Rethinking Scope of Practice
Alliance for Health Reform
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MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR and HEALTH POLICY ADVISOR: Welcome to the Alliance for Health Reform webinar on Scope of Practice. I'm Marilyn Werber Serafini and I'm with the alliance. Today we're going to be talking about the flurry of state activity on scope of practice legislation. The states have been working on legislation on scope of practice that would decide whether advanced practice nurses, nurse practitioners, and other medical providers would be able to do more to care for patients.

Due to the Patient Protection and Affordable Care Act, starting next year, millions more people will gain access to health insurance. At the same time, there are projections that there will be shortages of physicians and, in particular, primary care physicians. Our panelists today are going to give us an overview and a lay of the land about what is happening in the states regarding scope of practice, legislation, and activity in the states. They're also going to talk to us about the issues surrounding scope of practice.

Before I introduce our panelists, I'd like to thank the Robert Wood Johnson Foundation for sponsoring this panel. The Robert Wood Johnson Foundation has done quite a bit of work regarding nursing and scope of practice legislation.

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I'd like to also point you to the right-hand upper corner of your screen where you can submit questions that I can forward on to our panelists later in the conversation. There's also a button that says Webcast Materials that you can click to locate our panelists presentations and also to locate additional materials for this presentation. In addition, you can follow this presentation on Twitter #scopeofpractice. A recording of this presentation will be available on our website, www.allhealth.org today or tomorrow.

We have with us today three panelists who will be talking about scope of practice. Kavita Patel is Managing Director for Clinical Transformation and Delivery at the Engelberg Center for Healthcare Reform at the Brookings Institution. She is also a practicing primary care internist. She worked in the White House during the Obama Administration and also with the Senate HELP committee under the leadership of Senator Ted Kennedy.

Polly Bednash has been Executive Director of the American Association of Colleges of Nursing since 1989. She chairs the Nursing Alliance for Quality Care and has been appointed to the Secretaries Academic Affiliations Council of the Veterans Administration.

Reid Blackwelder is a family physician in Kingsport, Tennessee and is President-elect of the American Academy of

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Family Physicians. He is also Director of the Medical Student Education Division for the Department of Family Medicine at East Tennessee State University's medical school.

We're going to start with Kavita Patel, who is going to give us the lay of the land of what states are doing legislatively on scope of practice legislation. Kavita.

KAVITA PATEL, MD, MS: Thank you so much Marilyn and thanks to all of you who tuned in. I'm going to go quickly through some slides that highlight work we're doing at Brookings at some of the various levels of health care workforce, including everything from physicians and nurses, but also looking at frontline workers and the great variability between scope of practice of frontline workers, mid-level health care workers, as well as something we're going to be talking about today, physicians, nurse practitioners, and physicians assistants.

To Marilyn's point, there could never be more state-level activity in this area because every state is under pressure to deliver on increased access whether it's through Medicaid expansions or through the federally facilitated exchanges or state-based exchanges. The topic of workforce comes up in almost every discussion, so I'd like to briefly just highlight some top-level data and some analyses that we're

doing and work at the Brookings Institution that I'll allude to in the context of these slides.

This is something that those of you familiar with workforce issues are familiar with, it's the Bureau of Labor's statistics, which, today, is really our best source of health care workforce data, but has some limitations and I won't spend much time on that except to show you that the projected employment in the health care workforce is increasing. That's a statistic, it's a fact, it's also something that underlies the President's comments that health care as a growth sector is an important one and, in a time when we're recovering from a recession, we have an amazing job opportunity. The question that we all ask is what types of jobs are available in health care and are we actually thinking about the scope of practice of our health care practitioners for the demand we need in the health care system.

This shows some research done by some colleagues at the Graham Center for Workforce sponsored by the American Academy of Family Physicians on the geographic distribution of the primary care workforce and I really want to just highlight the viewers to one statistic—kind of in the middle column there. If you will look at it in terms of nurse practitioners and physicians assistants and the differences between rural settings and urban settings. Over the last ten years, as I

showed in a previous slide, we've seen an increase in growth in nurse practitioners and physician assistants, but we've also found that there is a dramatic concentration of NPs and PAs in rural settings, large and small. The implications for this on our workforce are two-fold: one, we have areas in our country where it's really hard to find qualified health professionals; and two, there is a growing workforce in terms of nurse practitioners and PAs that are serving in those settings. Scope of practice laws, active legislation in states, is supporting the efforts for independent practice of these health professionals in those states.

This is a comparison. I know that we don't like to talk about money sometimes, but there's certainly an inducement of professional choice based on the perceived expectations of what you'll make when you come out of training. I just put this—we have this slide that we put together based on some resources and other research around non-physician and physician salaries, and there's certainly a lot that drives some of these changes. I, again, want—there are a lot of numbers on this slide, I just want to highlight a couple of areas in terms of reimbursement for a certified nurse, midwives, nurse practitioners, and pharmacists, as well as on the right side all the physician specialties, as well as a general internist,

which is what I am, towards the bottom of the column on the right.

Then I want to highlight a couple of state laws around Medicaid reimbursement, which affect NPs, PAs around the country. Current Federal law requires state Medicaid programs to provide direct reimbursement to pediatric and family practice NPs under the traditional fee for service system. Some states actually pay nurse practitioners the same rates they pay for physicians for some of their services, but more than half of the states pay nurse practitioners a smaller percentage of physician rates for the same services. So, once again, we're talking about doing the exact same thing from nurse practitioners and physicians, but in several states, they are being reimbursed a percentage less. This is something that's an active, ongoing conversation. Polly may allude to some of this but I just wanted to highlight the trends.

This is a more colorful slide; don't over interpret the red or the blue to mean anything we just wanted it to stand out in contrast so that when you look at it, it's pretty obvious. This is a slide of national nurse practitioners scope of authority and it may be too difficult to read. All I'll highlight to you is to say that in the red states, physician involvement is needed to prescribe, diagnose, or treat, and in the blue states, no physician involvement is needed to

diagnose, treat, or prescribe and the other colored states, the teal states, are in between. This is just to gloss over, but to show you that in our country, when we think about Federal health reform and increasing access for millions, we have very different laws, and depending on if you go from one state, like Texas, to a neighboring state, where there are different scope of practice laws, there could be different implications for the way we receive care when we're enrolling in health insurance.

The other point on wanted to make on nurse practitioners is that even all—nurse practitioners are licensed in all states in the District of Columbia and practice under the rules and laws, requirements, scope of practice regs of the state in which they're licensed. Of the 26 states that require some level of physician involvement, so the red states, 11 of them require nurse practitioners to establish a collaborative relationship with a physician to ensure a means for consultation, referral, and review of provided care. When you think about what that means and what a nurse practitioner has to do in their own practice to complete those requirements, that can be—that can often be onerous and it can sometimes be an inhibitor to allowing for practitioners to engage in underserved areas.

Then this is—I wanted to highlight the physician's assistant's role and just kind of compare and contrast that.

This is a little bit—hopefully, it's a little bit more obvious to see. PAs, the issue with physicians' assistants and the boundaries around the practice tend to be around dispensing, dispensing of medications and the authority to do that and dispense. It's a different conversation between nurse practitioners and PAs. We often lump PAs and NPs, kind of in the same kind of bucket. I highlight this slide just to show you it's different issues. The issues with PAs have to do with the scope of practice in their dispensing authority in the red states, physicians' assistants do not have a dispensing authority. I will leave it at that and we can get into some more specific questions if there are questions from the audience about that but for the sake of moving this forward.

I wanted to actually then give you a preview of active legislation. In the 2012 legislative session, the National Conference on State Legislature tracked 827 bills to redefine provider's scope of practice in 29 states, 154 of which were enacted and I'll highlight some of the things that were enacted in a second. As of April 1st of 2013, so just two months ago, there have been 178 scope of practice proposals and related bills in 38 states plus the District of Columbia. The most popular scope of practice measures in that legislation related to—we take off from the most popular to the least popular, were around licensure, advanced practice nursing, which is always a

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hot topic, midwifery, physician's assistants and then we get into dentistry, prescriptive authority, and you can read the rest.

I want to highlight some of the bills that were recently enacted. In Oregon in June of 2013, just last month, Oregon House Bill 2684 removed certain restrictions on authorities for certified nurse practitioners to dispense prescription drugs. I offer Oregon as a contrast, where in Oregon, they're doing a number of accountable care reforms, great deal of Medicaid expansion, the governor has made a full born effort to say that they're going to control total cost of care. They have a real, I think, a real advanced understanding of supply and demand and as a result of that they've been able to drive and have some degree of success in the legislature to change and modify their scope of practice, which would have been considered generous to begin with, but to think about ways and barriers to access to care.

Then I'll offer you a couple of things that have actually failed. In Nevada, Senate Bill 69 failed this legislative cycle, which would have revised provisions that would have given advanced nurse practitioners the ability to not have to do the collaborative agreements. It's been difficult in some ways to get legislatures to strip away some of the legacy barriers in legislation, but in other cases,

where states feel like they have pressure and have had a governor as well as a legislature that can cooperate, we have seen a number of bills that have come through which have either expanded authority or have allowed for a limited use of nurse practitioners and PAs, more nurse practitioner's independently in rural areas.

I'll stop here and just say that for us in thinking about this from an analytic perspective, the bottom line is that states are now responding to some of the pressures they feel that the expansion in health reform by thinking through meaningful scope of practice modifications, changes, yet we still face resistance between, I would say, the kind of guilds that we've created in health care around how we can truly collaboratively work together. Thank you.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR and HEALTH POLICY ADVISOR: Great, thanks.

POLLY BEDNASH, PhD, RN, FAAN: Thank you, Kavita, that was a nice overview of what exists. I'm Polly Bednash, the CEO of the American Association of Colleges of Nursing and we represent [inaudible 00:14:19] colleges and universities in this country that grant baccalaureate and graduate degree nursing degrees and we represent 98-percent of the institutions who educate advanced practice registered nurses, otherwise known as APRNs.

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There are four titles for APRNs, nurse practitioners, nurse anesthetist, nurse midwives, and clinical nurse specialists. As a foundational element of this conversation, I want to tell you that all of these individuals have at least an undergraduate degree in nursing of four years in length plus three to four years of graduate education in nursing as part of their training.

This scope of practice issue isn't recent, it's been going on for a long time ever since nurse practitioners have existed and I'd like to talk today about the factual basis of the scope of practice limitations and its impact on health care providers. One of the first studies that was done was done by the office of technology assessment, an entity that did studies for congress which is no more in place, it does not exist anymore. That study looked at the existing research on NP, PA, and midwifery outcomes of practice and said that these coalitions could deliver 50- to 90-percent of primary care in a very high quality manner. It wasn't the first or the last of these different kinds of studies about the outcomes of care by nurse practitioners and other providers.

Barbara Safriet, who was then the Associate Dean of Law at Yale University reported in the *Journal of Regulation* that the removal of non-evidence-based limitations on scope of

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practice could dramatically improve access to care and maintain quality.

In the year 2000, Mary Mundinger and her colleagues at Columbia University did a study looking at the outcomes of care delivered by nurse practitioners and physicians when those individuals had the same primary care population to file, the same patient care responsibilities, the same requirements for productivity and found that the outcomes were comparable.

Then, in 2011, Robin Newhouse and her colleagues did a systematic review of research from 1990 to 2008 and found that the outcomes, again, of care delivered by these individuals was high-quality and, in fact, safe.

This actually has created this growing consensus among policy makers that Kavita alluded to, this concern about who's going to deliver care has caused a number of people to come into this conversation. The National Governor's Association has released a paper recommending that these scope of practice limitations be removed so that they are able to deliver care to the people in their states. The Institute of Medicine Report which recommended removal of the scope of practice limitations was driven by the evidence, the clear evidence that exists and the Federal Trade Commission has issued 11 state documents about what's happening in the states recommending that the scope of practice limitations are really anti-trust behaviors

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and that in order to be competitive these states should remove theses barriers and that the care delivered by nurse practitioners and advanced practice clinicians and PAs is high quality and can improve access to care.

We've had over 50 years of consistent revisiting of this issue, the same policy questions over and over despite the continued growth of evidence regarding the quality, safety and the satisfaction of patients with the level of care provided by these clinicians and, unfortunately, the opponents to loosening the scope of practice barriers continue to assert that the evidence is lacking. What's sad is that the opposition tends to be organizational rather than individual or local because when you see these clinicians working together at the local level, they have very close collaborative relationships that have respect for each contribution to the care spectrum.

I will say that similar evidence does not exist for the quality of care delivered by other providers. No other provider has been studied as much or delivered as much evidence about quality of care so the microscopic assessment of nursing has revealed data and evidence that are routinely ignored.

The reality is, as you were saying, Kavita, that the care demands in this country are going to require reproach that has everyone in giving health care to the people who will be seeking that health care. Instead of trying to place barriers

in front of qualified providers, we should actually be joining together and focus on having an agenda to get adequate financing for primary care to assure that primary care services can be delivered to all the individuals who demand that care and that all of the providers who are capable of providing care can be engaged in a meaningful way.

Now we agree that team-based care is an effective means of assuring that all the knowledge available on a health care issue can be brought to the patient. Health care delivered by a team means that you're going to bring in multiple providers, you're going to have a pharmacist, a social worker, a physical therapist, a nurse, a physician, all working together on a team to deliver that care. Being on a team, however, does not mean being directed by others or seeking permission from others to behave in the way you've been educated to behave. It means, instead, sharing best practices for the patient and bringing the array of expertise available to the patient experience.

One of the hottest issues that emerges in this conversation is the independent practice issue, it comes up all the time. It brings to mind the image of a nurse practitioner hanging out a shingle, sitting by his or herself somewhere without any opportunity to interact with others. In fact, very, very, very few APRNs are in what's called independent practice and the reality is that no clinician is really in

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independent practice or at least we hope not. We hope that they're all working with other providers, collaborating with an array of clinicians and professionals who can help us deliver the best care. When we talk about independence, what we mean is independence is defined as having the authority to use fully the knowledge and training that you have acquired through your studies without having to get permission from physicians or others to use that knowledge and training. Thank you.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Thank you, before we turn to Dr. Blackwelder, I just wanted to remind our viewers that they can click on the button that says webcast materials to see all of the speaker presentations and also to find other materials. So, Dr. Blackwelder.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Hi, thank you. I agree the discussion needs to change. In many ways the scope of practice issues are essentially distracting from what are some more important foundational discussions. Perhaps the most important point in this discussion is that states that have allowed nurse practitioners to practice without physician collaboration continue to struggle with the same problems as before. There are still primary care shortages, high cost, and fragmented care that persist. The bottom line is that while expanding scope has been proposed as

the solution to the primary care needs of this country, independent nurse practitioner has not revolved them.

The scope issues impact each state differently because of the huge variability in the education and training of NPs. We can't have an effective solution this way. We must address the need for standardized education, training and certification of NPs first. This process varies from school to school and state to state. Depending on the state, required NP course work and training can range from 3,500 to 6,600 hours, the four years as the undergraduate nursing degree, the additional time is usually only one to two years and not three to four to get the masters or doctorate in nursing.

The amount and intensity of the clinical training also varies dramatically. At some institutions parts of the training can primarily occur online rather than face-to-face in the clinical area. Accreditation can come from one of three groups, each with different criteria. This lack of standardization in NP education and training means that the degree does not tell you what education or training that person has. Comparison: a family physician completes eleven years and 21,000 hours of standardized education and training, including passing exams overseen by one certification body. Medical school rotations give us the necessary experience to basically take care of all the range of what you might see in a patient.

We get the skills and clinical training in that process. The degree clearly and consistently states the breadth and depth of training regardless of state of school. The wide variability in education and training of NPs is profound and one of the most important issues that must be corrected.

What is the answer? It's team-based care. This is hardly a new concept. A 2011 survey found that nearly 60-percent of family physicians in the U.S. reported working with NPs, physician assistants or certified nurse midwives to provide what they call a team-based model of care. In addition, the research has shown that a team-based approach to primary care can improve primary care access, ensure that patients get the full range of medical and nursing services, and have a positive impact on controlling health care costs. However, in order for America to realize the promise of team-based care, we all have to come to a better and shared understanding of what it means for medical providers to work together.

As with any team structure, we need to define roles. Each team member is critical but they're not interchangeable. Let me give you an example. One of my patients called me on a Sunday night with chest pain, he's 62, he has known heart disease, he's had a bypass surgery, has reflux and lung disease. We talked and decided it wasn't an emergency, he did

not need to be seen that night so I saw him first thing in the morning. I did more of a history, I did an exam, I did an EKG in my office, which was reassuring. It still made sense to get a stress test for him so I set it up for the next day and I addressed his reflux at that time.

His stress test was fine; he was already better. I provided one-stop shopping, essentially. My education and training prepared me for this but a less-trained provider likely would prefer or perhaps do more tests or even send the patient to the emergency room. Family physicians are uniquely trained to do this work, no one else is.

Much has been made of the research as commented on and in 2011 detailed analysis of the studies available about NP care, researchers at the University of Missouri found these studies tended to focus on a specific illness and on short-term outcomes or on care of chronic care conditions after diagnosis by a physician. They failed to examine comprehensive primary care outcomes, which includes treatment of complex problems requiring the broad set of diagnostic skills that I get in my training. Without a doubt, NPs perform well in studies that analyze patient satisfaction but we cannot conclude these results mean that NP care is interchangeable with physician care.

The Newhouse study just mentioned supports this distinction as well, to quote it directly, "the systematic review on care provided by NPs indicates their patient outcomes in collaboration with physicians are similar." Further, that same study suggests NPs provide effective care that can augment physician care and expand access to care. It did not say replace. The Newhouse article also said these study results should be interpreted carefully because of significant study limitations. In fact, several of the studies included outcomes of NPs working as part of a team or in collaboration with physicians and others. In short, these studies cannot be used to say that the care of NPs is the same as that of physicians.

Moreover, the U.S. is suffering not only from a shortage of primary care physicians but also of nurses and at even great shortage. As can be seen in this slide, by 2020, there'll be a primary care physician shortage of 45,000, yet there'll be a nursing shortage of 260,000 by 2025. Moreover, as see here, NPs are moving away from rural practice and into specialty care, shown there. This raises an interesting comparison. NPs who work with cardiologists, gastroenterologists, and dermatologists, are not seen as providing the same level of comprehensive care as those physicians. Primary care is much broader and much more complicated than is a practice limited to one organ system.

NPs cannot provide the same level of comprehensive care provided by primary care physicians. In all cases, they are critical members of the team who can provide core services but they must have collaboration with a more highly trained physician.

Where do we go from here? It's time to move beyond policies that further fragment health care and move toward building collaborative teams that will increase access and improve quality of care. Health care teams that include a variety of health professionals as we mentioned before and are developed to meet the needs of individual communities will help us do that. Surveys show that patients overwhelming want coordinated team approaches to their health care needs with a physician leader.

We're also starting to see some exciting data and this is some bullet points. Essentially, this is showing data from practices in a patient centered primary care collaborative in the just released Pioneer ACO models. This shows how team-based care is improving outcomes and lowering costs in a number of different areas. This is the answer that we're wanting to see. This is how we address the triple aim. As with any team endeavor, collaboration is key.

Collaboration means the family physician, the nurse practitioner, physician assistant, among others, work together

to maximize their individual expertise and skills and to provide the highest quality of care to their patients. We need to recognize that each member of the team has unique but not interchangeable skills. The discussion should not be about turf but about how we ensure that members of the care team can work together with clearly defined and distinct roles to improve patient outcomes. Thank you.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: We've just been talking quite a bit about team-based coverage and we are moving into an era, specifically with the ACA, of patient-centered medical homes of ACOs, of team-based care coordinated care. You mentioned team-based care with a physician in charge. Would everybody else here agree that the physician needs to be in charge?

POLLY BEDNASH, PhD, RN, FAAN: Well, I certainly would wonder what you mean, what you mean by the physician being in charge. I think leaders in teams can change from time to time, it depends on what the demands for care are. There might be an opportunity for a pharmacist to lead the team in terms of the pharmacogenetics and something that's going on with the individual's care or the pharmacotherapeutics that are ordered for the individual. The notion of one individual having the training and the capability to lead is really not cognizant in

terms of the varying demands of what's happening with an individual.

Again, as I said before, we have no problem with the notion of a team but if the individual who's part of that team has to consistently go to someone else to get permission to use the education and training and again, this isn't substitutive, it's not being a substitute for the physician, it's using what you have in terms of your knowledge and skills, and if you have to constantly move to someone else to get permission, you decrease access, you put barriers in the way of care being delivered by that individual and you increase the cost of care. There's lost time and productivity there.

I worked as a nurse practitioner in a family practice residency program for a number of years and the thing that delayed me the most was having to go to one of the family practice physicians and say, will you sign this, will you approve this? Now, routinely, they did that, because they trusted me and knew that I was capable of making good decisions but this constant having to move through someone else because they were in charge meant that we were really harming the flow of care, decreasing access, placing barriers, as you alluded to Kavita.

KAVITA PATEL, MD, MS: Yes, I think—I'll just Marilyn, because we spent a lot of time at Brookings kind of looking at

accountable care organizations, I will definitely say that for the—we have been treating all of primary care as the same thing and I think that's a flaw. I think that physicians should be, at least in the PCMH model or the Medical Neighborhood model. I think that makes a lot of sense to have physicians kind of helping to kind of lead efforts for the care of complex chronic conditions like exactly the scenario that Reid alluded to.

I think we're seeing, as Polly has said, I think that for a large proportion of what we see in primary care, ACOs, medical homes, we're realizing that you probably don't even need a physician to be involved and, in fact, it might be—I've seen models with ACOs that work well for high risk populations where a community health worker is actually kind of leading the efforts.

Marilyn, to the point you're making where dollars and kind of a huge degree of money is being spent on a health care system, I think we are going to see physicians really—whether it's called leading or being what they call the quarterbacks, I've heard all sorts of analogies, we're going to see physicians in those roles but I've been encouraging and I think Reid would agree with me, that what we need to do is have team-based care with physicians leading these efforts for where we really need a physician to be involved in the first place.

I think the biggest debate we have is well, what does that mean? Does that mean that if you have a sore throat you don't really need—we start to get into a lot of kind of quibbles over, so can we send someone to see a community health worker to talk through their social determinants issues and then a doctor really should never, because I'm not trained in that I should never be a part of that and I think that's where, unfortunately, we've had a lot of the back and forth. In my mind, the drivers of cost of care where we really see promise in the PCMH models and the statistics you cite, I do firmly believe there's a central role for physicians in that model. I don't think that that's applied to 100-percent of our care.

POLLY BEDNASH, PhD, RN, FAAN: You know, what's interesting is if you look at the Vermont Advance Primary Care model that they have where you have the multiple primary care sites delivering care. Actually who's leading that primary care advance model is a nurse, a registered nurse in the middle of the website and collaborating with the primary care providers to find the right kinds of resources for the individuals. The primary care physicians who work with that team lead by the nurse that's in the center, love this model because it allows you to use the right kind of resources for what the needs are for the patients if they need social services help, if they need psychological counseling or they

can be moved to—and it really then uses everybody to the maximum. It does then say that the lead in the middle is pulling all this together and some of its administrative, some of its care delivery and it's a very different model. It doesn't have to be a physician leading. Yes, perhaps a physician should be the only individual who manages certain types of patient populations because of the difference in their training, but there's a different model that has a nurse in the middle that's very effective and having tremendously good outcomes there.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: One of—I need to talk about that because the words are very powerful.

POLLY BEDNASH, PhD, RN, FAAN: Yes, they are.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: When you say leader that pushes a button, when you say independent—so part of the challenge in this discussion is the moment you use a word people pick a side and this can't be about sides. For one thing scope of practice, once again, has not resolved this. I don't care of the independent practice models, whatever you want to call it, states that have this kind of practice and variable versions of that model still struggle with the poor cost, poor out—or high cost poor outcome. I don't like getting

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distracted by the words because when you say leader it automatically says well who should be in charge.

The reality is teams are defined variably. Communities define teams, they're not all in one building, they're not all in contract, they work together and different people will obviously lead at different times. The bottom line on these teams is that it is about the best care for patients. This isn't an administrative function solely, it's not about maximizing profit; it is about providing the best care. Somewhere in that process, I don't care how you label it what word you use, as you said there must be a physician involved and permission is another one of those words because that obviously creates a lot of restrictions.

There needs to be a point. For example, in my patient, if I wasn't involved in that care, or maybe I didn't see him, what I would like is to have a nurse practitioner, somebody see my patient and instead of making a decision say, well, I know how to manage this, I'm going to send this patient to the emergency room or his cardiologist is in town, I'll send him, the call would be to me—somewhere in there. I don't care if I'm called the leader, the coordinator, the quarterback, it doesn't matter. At some point a phone call to me would say well here's some things, let's work through this together. I might not even have to be physically in the building.

The challenge again is be careful when we use a word because it creates an image for people and I don't know how to define the leader of the team. A team is fluid and a team has variable definitions. Teams and moving in that direction is where we need to have our discussions. Scope of practice, I still say, is distracting because each state is different for lots of reasons and each law is different and all the energy in those laws and it still hasn't solved the problem. What is more and more definite is team-based care so how do we shift that discussion to moving those forward, which will involve aspects of scope and leadership, but that shouldn't be the focus, that should be the tools each state has to use to make their model work. Every state's model will be different.

POLLY BEDNASH, PhD, RN, FAAN: We do need to reflect however—I need to reflect on something that you said. You're absolutely correct that words are powerful and it's how they get operationalized that's the concern. If you look at states where there's full scope of practice authority for nurse practitioners we see high quality care being delivered. It may be people who are not getting access to care because there aren't adequate numbers or providers, but the care delivered by those clinicians in those places is high quality and to assert that those individuals are harming care, which does happen in the rhetoric around scope of practice is wrong.

Let's at least start at the base with an agreement that these individuals are highly qualified, are well educated and at some point Reid, I know you've raised this issue in the past in other venues, I heard you on the Diane Rehm show about this, we should have a conversation about your assertions that the education of these clinicians is variable and uneven. That is not true. I'd be happy to sit down with you some time and give you clarity about that so that you could understand that and represent truth about what happens in the education of these clinicians.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Let's talk about quality and safety here because there's been a lot written about this, so let's talk about what evidence we do have about the quality of care and the safety of patients when they receive care both from physicians and from advanced care nurses. By the way, after we have that conversation we're going to talk about—we've talked a lot about the advanced care nurses, but we're going to talk about other medical professions as well. For right now, let's stick with this and let's talk about the quality of care and patient safety and what we know, what has been written, what has been studied, what do we know here in comparing?

POLLY BEDNASH, PhD, RN, FAAN: Well I did present the evidence and it was negated. I mean if you look at the study

done by Mary Mundinger and she's done several studies where they had comparable patient populations, comparable primary care demands, comparable accountability requirements for the clinicians, nurse practitioners, and physicians, the care outcomes were equal; either we believe evidence—we talk a lot about evidence-based medicine, but the evidence gets ignored.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: One of the challenges on that, because the moment you say research of any type that's another powerful word and people go, wow, there's research. Very few people, including clinicians go and find the primary source, fewer still have the skills to analyze is it a good study or not. We get kind of stuck at times and especially on something like this, you know, one side will say this; one side will say the other. I didn't negate what you had said, there's very good evidence it's just adding a couple of words from the Newhouse study that said, you know the care with collaboration is as good or even better than physicians alone.

A team-based care is the way to go, nobody works in isolation. A lot of the old—the Mundinger studies, a lot of those were combining things that really were somewhat apples and oranges. Some were collaborate practices, some were solo and individual practice, it's hard to generalize but again, this can be distracting.

Regardless of whatever the research says, our country is facing a crisis in terms of patients getting good outcomes, satisfactory care and low costs. Regardless of the research, that hasn't solved the problem and deciding which side you're gonna agree with won't solve the problem. We are now getting exciting data showing that regardless of that research, the patient-centered primary care collaborative, the pioneer ACOs, team-based care is showing improvement in the most important things, not who's research is better not what word you use, but in actually making an impact on what we should be talking about.

Again, I don't like to be distracted about a lot of these other issues because we're going to probably agree to disagree and it doesn't move us forward.

POLLY BEDNASH, PhD, RN, FAAN: Again, I think teams are a very important mechanism for delivering care. We agree fully, you need to bring a number of people to the patient care delivery experience. There's no argument with you about the fact that teams are better than individuals being by themselves, it's how you define and use the language about who can practice there and how they will practice and how they can function in terms of their education and training that's the issue. That's the fundamental thing and we all have the same goal here, we all want to make sure the patients get high

quality care, that they have access to care, that we meet the triple aim, that we decrease costs of care and that we don't put irrational barriers in the way of anybody being able to deliver the care.

Really, you know, we have the same issues, physicians and nurses have the same issues here about the fact that primary care is not valued and instead of fighting about whether or not we should be able to function fully, we should be joining our forces to go after the primary care policy issues and assuring that the right kinds of resource is there to support the patient-centered homes—care homes. By the way, patients don't like the notion of medical home, they think about a nursing home [interposing] and in Minnesota, they've outlawed the use of medical home, it's got to be called a health home. Let's talk about patient-centered health homes where we help people be healthy and we all work together.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: A number of our viewers want to know what patients think, what the public thinks about nurse practitioners and other providers, any provider other than a doctor seeing them. If they call for an appointment and their physician is not available and the receptionist says, well, your doctor is not available but you can see the nurse

practitioner or some equivalent. What does the public think, what is the opinion there?

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I think patients want access. They want to be able to be seen and they want good care. Those are the most important components and that's some of the challenge we face with patients need to see, as we have more people covered, they have to see somebody. I think that's what patients are initially very interested in; can I get in and see somebody?

The second thing that I think comes out and this is again, a challenge depending on which research you use and what words you use. There are aspects over all clarity that I think are important. I work with medical students and residents, I've had nurse practitioners with us before and it's very important that patients know who folks are. We teach our medical students to walk in and say I'm a medical student, because they're wearing a white coat, they're in an office, it is so easy for a sick patient to come in and not sit there and say by the way, before you touch me, before I talk to you, exactly who are you, what's your education? They don't do that.

They have to come in and know and this gets into some of the other word issues because a lot of people in this country, and more than just the health professions, deserve the

word doctor. Doctor in a health home setting means something to most people, so if somebody says I'm doctor so and so, then patients are going to make an assumption that may or may not be true. That doesn't mean that person doesn't deserve the title or that person is not a qualified and good provider, but the role clarity is another aspect that I think patients are pretty clear about. They love good care, they like care from lots of people but they also want to know who they're seeing and who's the team? What happens if you can't provide what I need is another thing I think patients want.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Is there data?

KAVITA PATEL, MD, MS: There's some—there is some data and when patients are, I think Polly alluded to kind of satisfaction as well as Reid, there are high levels of satisfaction in clinical settings in which the nurse practitioner is the primary provider. There is data that supports that there's a high level of patient satisfaction.

I think that where we do not have as much data, but we have some kind of qualitative research and some anecdotal data that shows that the labels are getting more confusing and as advanced practice nurses have doctorates appropriately so, are called doctor, there is a doctor confusion. Patients who have been surveyed, in kind of limited settings, when they're told

well you've have a doctor, did you know that your doctor was, and this includes MDs, doctors of osteopathy, MDs, DAs, NPs, patients have said, oh, I didn't realize, you know, what those initials meant after, they just will use the word doctor and they all assumed that that meant that they went to an allopathic medical school.

We have data that supports that patients are indeed satisfied with all these different types of care providers; however, we also have data that kind of points to a state of confusion that could potentially be even more confusing when you layer in I am doctor such and such in your health home at such and such. I personally think that the most important research that we have yet to do is what I think may be prechory [phonetic 00:45:15] and some other entities in the city—in the country are doing around what is it that actually patients want and where do they feel there is either—do they perceive that there is a difference in training and what impact that might have on their quality and then we can understand how to match our models that we're developing with what patients really, truly want. That to me is not data that we've had an abundant amount of.

POLLY BEDNASH, PhD, RN, FAAN: You know, clearly, every provider has a responsibility to represent themselves accurately about who they are and what their preparation is. I

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have to reflect back on a semi-humorous where our dog had to have surgery and when we went to pick up the dog, the veterinary medical office said you need to talk to the discharge nurse before you take your dog home. I said to my husband, you tell them that person's not a nurse and he said, how about you have that conversation after I pick up the dog? People use terms and I did speak with them and they said, well people trust nurses and so we use the term nurse and we use the label.

I think it's important that we use terms like, I am your physician, I am your nurse, and remove this doctor confusion by not using the term. Say I am your physician and I am your nurse and help people understand that. Believe me, we do teach our students that they have to accurately reflect themselves. I've been in a number of physicians' office where the receptionist is represented as the nurse and she or he is not a nurse. Accurate representation of who you are and the position you fill is really very important but again, when people do get care from nurse practitioners, they are happy with the care and they feel that they are able actually to have better communication experiences with the nurse practitioner.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Kavita, we have generally been talking to this point about advanced nursing. What about the other

professions? We're here to talk to about dentistry, we're here to talk about pharmacy, talk to me a little bit more about what's going on in the states with legislation and what some of the states are doing to expand scope of practice in some other medical professions.

KAVITA PATEL, MD, MS: Optometry, I'll use a couple of different professions, optometry, pharmacy, and chiropractic medicine. There are states that have active legislation around increasing the ability for chiropractors to diagnose, treat, and prescribe illnesses, for example. We've heard a lot also about pharmacists doing more intense kind of medical therapy management and laws that can help to reimburse for those services. Right now, pharmacists can do this but they do it without any sort of reimbursement. Different states are looking legislatively as to whether aspects of therapy can be reimbursed for that type of intense chronic disease management.

I think in terms of where—all of these pieces of legislation, optometry, chiropractic, pharmacy, all of them have kind of a thread in the legislation or a theme through the legislation. We want to do something, we see that there's an identified need for chronic care coordination or complex disease management and we thing optometrists who take care of diabetics have a role in doing something that otherwise they would not normally have had the scope of practice to do.

I think Reid's point of having us not get buried under scope of practice is an important one. The part that's hard is that when you get to the policy-making arena, we're limited by kind of these really arcane tools, unfortunately, of which scope of practice is one and reimbursement is the other. You see these two feeding into each other. What's interesting to me, I come from the state of Texas, and in Texas, over the time from when I went to medical school there and to the present day, it's been a dramatic increase in conversations that have, I would say, liberalized scope of practice across the different professions mostly because of a perception around being able to provide for care and underserved areas.

Let me reinforce something that Reid touched on, that even in these areas where there's very, what we would call, great parity in scope in different ways, they're still facing crises and shortages but they have noticed in those states that there is the efflux or influx of health care workforce of various types.

Some of the research we're doing, some of the greatest growth areas, Marilyn, I hit on it again, it's not at the level of the high licensure professions that are sitting here today, the nurses and doctors, the greatest growth are in some of the areas that have absolutely little to no definition around the occupation, personal homecare aides, community health workers,

and that is where it is growing by leaps and bounds. It will be really interesting, Marilyn, to see flash forward five years, what conversations we have around well wait a minute a behavioral community health worker shouldn't be doing those things because that's something a nurse should be doing. It's this conversation, I think, will spread to some of the other workers we've noticed increase over the last five to seven years.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: The issues with the patients in a medical home, team base care's again, confusing. I'm not so sure I like the health home, that sounds either like a spa or a nursing home [interposing]. I'm still going, I'm not feeling that one [interposing]. I think they just want coordinated care but whatever the word is and those are the things we get stuck with, they're kind of like our tools just like you're saying scope and reimbursement or payment. Those aren't great terms, but I think the key is seeing that these kinds of approaches, whatever you call them are starting to pay dividends quickly. That's what's really impressive to me is the pioneer ACO, in less than a year is showing some changes.

The patient-centered primary care collaborative models in two years are showing improved outcomes, improved diabetic control, decreased ER visits, decreased US Air Force. All of

these things in a short time is powerful because we don't know what we're doing yet. I mean the reality is it's just trying a pilot, so that to me is, again, where can we put our energy, realizing we still have to call it stuff, you still have to have legislation to work through it.

It reminds me when I was in Trenton, Georgia, it was a town of 1,400, they pretty much said as soon as I showed up, you're not from around here, it was a small place and I was a big city boy. We were a patient-centered medical home before it was cool, we didn't have the acronym, because I was the only MD, there was an osteopath who was in his 80s at that time and winding down. There was a health department, there was an EMS station, there was a pharmacy, two chiropractors, and a PT.

That was it but we actually were a home because we did weird things. We actually talked to each other, we didn't have EHRs then, so we actually picked up the phone. We did some things that are kind of hard to imagine right now, but we were that patient home and even if I wasn't seeing a patient, I was kind of that next stop, again, whatever you want to call me, leader, quarterback, the physician down the road. When somebody had a problem they would call me, even a patient I hadn't seen that's in my community. I'd say, well here's what we can do, bring him in, I'll see him now, or no, this one

needs to go further. It was ultimately, at that point, my job to go to the next level.

That worked then, it can work now, we just have to codify it with whatever our terminology is and, again, try really hard not to get distracted on battles that don't make a difference but say let's find the bright spots and let's follow those. I love hearing about some of the data you're saying because I think it's moving us in the right direction.

POLLY BEDNASH, PhD, RN, FAAN: Actually the VA calls them patient [interposing] packs.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: We can do a survey.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: A practical question, have the changes in scope of practice enacted in 24 states and DC in 2012 been summarized elsewhere and have any bills in 2013 been enacted?

KAVITA PATEL, MD, MS: Yes, so I mentioned that there have been some bills from the 2013 legislature that have been enacted and I just highlighted Oregon, there was actually some, going back to my crib sheet here for just getting you the exact ones. In terms of summary—

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Is there a good place to go to find a cheat sheet?

KAVITA PATEL, MD, MS: National Conference of State Legislatures and then we will also have one on the Brookings site. I'll make sure you guys have access to it, but NCSL-

POLLY BEDNASH, PhD, RN, FAAN: Also the National Council of State Boards of Nursing has a website that does—

KAVITA PATEL, MD, MS: I think they feed in—I think that they get some of that—I think NCSL is a good home for anybody who's interested in this. In terms of impact of 2012, we don't really know what does this mean and translate to well now we've had "x" percentage of nurse practitioners that can do the following compared to the year before. We do know, for example in California, Alabama, Texas, Oregon, where they've enacted legislation over the last several months, literally in the last 90 days, that there's already been kind of a push in some of these states to one, make people aware that, for example, controlled substances can be prescribed by nurse practitioners in some of these states, et cetera. There have been, quick on the heels of passing these things, efforts by associations to get the word out. That's definitely been palpable.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Okay, so one viewer from the University of Illinois, is actually commenting that in Illinois, insurers seem to be—she says that insurers are more the problem than the

law. She says that they are especially restrictive when it comes to nurse practitioners, more so, she says than other states and they often requires physicians to be onsite in order to reimburse for visits. She would like to know whether the federal government or state governments are doing anything to encourage insurers to panel nurse practitioners? She's saying it's the insurers that are being more restrictive. Is this common in some states?

KAVITA PATEL, MD, MS: I think it relates to reimbursement in some, but tell me, Polly, my sense is that it's really tied to the requirements for reimbursement, not necessarily for what a professional can do in that state. Because that's state law [interposing].

POLLY BEDNASH, PhD, RN, FAAN: Well, it may be state law but we know there are some places where, despite the fact that the individual has the authority to behave in this way, some insurers do then put additional requirements in place or restrictions in place. There is activity going on by the organizations to try and prevent that or overturn that, but it does occur, unfortunately. It's a second level of decision-making about who can be reimbursed and what kind of structure needs to be in place before the individual can be—

KAVITA PATEL, MD, MS: I would say that's not really—

POLLY BEDNASH, PhD, RN, FAAN: It's not common.

KAVITA PATELO, MD, MS: It's not common Marilyn and it's not something that I would say is an increasing trend, at all. There is no federal activity to mitigate it because I don't think it's popped up as a role for the federal government.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: It does point out another member of the team are the insurers and the payment processors [interposing]. It really is an aspect that needs to be addressed and we struggle in many ways in this country for a number of reasons and one of them is fee for service, the model that basically says you have to do something to get paid. That's affected all of us and it has driven up costs, it has decreased outcome.

POLLY BEDNASH, PhD, RN, FAAN: Another place where we collaborate, see.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Exactly, this is a huge area.

KAVITA PATEL, MD, MS: There is one thing, I'm in the middle for maybe an obvious reason, I think a natural bridge, I will say to you that I think primary care, just me speaking personally in my primary care practice, we are struggling to kind of—there's this promise of a medical home, a health home, an ACO, but you're going to most people in the country Reid, you know this, Polly, you know this, we're struggling just to

figure out how to do that. I completely agree, we have a lot more to benefit from working together than we need to have others watch us kind of pick each other apart.

I think the team is the perfect—I can't think of anybody who doesn't want to be part of a high functioning team. Most doctors I know, including myself, will say I don't care what label you use on me, I just want to know that the patients that I get to see really need to be seen by me and that the work that I'm doing isn't just in a silo, that I've got Polly down the hall and I can say hey, I need some help downloading this and then she can turn to me and say, I've got these two patients that I'd really like to have you come and see with—after I see them or however we coordinate it, and then low and behold share data about it. Up until now, we've done none of that and that's the truth.

POLLY BEDNASH, PhD, RN, FAAN: That's why our energy should not be directed at preventing people from functioning fully. The energy should be directed at trying to make these systems work better, to find the ways that we can define best practices, how people can work together in the most productive ways and how we can meet that triple aim to get people the care they deserve and need and have access and get it at the right cost at the highest quality. That's where we have a mutual

agreement that we need to focused on, not the other issue about what we could or should do.

It's very interesting that so many of the laws about scope of practice have been defined by where the individual sits rather than what they bring [interposing] because you sit in a rural area, we'll let you do more but if you come into an urban area where there's a concentration of other providers, your brain suddenly shrinks and you can't do those kinds of things. Again, let's talk about this whole spectrum of needs and focus on the things we all agree need to be done.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Yes, the key there is we talk about the who and the where as being so important, that's where scope often focuses rural versus urban, who's got which title. It's really how, is the more important question and that's what we're really talking about. It's hard though, we'll have this discussion then have you translate that but again, I think we're moving in that direction because we do share something.

Insurance companies are for profit, ultimately and we are for patients and that's where we have a real chance to again, find our focus to help us pull things together and then find out ways of making that team member be with the program. The primary care challenge is huge because people talk about it, which is great because they used not to. Now they're

talking about it, now we just have to help them understand what that means, especially in terms of different kinds of services and processes.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: We have a question here, what is the attitude of states toward allowing community health workers, workers who are not clinically trained but licensed by some states, to provide services such as diabetes self-management training? Are many state creating reimbursement codes for these services and expanding scopes of practice to allow them to support the clinical team?

KAVITA PATEL, MD MS: The topic of community health workers is very relevant because there is not really a standard definition or getting back to a standardization of education licensure, curricular, none of that currently exists and I'll even extend that to something that's a lot more familiar to most people which is medical assistance. These are not generally especially specifically, CHWs, community health workers, they are not necessarily on the radar for states to create definitions or standards of scope of practice.

The diabetes self-management and some of the other programs you're referring to, which are very common more and more in the country, are generally done as local requirements or resource-based requirements for the health system. In terms

of a reimbursement model, no, we do not have in place at a state level or at a federal level, a code or some sort of fee that we pay directly to that community health worker and we are not aware of any models that want to reimburse that.

What we have seen though is an integration of the community health worker into an ACO or a medical home model and then they're just hired as salaried or paid workers without any sort of the other financial arrangements that doctors or advanced practice nurses generally have like bonuses for quality or performance. I do think that given how much a growth area CHWs are, that there will be attention to and you can easily see a national infrastructure organization of community health workers that say, wait a minute, we're an important part of the team too and we deserve some sort of mechanism for standardized approaches to reimbursement et cetera. I think the question is a prescient one but we do not see any of that existing right now.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Okay, similar question about direct care workers, health care is intertwined with psychosocial issues, what role do you see for social workers and community health workers? Is there an evidence base for their involvement in primary care settings?

KAVITA PATEL, MD, MS: Yes, there is an evidence base for licensed clinical social workers of mental health, mental and behavioral health as well as an evidence base for trained, I won't call them community health workers, I'd rather call them trained community members. You can call it a health worker but lay members who receive some intense kind of short degree of training, not even resulting in a certificate necessarily, but training to work in conjunction with a primary care physician, psychiatrist or a behavioral health professional and a licensed clinical social worker in behavioral health. In Washington state where they've done this model and actually used a telemedicine model for doing this, they've seen dramatic increases in adherence to therapies for mental health which is an important area, as well as a dramatic decrease in utilization of services related to other co-morbidities.

Let me unWonkafy [misspelled? 1:03:16] that. What that basically means is that in teams, getting back to Reid's point, in teams where they've had community health workers or medical assistants that are trained a little bit more in behavioral health, a license clinical social worker in behavioral health, as well as either a primary care physician or a psychiatrist or a psychologist, they've been able to, through that team effort, been able to show reductions utilization in conditions like

diabetes and heart disease because we've been just starting to wake up and realize that the mind and the body are actually connected and that there's a relationship between your heart disease and depression. There has been really definitive evidence in that area and I think it's one of the most promising growth opportunities in health care, so it's a great question.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: It's also huge for teams, again talking about team-based care, because some of these issues are incredibly time intensive yet critical for patients' health, well-being and life. You and I are both trained, we can do that; we can identify someone, for example, with severe depression or a problem. We can spend time and do that, but other people can, too. When I'm spending that time, when you're spending that time, there are other things that aren't happening. There are specific team members, if we can find ways of bringing them in, again, they don't have to be in the same building, but we need to find ways of tapping into that so we pick up the phone, whoever's at that point of first contact, and identify the right next step.

This is so huge, this coordination of care, I'm so glad you brought up mental health because that does get short triffed in many ways in this country and that is a key component of health is how your mind works.

POLLY BEDNASH, PhD, RN, FAAN: Well it also points against to this notion of what a team represents and it represents bringing an array of skills and knowledge and expertise. I may have had training in mental health and how to identify depression, I'm certainly not capable of treating depression and I would want to be able to reach out to the social case—licensed social worker who could do that and treat in a way that would then ameliorate a number of other issues too. That's the notion of a team, bringing a variety of people in and saying, oh, I've got to hand off to you because you're the right person for this. That's how teams should be defined.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Alright, so we have another question about collaboration. In states, and in fact I like the subject line of this one, collaboration in name only? In states, for instance New York, where collaboration is defined as a nurse practitioner hiring a physician to review charts four times a year, how does that represent real collaboration between nurse practitioners and physicians? Are there problems with such an approach and how common is this?

POLLY BEDNASH, PhD, RN, FAAN: I'm not convinced it's very common. I think there are states where there are strange collaboration requirements about routine reviews that they have to figure out how to follow then. Perhaps that review does

help the quality of care if the individual is really looking at and providing, in a consultated way, information that's helpful, but if it's simply to follow some pro forma expectation, it's not helpful. Unfortunately, there are laws and regulations out there that require that somebody be within 10 miles, say, to be a collaborator, to be in the same building to be a collaborator. That's not collaboration. Collaboration is consultation and conversation about the issue at hand and then how you solve the problem and it's brining in multiple people. It's not routine, but it does happen and you've probably seen that in the review of the laws that you've seen.

KAVITA PATEL, MD, MS: Yes, right, that's exactly right. It's not as—I would argue that that exact—we start to confuse in policy, kind of, process with outcomes. Sitting down and reviewing charts four times a year, unless there's actually some kind of really thoughtful connection of what is my review [interposing] to yes, is there some kind of improvement activity that follows that?

I'm a physician and I'm recertifying myself and I'm doing that exact same thing. I'm giving my board of internal medicine data about my care for diabetics and at the end of it, they're going to have reviewed my charts and then come back to me to tell me how I can improve my practice. That's collaboration in name and in practice, but I don't know if it's

what happened, as a result of some of these laws which are not as many on the books as I think there may have been in the past, so I do agree with Polly, it's less of an issue. I do think that the collaboration, without tying it to some improvement activities, it's just checking boxes and not necessarily true collaboration which is the questioner's point, I think.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I would agree that that issue with just checking a box misses the entire point and any rule, any law, can be good and can be bad. Somebody's going to manage to do either with it. For example, I could see a role, if done properly, even with that kind of a law, for someone who's newly graduated and doesn't have a lot of experience, provided there's true feedback, even if it's chart review. It may not be let me call and talk about the patient, for anybody, especially in that setting.

If it is truly a review where I sit down and there's a designated time where I say I'm going to review X number of charts, we're going to have a conversation and go through it, we're going to talk about documentation, we're going to talk about the clinical aspects, I ask some questions. That would be of value but the trouble is, that gets hard because how do build all those into the law, it's more check boxes.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: This viewer, in particular, would like to hear from Dr. Bednash about the educational background of advanced practice nurses.

POLLY BEDNASH, PhD, RN, FAAN: Okay, well I will say again that people who are prepared as nurse practitioners have, at a minimum, a graduate degree in nursing and either a masters degree or a doctor of nursing practice.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: What does that mean? What kind of training do they actually go through?

POLLY BEDNASH, PhD, RN, FAAN: They get their undergraduate degree, which is four years of nursing and they have two and a half years of clinical training as part of that undergraduate degree as a registered nurse. Many individuals practice for a number of years before they go on also to their graduate degree, but nonetheless they have that undergraduate preparation. Then they have two, three, four years of graduate education depending on whether they go part-time, full-time, et cetera.

The important thing I think I need to reflect on here was the illusion that there's great variability in the requirements for these programs. There is not. There is a set of standards that our organization has developed about the

requirements for granting a graduate degree in nursing and it's called The Essentials. Every school of nursing that's accredited by the Commission on Collegiate Nursing Education is required to meet that set of standards.

If you are preparing somebody as a nurse practitioner, you also have to meet two other sets of standards. National standards that are consensus-based that have been developed by the community of clinicians out there about what the expectations are. First, the standards for the operation of the program and the standards for the content of the role in population that the individual is being prepared for. Are they being prepared to do care of adults, children, women? All of those have been standardized.

They've just gone through a national consensus process to standardize everything but it should not lead people to believe that because this is a new process that it didn't exist before. We basically just codified what the expectations are that had been operationalized already. People have a graduate degree, they meet several sets of national standards and then they are certified by an organization, which is an accredited, recognized certification organization and that certification either as an adult or geriatric or women's health or a pediatric nurse practitioner provides them the authority and the state licensure to practice. There is great

standardization in what the expectations are. There should be no confusion about that.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I guess since I raised some of those questions, I was not implying that any of those processes were necessarily inadequate, but they're different. I will say the AANP's own website has a discussion of the natural consensus need that there's, and I think it's a quote, a need for standardization, hopefully by 2015 which, again, suggests there's been a process. You just said that we've got a lot of these things happening, we're now pulling them together for national consensus and that's important because that does suggest—

POLLY BEDNASH, PhD, RN, FAAN: That shouldn't imply that that didn't exist before.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Well, what I was saying is there are different types of processes because is the variability in hours true, anywhere from 3,500 to 6,600, that a nurse practitioner can have that variety?

POLLY BEDNASH, PhD, RN, FAAN: It will depend on the population the individual is prepared to care for. For instance, if you are prepared as a family nurse practitioner, it's a more expansive curriculum than if you are prepared as a pediatric. It doesn't mean that because someone got these many and someone got these many that they were inadequate.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: No, but it does mean there's variability and so it does determine—

POLLY BEDNASH, PhD, RN, FAAN: Just as there is variability in medical education and residency programs and there are multiple accreditors in medical education and it depends on what the entity is that's being accredited.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Well, all medical students will get 21,000 hours. It's pretty darn consistent. It may miss a little bit, but it's not 15,000 to 25,000. Nurse practitioners will have different, again, that's not saying it's bad, but it's different. The recognition that there needs to be national standards is certainly appropriate.

POLLY BEDNASH, PhD, RN, FAAN: There are.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Yes, and I think continue to move forward would be important. A lot of the graduate education too is different and I really respect that a lot of the doctorate programs in nursing are really helping to design leaders, to use that word, in health care administration in people who are used to transforming process and doing research and that's valuable and needed, especially in systems change. That is different than someone who's going to be on the front line in a rural area practicing, seeing patients of a wide variety so there's some differences there.

POLLY BEDNASH, PhD, RN, FAAN: Remember that the doctorate is a degree. It's a degree just like the masters degree is a degree and you can get an MBA or you can get a Master of Science and Nursing. It's a degree, it's not a role. The degree can be provided to somebody who gets prepared for a variety of roles but if they're prepared as a nurse practitioner, they are meeting national expectations from the National Organization of Nurse Practitioner faculties, from our essentials, from our crediting body and from the certification body. There are multiple partners and the important thing about that consensus process is that it brought all those people together to again confirm that national set of expectations not to discover the for the first time.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: We're getting a lot of questions about how this team-based care thing is going to work and one of these questions is about how providers are going to be paid. If a patient is treated by a team, should payment for the services be tiered based on training, education and/or credentials? How is that going to work?

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I think Kavita has that answer, don't you?

KAVITA PATEL, MD, MS: Yes, well we've been looking [laughter]. It's funny because we talk about—we spend a lot of

time looking at bundled payments and just a lot of efforts in the Center on Medicare and Medicaid Evasion is around bundling of payments which the private sector and Medicare have done before and we're having this exact same debate about how do we unbundle payments and who gets what and how much and that's just physicians. We've spent a lot of time trying to think about how to move away from fee for service by doing this team-based care, group care, et cetera, and then the big question mark is how do you then unstructure these payments.

Right now, those payments do flow to physicians and then a lot of the private payers either use a proportion of that to pay other members of the team. In some cases I mentioned, some states and Medicaid, they're doing equal parity amongst nurse practitioners and physicians for services. For the most part, what we see is some sort of distribution with the physician getting the maximum and then a percentage of the others.

I think what's hard about that, one of the reasons just even sitting in on this discussion I realize, I don't think any nurse practitioner I know is trying to say that their training is equivalent to mine. I will certainly go to high horse and say there is no way the training is equivalent. The problem is that I think we've unfortunately, and it's a disservice to ourselves as professionals, we've been put into these little

cages to battle each other because we've been made to perceive that we can be substituted for each other.

When we talk about paying for team-based care, what we cannot have more of our conversations—I don't think anybody would argue that if a physician is handling the five percent of the patients that are the sickest and the most chronically ill and they're putting in the time and the hours and from my training and my level of experience and my, I didn't realize it was 21,000 hours, it felt more like 80,000 hours, I deserve to be paid a certain amount. Nobody is going to—I don't think anyone is arguing with that.

I think what people are disturbed by is that we then say well you're only 60-percent worth that health professional so that's how much you get. When we talk about true team-based care, Marilyn, I'll be honest with you, where we see it succeed is when people are salaried. I'm just going to cut to the chase and tell you that when we talk about moving away from the fee for service beast, there's this extreme, we all know the examples, Kaiser, Group Health, and it's capitation and salaries and then some spectrum in between.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Well let's talk about that a little bit because Kaiser Permanente has tried this with OB-GYN in areas where they have had trouble getting OBGYNs and they have put

nurse practitioners and other advanced practice to serve these areas. I don't know—I'm hoping that some of you are familiar with this and can you tell us—and those are salaried, it's a salary system. Tell us about that experience and how that has worked and what we've learned from that.

KAVITA PATEL, MD, MS: I know that—I don't know of, I know of examples where—I don't know of the Kaiser data specifically, I know of examples where they've had certified nurse midwives as well as advanced practice nurses doing OB and GYN services at salary levels and it has helped to attract gynecol—it has helped to attract—access professionals who can provide those services. They are not paid the same amount that OBGYNs are though in those settings. I'm familiar with some of those examples in Texas. When they are salaried, they're not- but again it goes back to, I don't think anybody is pretending to say that we should all make exactly the same amounts of money and that's—we can have that argument, but I think all of us would agree that our different levels of training and the time for that training should be reflected in what we are reimbursed.

POLLY BEDNASH, PhD, RN, FAAN: I would say it should be reflected in what our role responsibilities are and then I would also say that when we have this conversation about unbundling a team and who gets what it does go right back to

the fee for service models. Really, that's a model, if we are really going to give team-based care, where everybody's a part of it and we're all salaried employees then it's less about you make more than me and it's more about this functioning as a group that has a mutual interest in the right outcomes and mutual accountability about the outcomes and then rewards based on those outcomes.

KAVITA PATEL, MD, MS: Yes, right now, it is going to the physician.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Is this the answer? Does everyone need to be salaried, is that the answer?

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I have no idea but there's certainly a lot of disparities that are created by fee for service and honestly the more you do of something the more you make even among highly paid specialties, somebody who's doing more procedures. We have a very procedurally oriented country.

POLLY BEDNASH, PhD, RN, FAAN: It drives the demand to do more, do more.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: It drives the demand and interestingly enough, going back to evidence, we're getting some evidence that many of the

procedures that are being done really don't impact the ultimate outcome, which is death.

POLLY BEDNASH, PhD, RN, FAAN: Can harm—the overuse issue—

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Can harm. There's no question that a change must happen from fee for service. Now does that mean everybody's salaried, does it mean we find another way of leveling the playing field? I don't know but there has to be a shift and it is happening but it won't happen as quickly as it needs to.

I wanted to point out—make a comment on something that you both said. I really liked your saying that physicians and nurses are not the same and you were nodding with that and we're not. I think—what I like though, is I think in some ways we are being thrown in this process by others because it's also a distraction and when legislators and when insurers have a chance to have us go against each other, it helps delay us moving forward.

I think our role is to recognize that common ground and educate so when somebody's saying, at a higher level passing a law, that we're going to address this problem by substituting this piece for this piece, we all say, no, no, no, we're not the same. That's not the answer, the answer is this piece has to have this flexibility, this piece must have this and then we

can do some improvement. I think a lot of it's educating people who truly are making the assumption that we're not making.

POLLY BEDNASH, PhD, RN, FAAN: Well we may not be the same but there are components of our skills and knowledge that are the same that we can do some of the same things. I think that's where the problem comes, when there's an expectation and I go back to what I said earlier in my presentation about what it means to be independent. Independence means being able to use your education and training and the skills you've acquired fully without having to get someone else's permission to do that.

Understanding that we're different, we have different educations, we have different capacity to provide care for people, is something that I think any advanced practice nurse would agree about. It happens at the direct level when we're working together side-by-side and it's never really an issue in terms of that collaboration that occurs together. Understanding that the argument immediately moves then, at the state level, to you can't do this unless I tell you you can that just harms the bigger conversation that we need to have about how we join forces to get the right care to people.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: One of our viewers would like you all

to speak about medical malpractice occurrences for physicians versus nurse practitioners. This viewer is under the impression that there are typically less suits against nurse practitioners. Is that correct and why would that be?

POLLY BEDNASH, PhD, RN, FAAN: Well, the data seem to indicate that there are very, very low levels of malpractice for advanced practice nurses, nurse practitioners, and midwives and nurse anesthetists. Some people say well, it's because the deep pocket is the physician and they'll go after the physician and that's in fact where they target more than anybody. The reality is that patient care delivered by nurse practitioners, midwives and nurse anesthetists is high quality and they are not experiencing the same rate of malpractice suits.

KAVITA PATEL, MD, MS: I haven't looked at the two compared to each other, but I know that recent studies have kind of illustrated in physicians and malpractice that we used to often think it was just the high procedure specialties, neurosurgery, OB, that had—and certainly those have a little bit higher rate of malpractice suits that at least are initially filed but we're finding that all health professions face some degree of probability of being sued at some point in their career including what I do, general medicine and pediatrics, et cetera.

What is interesting is that the number of people who initiate a law suit and then the actual fulfillment of that malpractice law suit has been decreasing and there's a hypothesis that we, as a medical—as physicians in a medical profession, have become more transparent and more honest about mistakes we make something that culturally we've had to come to bear with over the last several decades.

I don't know enough about the data to compare the two, I would certainly believe the deep pockets argument to some degree but we also know that a number of these suits really don't actually—once the medical system, like in the State of Michigan, initiates an effort to have doctors be honest about mistakes have been made, patients drop the suits and patients say we just wanted someone to tell us what was really happening. I'll say that about physicians, I don't know Reid, if you've seen data?

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: I would certainly agree that there's more and more evidence that being transparent and recognizing upfront whenever an error occurs helps to decrease suits. Some of that is a shift in our culture and our process that is critical. I haven't looked at that data in great detail either. I will say that family physicians are generally sued less than other physicians and I think some of that goes with some of the things we share with

advanced practice nurses. We have a high satisfaction with our patients, good communication, it may also be—and I'm curious on the numbers, is it less suits relatively—what's the number? Is it based on total number of practitioners for each subspecialty or is it one [interposing] number is, right, because there are fewer independent nurse practitioners there are more physicians so is that one explanation for the number?

The other might be and it does go back to education and training because as a physician I'm trained to handle extremely complex cases, those are often sicker patients. There's often more of an opportunity for a patient of that complexity to have a problem either from my care or from another team, like a consultant. That may be another variable I would look at because I think that will vary in some of the practices.

KAVITA PATEL, MD, MS: Well and the large degree of suits that are, I think are some are either the most high profiled or the ones that have the highest dollar amount, largely are attached to procedures. Some of that, right now, there's just, honestly there's frank limitations on—I haven't met anybody who's—a nurse practitioner who's been able to put a cardiac stint in or do brain surgery. Since those are the suits that follow, I think that's why you're seeing, what I would say, is a disproportion. I wouldn't be quick to interpret that as some dramatic statement about doctors are

more negligent versus nurse practitioners. I think that kind of rhetoric just makes us pit ourselves against each other rather than look at the date for what it is.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: We're coming to the end of our allotted time here. Kavita, I'm hoping you could wrap us up here by telling us are we coming to the—near the end of what we're going to see in the way of scope of legislation—scope of practice legislation in the states? How much more of this are we going to see and are we going to see this evolve into different kind of legislation or have we pretty much seen the kinds of legislation that we're going to see at this point?

KAVITA PATEL, MD, MS: Yes, I think we're seeing—we're coming to not an end of the legislation because what would state legislatures do if there was an end to our legislation? I think what you're seeing is now—the maps I showed you—the differences between states, while some have some really dramatic differences around independent practice issues, most states are coming around and doing things to try to augment some of these old scope of practice laws and to say let's allow for nurse practitioners to practice independently but only in underserved or rural areas or there are some restrictions to some of these.

I think we're seeing a momentum that's peeked a bit in terms of the laws and the kinds of issues they want to deal with. What I do think is still on the horizon is that as our care models evolve and we're doing different things at the state level like what Oregon is trying to do, what Vermont has been doing, I think you'll see changes in the scope of practice that are a response to the actual changes at the delivery system level. I have now interacted with more health system leaders who have said we are frankly tired of some of these really old practice laws that are inhibiting us from doing the following. It's not just nurse practitioners and physicians, it's a number of licensed health professionals. I think you'll see conversations like that drive some state legislative momentum.

I think 2014 is—this year we're all kind of figuring out what's happening with health reform and what the response is going to be like. I think if you start to see the headlines like we saw in Massachusetts when I was watching what happened in the enactment of health reform of long wait time and problems of access, increases in emergency room visits, I think you're going to see another resurgence, Marilyn, of legislation and policymakers respond.

What we have not seen but I think will see is also a national response in some way. We've had very little

conversation on the federal side around licensing standardization and the requirements for getting licensure in these states, which are just completely arbitrary state to state. I think you'll also see a little bit more movement to have some standardization at the federal level even if it's just for the VA or some of the systems, which are across the country.

MARILYN WERBER SERAFINI, COMMUNICATIONS DIRECTOR AND HEALTH POLICY ADVISOR: Alright. I'd like to thank our panelists for a very valuable discussion and I want to remind our viewers that you can get more information, more materials, you can take a closer look at the panelist's presentations on or website, www.allhealth.org and I'd like to thank you for being with us today and to thank the Robert Wood Johnson Foundation for sponsoring this webinar.

REID B. BLACKWELDER, MD, FAAFP, PRESIDENT-ELECT: Thank you.

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