds/Cold Symptoms
3. Flu Symptoms
4. Cough
5. Sinus Infection
6. Allergies
7. Immunizations
8. Blood Pressure Testing

*Source: 2008 Market Strategies International report*
Positive Primary Care Impact

- Third-party data from RAND Health and other sources support the value of convenient care:
  - Equal to or better than primary care physician practices, urgent care centers, and emergency departments in terms of quality and cost.\(^1\)
  - Accessible within a 10-minute drive for 1/3 of Americans.\(^2\)
  - Reaching segment of the U.S. population that currently goes without care (up to 60% of clinic patients do not have a regular source of primary care).\(^3\)

State Case Studies: Massachusetts and Pennsylvania

- Massachusetts invested in insurance access *before ensuring it had the infrastructure to handle increased demand for primary care services.*

- In Pennsylvania, Governor Rendell invested in primary care infrastructure first, *setting the stage for insurance reforms in the future.*
Does Coverage = Care?

- Experiences in Massachusetts suggest not…circa 2006
- Numbers dwindle for primary care doctors: Medical students in US choosing other specialties (AP, Sep. 10, 2008).
Massachusetts Reform

- Since 2006, Massachusetts has gone from having as many as 650,000 uninsured residents to having 167,300 today (the lowest rate of uninsured residents in the nation).
- But, the State was not prepared for the influx in newly insured residents.
- In order to meet increased demand, in 2008, the state enacted a law increasing utilization of NMHCs, nurse practitioners and other non-physician providers, including physician assistants.
- Here advocacy mattered! See Craven and Ober, “Massachusetts Nurse Practitioners Step Up as One Solution to the Primary care Access Problem: A Political Success Story,” 94-100 10(2) Policy, Politics, & Nursing Practice (2009).
Pennsylvania’s Approach

- **Rx for PA**: Called for approximately 49 statutory / regulatory changes, many of which amended outdated language to allow CRNPs to practice to the full extent of their scope of practice.

- **Chronic Care Initiative**: The Governor’s Office of Health Care Reform, along with physicians, nurses, and insurers, has successfully begun the implementation of Wagner’s Chronic Care Model in selected primary care practices in Southeastern PA. *Three nurse-managed health center networks are participating, with great results so far.*
PA Legislative Changes

- PA Reform called for approximately 49 statutory/regulatory changes to allow NPs to practice to the full extent of their scope of practice. NPs in PA can now:

1. Order home health and hospice care
2. Order durable medical equipment
3. Issue oral orders to the extent permitted by the state’s health care facilities
4. Make physical therapy and dietitian referrals
5. Make respiratory and occupational therapy referrals
6. Perform disability assessments for the program providing Temporary Assistance to Needy Families (TANF)
7. Issue homebound schooling certifications
8. Perform and sign the initial assessment of methadone treatment evaluations
In 2008, the Governor’s Office of Health Care Reform, along with physicians, nurses, and insurers, successfully began the implementation of Wagner’s Chronic Care Model in selected primary care practices in Southeastern PA. Eight of the initial 32 practices were nurse-led.

In 2010, the initiative was expanded throughout the state and now includes 151 participating practices.

Outcomes are extremely positive - 2009 data shows that participating diabetics are 33% more likely to have control of their blood sugars, 40% more likely to have control of cholesterol levels and 25% more likely to have normal blood pressures when compared to non-participating diabetics.
Continuing Challenges to Nurse-led Care

- Patchwork of reimbursement in the U.S.
- Hard to financially sustain in a complex health care system that doesn’t consistently recognize NPs for reimbursement purposes
- NP state-level policy issues affecting reimbursement and scope of practice
- Shift from Medicaid/Medicare FFS system to privatized managed care displaced direct reimbursement for NPs because of network contracting policies of individual insurance companies
Strategies for Fully Utilizing Advanced Practice Nurses

- IOM’s Future Nursing Report Message:
  - Nurses should practice to the full extent of their education and training. (Requires scope of practice reform)
  - Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. (Requires promulgating NMHCs and providing access to students for clinical sites)
  - Nurses should be full partners, with physicians and other health professionals, in redesigning healthcare in the United States. (Requires including NMHCs in ACOs and state insurance exchanges)
  - Effective workforce planning and policy-making with better data collection and information infrastructure. (Requires promoting NMHC participation in Patient Centered Medical Home projects, as NCQA did in October, 2010)
Non-Physician Providers: A Disruptive Innovation

“The twentieth century’s physician-centric hierarchical model for the provision of diversified services is failing in the face of the increased complexity of modern health care. Far from being a political or cultural problem, however, we argue that successful delivery system reform requires major technical and intellectual development and organizational redesign.”

It’s Time to Think Outside The Box

- Increased reliance on non-physicians:
  - Nurse Practitioners (NPs)
  - Other Advanced Practice Nurses
  - Physician Assistants

- In non-traditional settings:
  - Nurse-managed health centers (NMHCs)
  - Convenient care clinics (CCCs)
For More Information

Tine Hansen-Turton
Chief Executive Officer
tine@nncc.us / 215-731-7140

Jamie Ware
Policy Director
jware@nncc.us / 215-731-7142
Nurse Practitioner Practice: Legal and Regulatory Landscape

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Presentation Objectives

- Provide an overview of the legal landscape governing Nurse Practitioner practice

- Describe the legal research method used in this survey, and how it differs from existing efforts

- Highlight some of the differences that exist between states
Background: It’s Complicated

- Few legal questions are straightforward. This one is particularly complicated.
Background: It’s Complicated

- Legal landscape governing non-physician practice is shaped by a wide variety of forces
  - Statutes
  - Regulations
  - Formal rules
  - Informal rules
  - Advisory opinions
  - Contracts
  - ..and more!
In many states, NPs are governed by numerous laws and regulations as well as rules of both a medical board and nursing board. For simplicity, we refer to all of this authority as “law.”

To make sense of it all, we need to understand not only what the law is, but how the various laws interact. This can get very complicated very quickly.
Regulation of medical practice has long been left largely up to the states. See, for example, Oregon’s Death with Dignity Act.

This means that every state is more or less free to decide who can do what, when and with what oversight. The federal government even lets states decide who can prescribe controlled substances.

Some efforts at reciprocity and standardization, but overall mainly a patchwork of state-level law.
Legal Research Process

- Gather laws
  - We gathered all relevant law and regulation governing nurse practitioner practice in 50 states and DC
  - We recorded all relevant law in a custom database
  - Over 500 laws

- Code laws
  - We then broke aspects of nursing practice down into their component parts
  - Finally, we used the legal database to answer granular questions about practice
Topics Covered

- Scope of Practice generally
  - Authority to practice independently
  - Authority to diagnose, treat, refer
- Prescription Authority
  - Authority to prescribe
  - Requirements for obtaining prescriptive authority
- Oversight Requirements
  - Applicability
  - Mandated supervision ratios
  - Protocols and collaborative agreements
Things We Didn’t Examine

- **Reimbursement**
  - Is there a minimum or maximum reimbursement level?
  - Can NPs bill insurers directly?
  - Etc.

- **Liability**
  - Where NP practices under physician supervision, is the physician legally responsible for NP’s actions?
Yes – several organizations collect and publish information regarding NP practice. These resources can be very useful for high-level questions, like whether independent practice is permitted, whether NPs can prescribe, etc.

However, they often aren’t detailed enough to answer the types of discrete questions practitioners and researchers have.

Our goal is to provide a very granular look at NP practice.
Using the Database

- For example, contrast this question with the one on the next slide:

  1. Can nurse practitioners in Kansas prescribe drugs without physician oversight?
Using the Database

2. Can a nurse practitioner, who holds a current Kansas license and is physically located in the state, who has not taken any extra courses in pharmacology but is current with CME requirements, prescribe and dispense a Schedule II drug to a patient he has examined via teleconference only, where the drug in question was a drug sample, for a period of greater than 30 days, without having that order co-signed or reviewed by a physician, and if so can the resulting prescription be renewed, and if so with what, if any, restrictions?
Using the Database

- Most other databases will permit you to answer #1
  - That’s very useful for some purposes

- Ours will let you answer #2 (or at least get very close)
  - That is, we think, more useful to practitioners “on the ground”
  - It also provides researchers and policymakers with more information on which to base decisions and govern actions
An Example

Medication samples

- Can NPs receive controlled substance samples?
- Can NPs receive non-controlled substance samples?
- Can NPs dispense controlled substance samples?
- Can NPs dispense non-controlled substance samples?

**And under what conditions?**

**La. Admin. Code tit. 46 § 4513(4)(a)**
APRNs shall not receive samples of controlled substances. An APRN may receive and [dispense] . . . samples of non-controlled substances . . .

[An authorized NP] . . . may request, receive, and sign for professional samples, except for controlled substances in Schedule II, and may distribute professional samples to patients as listed in the approved written protocol . . .

<table>
<thead>
<tr>
<th>State</th>
<th>Legal Citation</th>
<th>Can NPs dispense</th>
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<td>Cont. Sub. Samples?</td>
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<td>La. Admin. Code tit. 46 § 4513(4)(a)</td>
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<td>S.C. Code Ann. Regs. 40-33-34(2)</td>
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An Example

- **Medication samples**

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Maps, Graphs and Tables

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Maps, Graphs and Tables

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An Example

- Medication samples
Another Example

- Independent Prescribing Authority

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**Map**

- Law requires some form of oversight of NP prescribing by MDs (n=38)
- NP have independent prescribing power (n=13)
In many states, there is no need for the state of the law to be this complex and confusing. Legislatures and regulatory bodies may wish to consider examining whether simplifying existing law may increase access to NPs and other non-physician medical professionals.

We will publish the full dataset, codebook, and research protocol plus maps in early 2012.
Thank you!

Corey Davis, JD, MSPH
Staff Attorney
Network for Public Health Law
cdavis@networkforphl.org
Question & Answer

Type your question in through the Q and A panel