

# SUMMARY *of the* FLORIDA TAXWATCH ARNP SCOPE *of* PRACTICE SUMMIT

Center for  
**HEALTH & AGING**  
FLORIDA TAXWATCH



ARNP  
Scope of Practice  
Summit

Florida  
**TaxWatch**

## DEAR TAXPAYER


Florida TaxWatch is excited to share this summary on the 2013 Advanced Registered Nurse Practitioner (ARNP) Scope of Practice Summit, held by the Florida TaxWatch Center for Health & Aging. By gathering a diversity of experts, a rich discussion about the role of ARNPs in Florida's healthcare workforce took place.

Florida TaxWatch has recommended expanding the scope of practice for ARNPs, which was the topic of the November 2011 *Briefing: Expanding the Scope of Practice for Advanced Registered Nurse Practitioners and Physician Assistants Would Generate Fiscal Savings While Enhancing High Quality Medical Care*. However, the details of how that expansion looks still need to be carefully evaluated. The 2013 ARNP Scope of Practice Summit was a unique, ground-breaking opportunity for interested stakeholders of diverse backgrounds and opinions to collectively discuss and consider what policy decisions were best, not necessarily for their organizational or personal interests, but for the Florida taxpayer.

The time is ripe for a fresh discussion about this issue. The discussion should not be delayed, and interested stakeholders beyond nurse practitioners and physicians need to be included in health policy development for thorough consideration and analysis.

Stakeholders across health sectors are ready to come together to the discussion table on ARNP scope of practice, have productive negotiations based on evidence-based reports, and focus on doing what is best for Floridians. Now is the time to put aside historical disagreements among interest groups, and work together toward a healthier, efficient, and cost-effective Florida.

Sincerely,



Dominic M. Calabro  
President & Chief Executive Officer, Florida TaxWatch



Robert Weissert  
Vice President for Research & General Counsel



Tamara Y. Demko  
TaxWatch Center for Health & Aging Executive Director

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Note: This paper is a recap and overview of the Florida TaxWatch ARNP Scope of Practice Summit, and does not include new Florida TaxWatch research.

## EXECUTIVE SUMMARY

On February 11, 2013, the Florida TaxWatch Center for Health & Aging hosted the Advanced Registered Nurse Practitioner (ARNP) Scope of Practice Summit in Tallahassee, Florida. Stakeholders from across the state gathered to discuss the role played by ARNPs in access to care, quality of care, business models, and taxpayer return on investment for Florida’s families. The Summit captured issues discussed in the Florida TaxWatch November 2011 *Briefing* entitled *Expanding the Scope of Practice for Advanced Registered Nurse Practitioners and Physician Assistants Would Generate Fiscal Savings While Enhancing High Quality Medical Care*.

Florida TaxWatch President and Chief Executive Officer, Dominic M. Calabro, welcomed attendees and spoke to the importance of making effective and efficient health policy decisions to safeguard Florida taxpayer dollars. An overview of ARNP scope of practice issues was presented by Tamara Y. Demko, JD, MPH, Executive Director of the Florida TaxWatch Center for Health & Aging. Three keynote speakers followed.

First, Eileen T. O’Grady, PhD, RN, NP, peer-reviewed published author, professor, wellness coach, and Policy Editor for the *American Journal for Nurse Practitioners*, shared lessons from her research regarding how ARNPs impact access to care issues. Next, Anna G. Small, CNM, JD, Vice President of the Florida Nurses Association and Attorney, shared lessons from the nursing field regarding how ARNPs affect quality of care issues. She also discussed contractual and legal relationships between nurse practitioners and physicians. Then, Sandra F. Ryan, MSN, CPNP, FCPP, FAANP, Chief Nurse Practitioner Officer of Take Care Health Systems, Walgreens, shared lessons from the business world on the role of ARNPs in health and business innovation.

The meeting concluded with a ground-breaking stakeholder panel discussion of distinguished leaders from various health sectors for a discussion on where the scope of practice issue currently stands, what barriers exist in moving the issue forward, and what stakeholders can do to advance progress in policy development.

PANELIST	ORGANIZATION
Tom Feeny	Associated Industries of Florida (AIF)
Phillis Oeters	Baptist Health South Florida
Mary Lou Brunell, MSN, RN	Florida Action Coalition & Florida Center for Nursing
Lori Schirle, CRNA, MSN	Florida Association of Nurse Anesthetists (FANA)
Stan Whittaker, MSN NP-C	Florida Association of Nurse Practitioners
David A. Pizzi, RN, MPA	Florida Blue (Blue Cross Blue Shield)
Anna Small, CNM, JD	Florida Nurses Association

\*\*The Florida Medical Association (FMA) was invited to participate in the panel discussion to represent physician interests but, unfortunately, declined the invitation.

Important messages from keynote speakers, panelists, and attendees alike were that federal health care reform would increase the need for primary care services; the time is now for a fresh discussion about ARNP scope of practice; all interested stakeholders should be involved in policy development; and stakeholders across health sectors are ready to come together to the discussion table on ARNP scope of practice, utilizing evidence-based research to do what is in the best interest of Florida.

## OVERVIEW OF PRESENTATIONS

### TAMARA DEMKO

JD, MPH

*TaxWatch Center for  
Health and Aging  
Executive Director*



Unlike many other states, Florida law currently restricts ARNPs from practicing to the full extent of their training. Seventeen states allow ARNPs to practice without the supervision of a medical doctor. Forty-eight states permit ARNPs to prescribe controlled substances under specific conditions. Florida is one of two states that do not allow such prescribing. More than 80 percent of ARNPs work in primary care.

Tamara presented an overview of the Summit schedule and the ARNP scope of practice issue. The Summit was convened to bring stakeholders together to share lessons, further discussion on ARNP scope of practice policy development, identify challenges and break down barriers, and promote collaboration for a healthier, more cost-effective Florida.

Tamara offered several topics and questions for attendees to consider as the Summit progressed and the keynote speakers presented. Attendees were asked to weigh whether ARNP care was equivalent to physician care, how patients perceived quality, and if special needs populations were addressed differently under nursing care. She asked attendees to look at ARNPs in business practice, to assess cost savings, to consider physician liability issues attached to signature requirements, and to question whether additional layers of supervision and signatures incurred a cost to patients who might have delays in timely care.

Tamara noted that previous legislative attempts to expand ARNP scope of practice have been unsuccessful in Florida, and that there appeared to be some disagreement among stakeholders as to what practicing to the “full extent of training” really means. The Patient Protection and Affordable Care Act (PPACA)’s impact on increasing the volume of patients to Florida’s health care system and the need for primary care was raised. Recommendations from the 2010 Robert Wood Johnson Foundation/Institute of Medicine (IOM) Initiative on the Future of Nursing were discussed.

Differences between nurse practitioners and physicians were raised in consideration of training hours and degrees. If scope of practice were expanded, how would it impact primary care physicians, billing practices, and incentive structures? Challenges to expansion include the state regulatory environment, health system fragmentation, retirement of experienced nurses, the transition from education to practice, and historical perceptions.

Tamara asked attendees to consider the information presented by speakers and fellow attendees through multiple lenses: 1) lifespan—the benefits/challenges to various age groups; 2) diversity—impact to individuals and groups with different backgrounds, socioeconomic status, health occupations, etc.; 3) multilevel—the upstream and downstream impact of scope expansion; and 4) 360 degree—previously unidentified stakeholders, incentives created, and unintended consequences. She concluded by providing an overview of the Summit agenda and goals of the stakeholder panel.

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## EILEEN O'GRADY

PH.D., RN, NP

*Peer-reviewed published author, professor, wellness coach, and Policy Editor for the American Journal for Nurse Practitioners*

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“An estimated 50% of ER visits could be avoided if people had access to primary care when they needed it.”

Dr. O'Grady discussed the history of nursing and access to care. Access to care is linked to nurse practitioners, whose role emerged in response to access issues in rural Colorado around 1965. Dr. O'Grady explained the health policy triad of balancing access, cost, and quality. Access to care requires system entry, access to sites of care, and finding providers that can address needs and develop long-term relationships. Health insurance only addresses system entry, and financial, geographic, and other barriers to care still exist. Dr. O'Grady presented a slide showing that in other countries, a majority of resources are placed in primary care, whereas in the United States, the health care system is upside-down with little primary care investment. With top-heavy resources in tertiary and specialist care, the U.S. system is unstable and shaky.

Efforts to improve access always improve quality. Regulation of health professionals is done in a piecemeal fashion, with no Constitutional mandate regarding regulation. Dr. O'Grady discussed disturbing health trends of increasing uninsured and ethnic and racial disparities, with family costs doubling over the past nine years. Primary care encompasses many services, reduces costs – especially for patients using costly emergency room services as a form of primary care, and improves quality.

“An estimated 50 percent of ER visits could be avoided if people had access to primary care when they needed it.” – Dr. Eileen O'Grady referencing a study published in the Milbank Quarterly (2005).<sup>1</sup>

Dr. O'Grady noted that there have not been changes in the earnings of medical doctors in states having an expanded scope of practice, and stated that education is standardized for nurse practitioners. She said that there are no studies showing nurse practitioner care as unsafe, noting that data collection and availability remains limited

A question was raised as to whether total costs are higher when physician supervision is billed on top of nurse practitioner services. Billing practices may need review. Adequate data on rural NPs is not available as a result of billing, licensure/certification and other issues. There may be better data over time. Differences in physician and nurse practitioner salary averages were discussed. The question of “disparity” based on title rather than years of experience or extent of training was discussed as antiquated.

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<sup>1</sup> Full citation and more information available in Dr. O'Grady's presentation on page 25.

Dr. O'Grady noted that the state of Florida may be paying to train ARNPs, but then will not allow them to practice. This may lead nurses to seek employment in states with less restrictive practice requirements. One attendee noted the overly burdensome need for 17 separate signatures on protocol agreements.

Dr. O'Grady likened the impending influx of newly insured to a great "silver tsunami." Where conditions are going, the industry and model will have to evolve to meet patient needs. For this reason, Dr. O'Grady believed that expanding ARNP scope of practice was not a matter of "if," but a matter of "when." There will be older, sicker rural populations, an uptick in chronic illnesses, and newly insured are likely to be higher users of care. Only seven percent of new medical graduates go into primary care practice.

Access problems are always delay problems. Low birth weight, heart failure, hypertension, asthma, and diabetes are "primary care sensitive conditions" that drive up hospital and emergency room costs but could have been prevented or managed with primary care. Massachusetts taught the nation that access to health insurance creates a surge in demand, and nurse practitioners were being underutilized. There are 6,000 health professional shortage areas (HPSAs) nationwide, with 248 HPSAs in Florida.

A National Governors Association report entitled *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (2013) found that ARNP scope of practice expansion could increase access to care in underserved areas and incentivize involvement in primary care. A 2012 study showed no variation in medical doctor earnings among states with and states without expanded scope of practice.

Dr. O'Grady's published study on *Unleashing the Nation's Nurse Practitioners* showed that the nurse practitioner workforce is underutilized, that variations across state practice acts suggest lack of evidence, and that a new regulatory model would provide a strong state framework. National standards allow for a uniform basic requirement and safe practice. This would consist of LACE:

- Consistent NP **Licensure** standards across states
- **Accreditation** of NP programs
- **Certify** all NPs
- **Educattion** standardized

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## ANNA SMALL

CNM, JD

*Attorney,  
Vice President of the  
Florida Nurses Association*

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A number of studies interviewed patients to determine whether there was a difference in quality of care between ARNPs and physicians. The studies...concluded that NPs could be substituted for physicians in 90% of primary care services and 25% of certain specialties.

Anna presented on quality of care issues for ARNP scope of practice and the history of legislative efforts to expand scope of practice. Anna was asked to discuss whether there was a difference in the level of quality of care provided by ARNPs versus physicians. She concluded that there was no significant difference in outcomes and the research suggested greater patient satisfaction with nurse practitioner care. Furthermore, a point-by-point comparison was not appropriate as NPs had formal health care education and experience prior to entering graduate programs, and education was based on competency, not time spent in studies. She noted that it was important to understand the subtle distinctions in education and training among classifications of nurses, and that titling of nurses may vary confusingly from state to state.

Anna lobbied for the Florida Nurses Association for six years. She noted that ARNP scope of practice issues have been contemplated for nearly 20 years, with small incremental policy steps forward. A bill has not been heard on this issue for a long time, which was suggested by Anna to be indicative of other forces at play, such as politics. Anna noted that the nurses association has had recent discussions with physician associations.

The hospital association and a number of business groups have supported legislation to expand ARNP scope of practice. Anna believes it is a cost savings issue. ARNPs that have a protocol relationship with a physician are generally directly employed by the physician or, if not directly employed, still generate money for physicians. Nurses pay for the supervisory relationship.

Several Summit attendees who were nurse practitioners expressed concern regarding the potential liability physicians may incur by signing off on patients they did not directly examine. These nurse practitioners felt that a great deal of trust had been placed in them by the physicians, and they did not feel it fair to physicians to be responsible for people they could not directly supervise.

Anna noted that liability was a valid concern. She spoke of a malpractice case that came out a couple of years ago in which the nurse practitioner made a misdiagnosis which was then affirmed when the physician signed off on the misdiagnosis. She believed the court held that the physician had violated the standard of care by not catching this misdiagnosis. The physician in that particular case did not carry malpractice insurance, however, so it did not benefit the plaintiff.

Anna noted that a number of studies interviewed patients to determine whether there was a difference in quality of care between ARNPs and physicians. The studies included clinical benchmarks such as blood pressure readings and control of blood sugar. In addition, the patients were asked whether they were satisfied

with the visits they had, and whether they felt that the practitioner took care of them and answered their questions. Anna commented that health care can be a de-humanizing experience. The studies she referenced reported greater patient satisfaction with nurse practitioners than with physicians. The studies also concluded that nurse practitioners could be substituted for physicians in 90 percent of primary care services and 25 percent of certain specialties.<sup>2</sup>

Anna was asked by a Summit attendee whether she believed there had been a paradigm shift suggesting people generally believe that nurse practitioners are just as qualified as physicians to perform the same services. Anna did not believe that the nurse practitioners have been very good at educating patients as to the specific role that they play in comparison to physicians and physician assistants. Physician assistants are not exactly the same as nurse practitioners, just as nurse practitioners are not the same as physicians. A better job of patient education is needed. In the studies Anna has reviewed, patients were satisfied when they understood the difference. Attendees asked how nurse practitioners could go about better educating patients. Anna suggested that more money could be spent on a public relations campaign similar to a recent Florida optometrist billboard campaign that advertised the scope of care available from an optometrist.

A nurse practitioner who owns a practice asked Anna about malpractice insurance. The attendee noted that few nurse practitioners owned practices. She carries malpractice insurance, and the physicians with whom she collaborates carry their own malpractice insurance. They have the appropriate collaborative agreement signed with the State of Florida that incorporated language found in Florida Statutes Chapters 458 and 459 regarding the Board of Medicine and the Board of Osteopathic Medicine that related back to portions of Chapter 464, encompassing the Florida Nurse Practice Act. Both boards say that the action is permissible if it is in both the Nurse Practice Act and the practitioner's specific protocol agreement.

An attendee was concerned as to what would happen with Medicaid patients when Medicaid managed care was fully implemented. Some Medicaid patients were confined at home and no other practitioners wanted to care for them. When rolled into a managed care plan, those Medicaid patients may not receive needed care. A nurse attendee noted that the Executive Office of Governor Rick Scott was helpful and responsive to her in clarifying that nurse practitioners are being considered primary care providers in the new Medicaid managed care plan. Concern was raised that if nurse practitioners were not allowed to be empaneled as individual providers, this may have an unintended effect on the care of Medicaid patients.

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<sup>2</sup> For more information, see Anna's presentation on pages 32-33

Anna clarified that there was no law prohibiting a nurse practitioner from being empaneled. However, if a particular health care organization assigned to a region did not want the nurse practitioner, it could prohibit an individual empanelment. Anna stated that nurse practitioners should consider going to particular areas where they practice, going to the health plans that won contracts, and making a case that they deserve to be empaneled because they are seeing patients in a cost-effective, high-quality way, when no other practitioners want to see them.

A nurse attendee remarked that in speaking with some of the representatives from the insurance panels, the nurse practitioners were wanted, but panels were concerned that they were contractually tied to another individual who was responsible for that patient, and would not see NPs as true primary care providers. The insurers need to find a way to realistically empanel nurse practitioners, who would assume the risk if they are allowed full practice authority under statute. With the insurance company, when a physician assumes risk for a group of patients, that physician is liable. If a nurse practitioner is empaneled as a primary care provider but is legally tied through a collaborative practice agreement to another individual, it is an unsettled legal question as to who holds the risk.

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## SANDY RYAN

MSN, CPNP, FCPP, FAANP

*Chief Nurse Practitioner  
Officer of Take Care Health  
Systems, Walgreens*

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“That was really the first time when I retired from the Air Force, that I really felt, as a nurse practitioner, that I was not an equal player at the table in health care, because, prior to that, I was part of professional staff in the military, working side-by-side with physicians and pharmacists.”

Sandra “Sandy” F. Ryan presented health innovations with nurse practitioners nationally, the Walgreens Take Care Health Systems model, and why Walgreens was in the retail clinic business. Sandy is a nurse practitioner and a retired Air Force officer, having practiced for almost 17 years. After leaving the Air Force, Sandy encountered a different attitude toward nurse practitioners and found that individuals had to fight for access to care, unlike in the military.

“That was really the first time when I retired from the Air Force, that I really felt, as a nurse practitioner, that I was not an equal player at the table in health care, because, prior to that, I was part of professional staff in the military, working side-by-side with physicians and pharmacists. Everyone worked collaboratively as a team, and everybody was respectful, we did quality review processes, peer-to-peer, and it was really the first time, as I said when I realized it was different in the civilian world.”

With its new, “on the corner of Happy and Healthy” slogan, Walgreens is trying to become the community health destination for patients. Seventy-five percent of all Americans live within a three to five mile radius of one of Walgreens’ 8000 stores nationally. Sandy was part of a startup company that was acquired by Walgreens. Her cofounders were businessmen who questioned, after reviewing quality of care studies showing high quality of care and patient satisfaction, why nurse practitioners are not better utilized in the health care system. They built a non-traditional model that was nurse practitioner-centric in which nurse practitioners played a pivotal role to meet patient needs and address practitioner shortage.

“The harsh reality today is that 50 million people are uninsured, and one in eight of them are children. Thirty percent of Americans lack a regular source of primary care. Seventeen million patients have been seen in a retail environment, by anywhere from 5,000-10,000 nurse practitioners who are hired in this industry alone.”

Take Care Health Systems, a wholly-owned subsidiary of Walgreens, has 50 clinics in the State of Florida (Miami, Tampa, Orlando, West Palm) out of 360 clinics and about 1300 nurse practitioners nationally. The industry is expected to grow from 5000 nationally. The walk-in clinics provide value-added convenience and non-work hour/weekend access to care for families, who want to limit exposure to illness for other family members and avoid the significantly higher costs associated with urgent care and emergency room visits. Walgreens accepts insurance plans and has negotiated contracts with insurers. All nurse practitioners bill under their own number and are credentialed with every insurer, which allows Walgreens to track data and outcomes for every nurse practitioner it employs.

Walgreens has designed their clinics to be in the back of the store, with the two most trusted health professions (as reported by survey)—nurse practitioners and pharmacists—working together to counsel patients in managing their disease conditions. The Walgreens clinic model is driven by technology and transparency of pricing. Patients sign in via kiosk, entries are tied to the patient’s new or existing electronic health record, nurses are alerted if someone is waiting, and prices are listed outside the clinic on big LCD screens along with insurance information. Walgreens has designated a “health navigator” for these clinics who help patients to navigate within the store and outside of the store, knitting all of Walgreens health care services—pharmacy, clinic, and home infusion—together. Prevention services are now offered along with treatment and management of conditions. Retail clinics have served as access points for getting needed and hard-to-obtain vaccinations like shingles. Clinical treatment is for acute conditions, and the industry model is evolving toward chronic disease management.

Walgreens wanted customers “to have an exceptional patient experience.” Patients love their providers—they love their physicians, they love their nurse practitioners, but they don’t love the current system. Walgreens has focused on a seamless process of access, providing more transparency in health care—particularly for costs, billing, scope of services, and simplicity in navigating a complicated system.

Walgreens is in the top 10 percent of Gallup’s global database for health care entities as well as for overall customer experience among businesses. Sandy noted that it is all driven by the nurse practitioners, who love taking care of patients. “Patients reported that the nurse practitioner really listened to them, validated their concerns, and provided appropriate care.” Walgreens focuses on evidence-based guidelines, educating their nurse practitioners, and being able to track HEDIS—the Healthcare Effectiveness Data and Information Set—that insurers use to measure quality. Walgreens ensures that evidence-based resources and other electronic tools are available to nurse practitioners in the clinical setting to support them in providing quality care.

“Patients reported that the nurse practitioner really listened to them, validated their concerns, and provided appropriate care.”

Walgreens works to track and ensure that nurse practitioners write prescriptions appropriately, and the patient always has a choice of where they want their prescription filled. For example, where the community standard was that 37 percent of adult patients do not get antibiotics when presenting with acute bronchitis, normally a viral infection, in the Take Care clinics, 75 percent of patients are not getting an antibiotic, which improves community resistance to superbugs and reduces overutilization of antibiotics.

“Studies show that 13-27 percent of ER visits could take place either in an urgent care or retail clinic and, if they did, they could have a potential savings of \$4.4 billion. This shows that if we can drive patients to the right level of care at the right time, we can decrease our overall cost of spending.”

Studies show reduced copayments and overall costs when patients are directed to clinics. Patients were unlikely to go to a physician's office following a retail clinic due to dissatisfaction with services. Convenient care clinics have provided the opportunity for nurse practitioner-specific studies with the ability to identify nurses and run data because of electronic medical records technology.

Sandy presented a map. The 16 states that are in green are full practice states, yellow-colored states are reduced practice, and red represents the restricted states, where too many barriers exist that prevent access, and don't really improve quality of care. These barriers generally center on the supervision and delegation of team management by an outside health discipline, resulting in the need for collaborative practice agreements with very specific, protocol-driven language for nurse practitioners.

From an economic perspective, some states are much more expensive for Walgreens to run a business and, therefore, it takes longer to achieve profitability. In the state of Florida, Walgreens needs multiple collaborative practice agreements with different practitioners, because collaborative practice physicians are assigned to a site, versus an NP. For running a model of care in the Florida market, when Walgreens has independent clinics functioning by nurse practitioners working autonomously in those clinics, the multiple collaborative agreements are "a logistical nightmare." All agreements need to be executed and filed with the Board of Medicine, with re-signing and re-filing at any change to scope of service. This makes it "very troublesome for us to run businesses" due to oversight and written protocols. In addition, Florida is one of the only states where protocol approvals are required for prescriptive privileges. Walgreens clinics do not prescribe controlled substances. This is a business decision, in part, because DEA licensing would be a significant additional cost.

Walgreens has found doing business in Florida to be challenging and burdensome. Typically, markets of four to five clinics are run by a manager, who is a nurse practitioner. Walgreens then has to institute an additional level of administrators to oversee those clinics in fulfillment of Florida's Agency for Health Care Administration (AHCA) requirements. Walgreens has an automated chart review process that is signed off electronically, but AHCA will not accept that without a special additional manual sign-off. In addition, Florida is the only state out of 19 states with Take Care clinics that requires a level 2 background screening. Neighboring states where restrictions are less burdensome may be more appealing to the nurse workforce.

Sandy recently spoke to the Florida House of Representatives Health Innovation Subcommittee about the retail model and its potential benefits in access to care for currently uninsured. The committee was interested in current barriers and restrictions, and was very open to Walgreens' innovative model.

"Studies show that 13-27% of ER visits could take place either in an urgent care or retail clinic and, if they did, could have a potential savings of \$4.4 billion. This shows that if we can drive patients to the right level of care at the right time, we can decrease our overall cost of spending."

Walgreens executes collaborative practice agreements with physicians in every state with clinics. Contractual language varies across states. Walgreens conducts a 10 percent chart audit of collaborative practice peer-to-peer review, and physicians review 10 percent of nurse practitioner records electronically. Collaborative physicians are paid by the company to do certain defined things and to be available for the nurse practitioners during the hours that the clinics are open.

More than 30 million people are coming into the system. Nurse practitioners are positioned to lead in health, wellness and education, and to be a part of new innovative types of teams such as accountable care organizations (ACOs). Grants for nursing education are needed to ensure a continual pipeline of available practitioners. For the retail industry alone, about 20,000 nurse practitioners are needed. Utilizing nurse practitioners to their highest potential, utilizing technology, not being afraid of change and innovation, and really seeking to meet patient needs will better accomplish the triple aim of better care, better health, and lower cost.

Sandy presented a filled five-inch binder of quality studies (dating from 2000 forward) showing that nurse practitioners provide great care, and that patients love them. Sandy stated that the message needs to be conveyed beyond the Summit: how do we utilize a great profession to improve health care?

## PANEL DISCUSSION

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The stakeholder panel, moderated by Florida TaxWatch, began with brief self-introductions by the panelists. Panelists were then asked to discuss how their organization viewed the ARNP scope of practice issue, what barriers or challenges existed in advancing the issue, and what their organizations could contribute to furthering future discussion. What follows is a synopsis of each panel member's comments during the session.

**Associated Industries of Florida (AIF)** remarked that businesses pay for the cost of health care: They pay for the insurance for their employees. They pay the cost shifting from uncompensated care. They pay for Medicaid. Businesses can no longer afford to stand on the sidelines. Business will now get involved in the scope of practice discussion. Florida's businesses cannot afford the cost. They need wellness and a healthy workforce, and ARNPs will increase access. ***If Florida does not get health care right, Florida will not be competitive. Scope of practice is now a business community issue.***

Health care and business: it is a supply and demand issue. If not addressed, businesses may not come to Florida. ***You can ignore small issues, but once the Affordable Care Act kicks in, and we start to address state issues, this is going to be like your house on fire. It's time to decide what to do.*** What business needs to do is help to make the case that wellness is the focus. Expanding supply is one of the major components. We need to expand the pool of quality care providers. The business community does not look at the issue in terms of "good guys and bad guys." There is fragmentation and silo-ing in the industry (beginning with the licensure and regulators) and so there is battling among the silos. Instead, Florida needs to view it as a system, attack the problem collectively, and reward efficiency. The Affordable Care Act has provided an opportunity for change. Now is the chance for major change. The State of Florida should align incentives and work together.

**Baptist Health South Florida** views regulation as a tax, particularly levied on providers and insurance companies, but a tax passed through to all Floridians. Physicians are concerned with protecting their patient base and finances. In theory, hospital systems can bill at physician rates at higher returns, so there is no financial benefit to supporting an expanded scope of practice. However, hospital systems like Baptist Health South Florida still support expanding ARNP scope of practice because it is better for patients and for Florida business. Nurses and doctors work very well together in provider settings and hospitals. Physicians that work with ARNPs have positive attitudes toward them. One barrier is getting more doctors to have personal experiences with ARNPs, because those who have such experiences support scope of practice expansion. Access to primary care is an issue, particularly in light of a shortage of primary care physicians. It is a nationwide experience that NPs provide good quality primary care services. Policymakers need to see a return on investment and evidence. ***A business case must be made. "We can continue to educate businesses. It's really the voice of business that the Legislature is listening to."***

**The Florida Action Coalition/Florida Nursing Center** commented that there should be focus on implementing the Institute of Medicine (IOM) recommendations. There are other groups (LPNs, RNs, & others) that have limitations on their scope of practice, such that they are practicing at a level lower than their training. ***Scope of practice issues affects all health care practitioners, not just the ARNPs specifically. It is important to consider the supply and demand for primary care and, most importantly, what is in the best interest of all Floridians. "There is a lot of emotion in the issue. We need to get past that and move forward to make sure we are competitive."*** There is a need to educate everyone and perform a gap analysis. Florida should ask whether there are issues that we could be looking at to help improve the care that can be given and maximize efficiency in the system. Florida needs to keep the focus on how to best serve the patient rather than organizational positions or benefits. The organization may soon receive a grant to help promote nurses as leaders.

**The Florida Association of Nurse Anesthetists (FANA)** noted that *nurse anesthetists had been practicing for 150 years, and historically were the individuals who trained physicians.* FANA pointed to studies showing equal quality of care among nurses and physicians, and reiterated that no physician supervision requirements exist in 17 states. FANA commented that attitudes are entrenched. Hopefully, with the support of larger organizations and partners like Florida TaxWatch, Florida Blue, and AIF, Florida can make some movement forward and make expanded scope of practice a reality.

**The Florida Association of Nurse Practitioners (FLANP)** advocated for a complete move to full practice authority to the full extent of training without taking incremental “baby steps.” FLANP noted that the shift to Medicaid managed care will significantly affect practice as 20 percent of practitioners are ARNPs in the fee-for-service arena. *FLANP noted that there was an in-depth, county-based study conducted in Texas showing billions in cost savings through expanding ARNP scope of practice.* Concern was raised for access to care in rural areas where providers were reluctant to go. Ensuring access through scope of practice expansion would stimulate the economy, create more jobs in health care, and encourage more people to move to rural and new areas because health care would not be a barrier to economic development. FLANP observed that legislators now have a barrier too in that they must seek alternative ways to fund health care. Now is an opportunity for nurse practitioners to work with legislators to make needed changes. Nurse practitioners need to be equal members on the team.

**Florida Blue** fully supports its *longstanding position that ARNPs should be able to practice to the full scope of their training. Florida Blue has been one of the few insurance companies that have offered Provider ID numbers to ARNPs.* Specifically, Florida Blue supports the elimination of regulations that limit ARNPs from practicing to the full extent of their licenses, under the supervision of a physician, and reimbursement of ARNPs commensurate with their education and training. Expanding scope of practice is not a panacea for all healthcare funding issues as the cost savings are not always realized when physicians use their Provider ID numbers. Florida Blue noted that it was important to remember that not everything has to happen through lobbying. There are other discussions that should occur and good information is needed. Florida Blue believes the discussion should take place, but not necessarily in the Capitol Building. Florida needs to talk about how best to resolve real problems and create a policy-based solution.

**The Florida Nurses Association (FNA)** directed focus to what is best for the people of Florida. *FNA believes this issue is about access and standing up for the needs of patients. Expanding scope of practice is positive because it will better help patients.* All groups, including business, nurses, and others, need to speak with one voice to counteract the forces fighting this issue. The conversation needs to change from the turf-battle that it has been into something focused on doing what is best for the state. Everyone needs to work together. We need to continue to educate business. After trying for 20 years, it is time to get more partners.

# SPEAKERS

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## **Tamara Y. Demko, JD, MPH**

### **TaxWatch Center for Health & Aging Executive Director**

Tamara Y. Demko, JD, MPH, joins TaxWatch as Executive Director of the Florida TaxWatch Center for Health and Aging. Earlier in her career, Tamara practiced law for several years in the private sector focusing on white collar criminal defense and health litigation, primarily Medicare and Medicaid fraud and abuse investigations of pharmaceutical companies, medical device manufacturers, and health care providers. She is an active member of the Florida, Massachusetts, and District of Columbia Bars. She regularly appears as a law school guest speaker on the nexus of public health, politics, law, and medicine.

In 2007, after serving on the gubernatorial legal affairs transition team, she entered into government service as the Assistant Deputy Secretary for Health at the Florida Department of Health, working with nine public health divisions, overseeing the Office of Minority Health, and fulfilling the prior statutory role of Florida's Officer of Women's Health Strategy. By the end of 2008, she was serving as the Chief of Staff for the Agency for Persons with Disabilities, a billion dollar agency serving the needs of 49,000 Floridians. During this period, she also served concurrently as the Executive Director of the Governor's Task Force on Autism Spectrum Disorders. In addition, she has served as a senior health policy advisor during gubernatorial transitions and with the Executive Office of the Governor, and has lobbied on behalf of the State of Florida in various roles.

## **Eileen T. O'Grady PhD, RN, NP**

### **Peer-Reviewed Published Author, Professor, Wellness Coach**

Dr. O'Grady is a certified adult nurse practitioner and wellness coach and serves as Policy Editor for the *American Journal for Nurse Practitioners*. She writes a monthly column on health policy in Nurse Practitioner World News. She is currently an adjunct professor at Pace University in Manhattan and Georgetown University where she teaches doctoral students health policy.

She has authored numerous articles and book chapters on advanced practice nursing and health policy. She has an active public speaking calendar in which she creates a compelling case for advanced practice nurses to influence health policymaking as a core function of their role, to develop a greater degree of political competency and to more forcefully engage in the health policymaking process.

## **Anna G. Small, CNM, JD**

### **Vice President, Florida Nurses Association**

Anna Small joined Allen Dell after serving as Assistant General Counsel and then General Counsel to one of the nation's largest long term care management companies. Anna's area of legal expertise includes regulation of health care facilities by the Centers for Medicare and Medicaid Services and the Florida Agency for Health Care Administration. In addition, Anna is well versed in state and federal health care compliance, health care licensing and permitting, Zone Program Integrity Contractor (ZPIC) audits, state attorney general investigations, Medicare and Medicaid fraud investigations including overpayment issues and large scale discovery.

Anna also represents individual health care providers in disciplinary actions, medical staff issues, permitting, and transactions. Prior to becoming a lawyer, Anna practiced as a Certified Nurse Midwife; her experience as a health care provider lends her current legal practice additional depth. Her primary clients are long term care facilities, assisted living facilities, home health agencies, as well as a variety of other healthcare facilities and providers.

After obtaining a B.A. in Anthropology from Swarthmore College, Anna attended Columbia University School of Nursing where she graduated with a BSN (1996) and then an MSN (1997). After practicing for five years as a Certified Nurse Midwife and delivering approximately 1,500 babies, Anna attended law school and graduated from Florida State University College of Law in 2005. She is a member of the bar in Florida and Georgia and is also admitted to practice in the United States District Court, Northern District of Florida and the United States Court of Appeals, 11th Circuit. Most of Anna's practice is in the administrative courts including the Departmental Appeals Board of the Department of Health and Human Services and the Florida Division of Administrative Hearings.

A frequent public speaker, Anna also serves as Vice President of the Florida Nurses Association. She is a member of the American College of Nurse Midwives, American Association of Nurse Attorneys, and American Health Lawyers Association. Anna enjoys international travel, speaks several languages and maintains an interest in public service.

In 2011, she taught Maternal Newborn Nursing to undergraduates at Faculté des Sciences Infirmières de l'Université Episcopale d'Haïti in Léogâne, Haiti.

### **Sandra F. Ryan, MSN, CPNP, FCPP, FAANP Chief Nurse Practitioner Officer, Take Care Health Systems, Walgreens**

One of six founding officers at Take Care Health Systems, Ryan was the first chief nurse practitioner officer in the convenient care industry. She currently leads nearly 1,300 board certified nurse practitioners and physician assistants who practice at Take Care Clinics – walk-in clinics located at 360 Walgreens drugstores in 19 states that provide access to high-quality, convenient and affordable health care services. Ryan oversees clinical and operational leadership for the business while working closely with Walgreens chief medical officer in such areas of clinical governance, research and quality initiatives. Ryan has played an integral role in the development and implementation of integrated technology, quality assurance programs and evidenced-based guidelines to create a consistent and unprecedented patient-focused experience for those who seek treatment at Take Care Clinics.

Ryan serves as chair of the Clinical Advisory Board of the Convenient Care Association (CCA), the industry's trade organization, where she was instrumental in developing the CCA's Quality and Safety Standards and implementing a third-party certification process for these standards. To address the educational needs of nurse practitioners in the convenient care industry, Ryan helped to orchestrate the first ever Retail Clinician Education Congress, fostering camaraderie, enhancing education and support within the NP community for the emerging model of health care. Ryan has over 25 years of health care and leadership experience in various clinical, management and leadership settings. She is a highly decorated Air Force Officer and is a nationally certified nurse practitioner. Ryan's experiences as an Air Force nurse corps officer include working as a clinician, charge nurse and director of ambulatory services in inpatient and outpatient settings. She currently is Chief Nurse Practitioner for Take Care Health Systems, Walgreens. Ryan has been recognized for her leadership as the recipient of the Nancy Sharp Cutting Edge Award by the American College of Nurse Practitioners; as the first NP inducted as a Fellow of the Philadelphia College of Physicians; and the CARE Leadership Award for her contributions to NP practice in the Convenient Care industry. Ryan earned a B.S.N. in Nursing from Niagara University, and an M.S.N. from Arizona State University. She is a Fellow of the American Academy of Nurse Practitioners and a 2011 Robert Wood Johnson Executive Nurse Fellow.

# PANELISTS

## Tom Feeney

### President/CEO, Associated Industries of Florida

A seasoned lawmaker who has served at both the state and federal levels, Tom Feeney represented the 24th Congressional District of Florida from 2002 to 2008. During his time in Congress, Feeney was the Ranking Member of the U.S. House of Representatives Space and Aviation Subcommittees, and Deputy Ranking Member of the U.S. House of Representatives Intellectual Property Subcommittee. His service on the U.S. House Financial Services Committee earned him experience in banking, insurance, monetary and fiscal policy, corporate governance, and a wide variety of financial issues. Additionally, he served on the U.S. House Judiciary Committee, leading on Intellectual Property and Anti-Trust issues.



Tom was elected to the Florida House of Representatives where he served two terms before being chosen as Governor Bush's running mate in his first race for governor in 1994. He returned to the State Legislature in 1995 and, in 2000, was elected Speaker of the Florida House. He continued his service in the Florida House until his election to Congress in 2002. He holds a B.A. in Political Science from Penn State University and obtained his law degree from the University of Pittsburgh.

## Phillis Oeters

### Corporate VP, Government & Community Relations Baptist Health South Florida

Phillis Oeters is the Corporate Vice President of Government and Community Relations for Baptist Health South Florida, the largest not-for-profit multi-hospital health care system in the region. In this role, she is responsible for strategic planning of government and community relations, developing a state and federal legislative agenda to include issues of health care funding, insurance regulation and general health policy development, as well as family and work life issues. In addition, she is responsible for the interface with local government as it relates to permitting, zoning and general expansion plans for Baptist Health.



Currently, Phillis serves on many community boards, including, the Greater Miami Chamber of Commerce (Vice Chairman), Beacon Council, United Way, Coral Gables Community Foundation, Nat Moore Foundation and Orange Bowl. She is also Chairman of the Board of the Neurologically Injured Compensation Fund for the State of Florida, a billion dollar fund responsible for caring for children injured at birth. Phillis is a graduate of James Madison University and received her Master's Degree in Social Work from Barry University.

## Mary Lou Brunell, MSN, RN

### Executive Director, Florida Center for Nursing Co-Lead, Florida Action Coalition

Mary Lou Brunell was appointed to the position of Executive Director for the Florida Center for Nursing November 2002. Mrs. Brunell completed her graduate work at the University of Pennsylvania. She has worked as a critical care nurse, administrator, and educator prior to her current commitment to nurse workforce and health policy issues. Mrs. Brunell's professional activities are extensive including two terms as President of the Florida Nurses Association. She serves on the Board of Directors for Workforce Florida, Incorporated. Additionally, Mrs. Brunell is a member of the Florida



Chamber Foundation's Talent Supply and Education Caucus. Mrs. Brunell is an appointee to the National Advisory Council for Nurse Education and Practice. In partnership with the Blue Cross and Blue Shield of Florida Foundation, Mrs. Brunell co-leads the Florida Action Coalition, convened to advance the Future of Nursing: Campaign for Action, a collaboration created by the Robert Wood Johnson Foundation and the AARP Foundation.

### **Lori Schirle, CRNA, MSN**

#### **Past President, Florida Association of Nurse Anesthetists Co-Lead Practice Committee, IOM Future of Nursing Campaign for Action**

Lori has been a nurse for 28 years, 10 years of this time as a certified registered nurse anesthetist. She has been an active member of the Florida Association of Nurse Anesthetists for 10 years, serving as the Federal Political Director for 3 years, and also as Past President. In addition, Lori serves on the Steering Committee of the Florida Action Coalition as part of the Institute of Medicines' Future of Nursing Campaign for Action, and has recently assumed the nursing co-lead role of their Practice Committee.



### **Stan Whittaker, MSN NP-C**

#### **Board Chair, Florida Association of Nurse Practitioners**

Stan started his career as an EMT-Paramedic. He worked for 13 years in that capacity before becoming a critical care respiratory therapist. In 1990 Stan graduated with his Bachelors in Nursing and obtained his RN license and began work as an RN in the ER of a remote Alaskan hospital. While working in the ER he attended Gonzaga University and studied for his Masters in Nursing as a Family Nurse Practitioner, graduating in 1999. After passing his national certification exams, he began working in the same ER as a nurse practitioner.



He moved back to Florida in 2004 to care for his aging parents and was shocked to find out that he could not practice without a protocol agreement with a physician and could not use his DEA license. Stan has been an active participant in the Florida Coalition of Advanced Practice Nurses since 2006. In 2007, he helped in the production of the educational video: "Florida's Health Care Crises: The Advanced Practice Nurse Solution." In 2010, he co-founded the Florida Association of Nurse Practitioners and was elected as Board Chair. He continues to hold that position today. Stan visits Tallahassee frequently, meeting with legislators to educate them on nurse practitioner issues and patient access to health care. His efforts led to a change in the statutes governing the proposed Medicaid waiver by recognizing in statute that NPs may be primary care providers. He frequently attends meetings at the Agency for Health Care Administration and has made hundreds of suggestion to change rules that pose as barriers to nurse practitioner practice. His work at AHCA led to an appointment on the Medical Care Advisory Board. This is the first time an NP has been appointed to this federally-mandated state board.

### **David A. Pizzi, RN, MPA**

#### **Director, Political and External Relations, Florida Blue**

David is responsible for coordinating and executing political influencing and public policy strategies on federal, state and local health care issues. David works with legislators and legislative staffs, trade association and business coalitions, special interest representatives, health care advocacy groups and political party leaders. He has held roles at Florida Blue as the



Director of Health Policy, Director of Health Care Reform and Senior Policy Analyst, and has been with the company for over 11 years.

David represents Florida Blue on the Florida KidCare Coordinating Council, and is a board member of the Florida Justice Reform Institute and the Florida Chamber Alliance CCE. He is also a board member, treasurer and policy committee chair of Florida CHAIN, the state's largest consumer advocacy organization. David is an active member of the Florida Chamber of Commerce's Political Institute and Associated Industries of Florida's Political Council, and is a member of the Florida Association of Professional Lobbyists, achieving Designated Professional Lobbyist (DPL) status. David is also an active public speaker, having presented at over 50 national health policy conferences numerous other venues.

Prior to joining Florida Blue, he was a health policy researcher with the Health Services Policy Research Institute. David is also registered nurse who has worked in pre-hospital emergency, critical care, specialty care and home health care settings in provider and administration roles, and was a field clinical Nursing instructor for the University of Delaware's College of Health Sciences. David holds a Master of Public Administration degree with dual specializations in Health Care Policy and Management and a Bachelor of Science degree from the University of Delaware, and an Associate of Science degree in Nursing from Delaware Tech.

## SPEAKER PRESENTATIONS

# TAMARA DEMKO PRESENTATION

## Summit Overview & Overview of the Issue

Tamara Y. Demko, JD, MPH  
Florida TaxWatch Center for Health & Aging  
Executive Director

Center for  
**HEALTH & AGING**  
FLORIDA TAXWATCH

**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Summit Goals

- Bring stakeholders together to share lessons
- Further discussion on ARNP scope of practice policy development
- Identify and break down barriers
- Collaborate for a healthier Florida

Center for  
**HEALTH & AGING**  
FLORIDA TAXWATCH

**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Overview of the Issue in FL

- FL currently restricts ARNPs from practicing to the full extent of their training
- Many other states authorize ARNPs to perform general medicine duties within training
- One of 2 states not permitting ARNPs to prescribe controlled substances (rules apply)
- 17 states allow ARNP practices without MDs

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**HEALTH & AGING**  
FLORIDA TAXWATCH

**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Access to Care

- General shortage of primary care physicians as monetary incentives favor specialists
- More than 80% ARNPs work in primary care
- Lower cost of primary care with ARNPs

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**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Quality of Care

- Is ARNP care equivalent to physician care?
- Time spent with PT during routine exams
- Primary care referrals to specialists
- Patient perception of quality
- Special needs populations – aging, individuals with disabilities

Center for  
**HEALTH & AGING**  
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**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Business Practice

- ARNPs in retail clinics
- Consideration of cost savings
- Consideration of signature authority and supervising physician liability issues
- Reverse consideration of signature authority and PT health liability issues (increased personal and business costs to lack of timely care)

Center for  
**HEALTH & AGING**  
FLORIDA TAXWATCH

**ARNP Scope of Practice Summit**  
Feb. 11, 2013 Tallahassee, FL



## Policy & Legislation

- Previous attempts to expand current ARNP scope of practice in Florida have not succeeded
- Disagreement and/or misperceptions over what practicing “to the full extent of training” really means Is there any common ground?

## Affordable Care Act

- The Patient Protection and Affordable Care Act will add millions more insured PTs to Florida’s health care system
- Increased need for access to primary care

## IOM Recommendations - 2010

*RWJF/IOM Initiative on the Future of Nursing*

1. Nurses should practice to the “full extent of their education and training”
2. Nurses should “achieve higher levels of education and training through an improved education system that promotes seamless academic progression”

3. Nurses should be “full partners, with physicians and other health professions, in redesigning health care”
4. “Effective workforce planning and policy making require better data collection and an improved information infrastructure”

## Concerns Raised

- Number of hours of practical training (differences between ARNPs and physicians)
- Training different for a reason/degrees not same
- Slippery slope of policy development
- PCPs pay is already low, ARNPs would divert more money away, more PCPs leave practice
- Double billing of ARNP and physician oversight may increase costs

## Barriers of Different Forms

- State regulatory environments vary
- Fragmentation of the health care system
- Aging workforce/institutional and practice knowledge
- Transitional period from education to practice
- Historical notes – Perceptions of nurse role versus physician role

## Policy Analysis – Multi Lens Paradigm

- Lifespan – benefits/challenges to various age groups
- Diversity - benefits/challenges to individuals and groups across race, ethnicity, socioeconomic status, religion, health care sector, etc.

- Multilevel – upstream and downstream impact at community, county, state, national levels: What ripples are created?
- 360 Degree – What have we not considered before? Does the policy impact a group indirectly? What incentive structures are created?

## Stakeholder Perspectives

- What lessons have been learned in your industry practice?
- Where are the most likely areas for collaboration due to greater consensus?
- How would expanding ARNP scope of practice impact your industry? (Finances, reputation, client mix, reimbursement)

## Summit Overview

Topic/Event	Speaker(s)	Start Time
Presentation 2: Increasing Access - Lessons from Rural Care	Ellen T. O'Grady, PhD, ANP-BC Peer-Reviewed, Published Author, Professor, Wellness Coach	2:50 PM
Question and Answer Period		
Intermission		3:30 PM
Presentation 3: Quality of Care provided by ARNPs - Lessons from the Front Line	Anna G. Small, CNM, JD Vice President, Florida Nurses Association	3:40 PM
Question and Answer Period		
Presentation 4: Cost-effectiveness of ARNPs - Lessons from Business Practice	Sandra F. Ryan, MSN, CPNP, FCPNP, FAANP Chief Nurse-Practitioner Officer, Wake Care Health Systems, Walgreens	4:00 PM
Question and Answer Period		
Intermission		4:40 PM
Stakeholder Panel - Breaking Down Barriers for a Healthier Florida	Associated Industries of Florida, Baptist Health South Florida, Florida Action Coalition, Florida Association of Nurse Anesthetists, Florida Association of Nurse Practitioners, Florida Blue, Florida Nurses Association	4:50 PM
Question and Answer Period		
Concluding Remarks		5:50 PM

## Stakeholder Panel Overview

- Purpose – To identify and break down barriers for a healthier Florida
- Participation – Questions from audience
- Please & Passion – Please use courtesy when expressing passionate opinions.
- Practice Takeaways - Can stakeholders “get to yes” on ARNP scope of practice issues? All or some? Baby steps best?

## Stakeholder Panel Process

Panel Element	Description
Introductions	Brief personal background introductions by each panelist
Perspectives	Panelists individually state their organization's position on scope of practice issues and rationale. Note that no questions will be accepted from the audience at this time.
Barriers & Collaborative Action	Panelists will be asked opinions on: 1) What is the greatest substantive barrier that scope of practice expansion faces? (Looking for something actionable without finger-pointing, so to speak.) 2) Can there be agreement on any scope of practice aspects during this legislative session? 3) What is needed to move forward?
Q&A – Audience	Question and answer period for audience

# DR. EILEEN O'GRADY PRESENTATION

## Increasing Access to Nurse Practitioners



Eileen T. O'Grady PhD, RN, NP  
Certified Nurse Practitioner

Policy Editor, *American Journal for Nurse Practitioners*



Florence  
**Nightingale**  
1820-1910

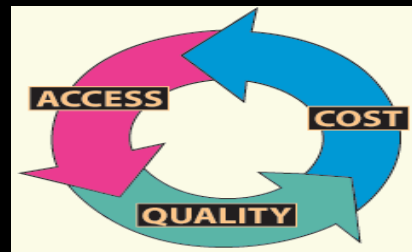
Nursing  
Pioneer, Writer,  
Statistician

## Access and Nurse Practitioners

- Access to care linked to NP roots
    - NP role developed as a policy response to access problems in rural Colorado, 1965.
- "Florida has 4 million adults who are obese, immunization coverage for kids is dropping and 20% of Floridians are uninsured."



## Health Policy Triad

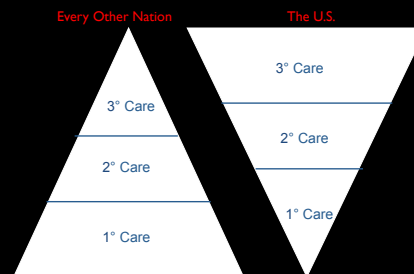


## Many forms of Access to Care

*"The timely use of personal health services to achieve the best health outcomes" ( IOM, 1993)*

- Requires 3 distinct steps:
  1. Gaining entry into the system
  2. Getting access to sites of care
  3. Finding providers who meet the needs of individuals and develop long term relationships. ( health Care Home)
- Having a health care home makes enormous difference in stage of illness that care is sought.
- Availability of health insurance- Only the first STEP
  - Financial
    - Ability to pay for care (including co-pays)
  - Geographic
  - Health Literacy (1/3 of population)

Every other nation starts at the base of the pyramid with primary care and work their way up until the money runs out.



## Without Access there is NO Quality

Efforts to improve access always improve quality

Any care is better than no care

Early care is better than delayed care

The Institute of Medicine (1996). *Primary Care: America's Health In a New Era*. National Academy Press: Author.

## Emerging Roles of States

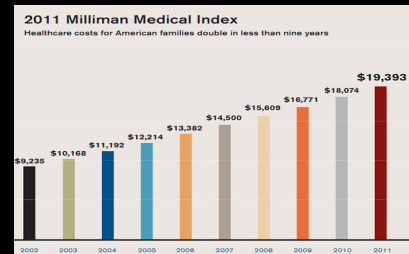
- Nothing in the constitution about regulating health professionals
  - Piecemeal, ad hoc approach
- Uncompensated care burden lands on states
- Taking on health workforce planning
- Access solutions

## Disturbing Health Trends



- 44% ages 19-64 are uninsured during a year
- Ethnic and racial disparities
  - 2x incidence of diabetes
  - leg amputations 4x higher in blacks
  - 24% higher incidence of cancer
- \$8,042 per capita for health insurance ([www.kff.org](http://www.kff.org))
- Health care spending (including premiums) for family(4): \$18,000
- \$23,500: Federal Poverty level 2012

## US Health Care Costs per Family more than Doubles in 9 years



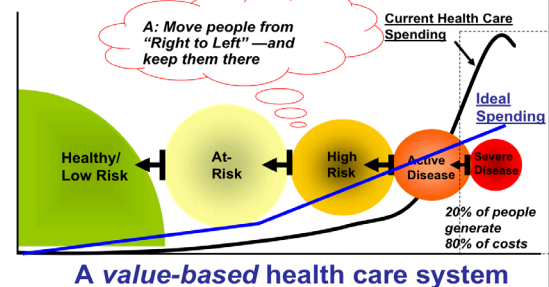
Milliman Actuarial Index 2011, [insight.milliman.com/index.php](http://insight.milliman.com/index.php)

## Why Primary Care?

- Encompasses the broad range of services
  - initial evaluation, new symptoms, chronic care, prevention.
- Associated with lower mortality, reduced ER use/hospitalizations
- Gateway to appropriate care delivery.
- Decades of research demonstrates unequivocally:
  - primary care reduces costs and improves quality
- 1/5 sick people visit the ER for “primary care”
- Estimated that 50% of ER visits could be avoided if people had access to primary care when they needed it.

Starfield, B., Shi, L. & Mecino, J. (2005). *Contributions of Primary Health Care to Health Systems and Health*. *The Milbank Quarterly*—Vol. 83, No. 3, (pp. 457–502) Milbank Memorial Fund.

## What should a “value based” Health Care Delivery System Do?

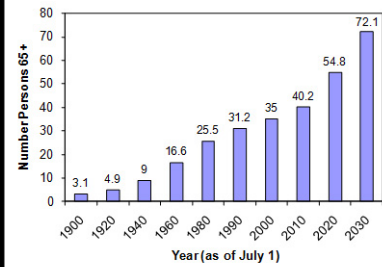


## Surge in Demand

- Silver Tsunami
- Newly insured are higher users
- Aging, sicker rural populations
- Uptick in chronic illness overwhelming system
  - Chronic Care needs fundamentally different than acute care.



Figure 1: Number of Persons 65+, 1900 - 2030 (numbers in millions)



## Ebb of Supply

- Reduced interest (7%) in primary care among new medical graduates
  - Payment schemes value specialty care
  - MDs may feel over-qualified
  - Lag time to incentivize MDs into primary care may take “decades”
- 2013 US will be short 16,000 primary care MDs

*Bodenheimer, T. & Hoangmai H (2010). Primary Care: Current Problems and Proposed Solutions. Health Affairs 29, no. 5: 799-8*

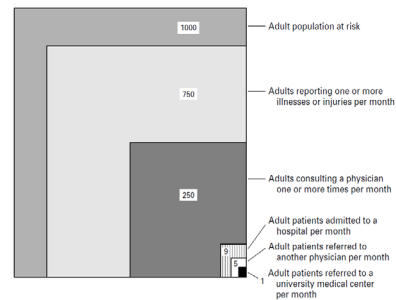


Figure 1. Monthly Prevalence Estimates of illness in the Community and the Roles of Physicians, Hospitals, and University Medical Centers in the Provision of Medical Care. Data are for persons 16 years of age and older. Reprinted from the 1961 report by White et al.

## Barriers to Health Care

Regardless of the specific access barrier, an access problem is always a delay problem

- 33% of people report inability to obtain a timely appointment
- 40% of ER visits are not urgent

*CDC (2012). Emergency Room Use Among Adults Aged 18-64: Early Release of Estimates From the National Health Interview Survey, January-June 2011. [http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency\\_room\\_use\\_january-june\\_2011.pdf](http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf)*

## Primary Care Sensitive Conditions Drive Costly Hospitalizations/ER visits

- Low birth weight
- Heart failure
- Hypertension, uncontrolled
- Adult and pediatric asthma attacks
- Diabetes
  - Amputation from diabetes



## Lessons from Massachusetts

- Health insurance access created surge in demand.
- Realized NPs were underutilized, despite being qualified.
- Modernized their practice act to make greater use of NPs, expand convenient care, etc.



## Health Professional Shortage Areas

- 55 million residents live in primary care HPSAs
- NPs represent 20% of the primary care workforce
- 6,000 HPSAs nationwide
  - Florida:
    - 248
    - 4 million people
    - 22% of the population living in HPSA
    - 753 providers needed to remove HPSA designation
    - 1,300 needed to meet 1:2000 ratio
- 10% increase in Primary Care MDs showed a 7% drop in Medicare spending

<http://www.statehealthfacts.org/profileind.jsp?rep=112&cat=8&rgn=11>

## Unique Aspects of Rural Health Care

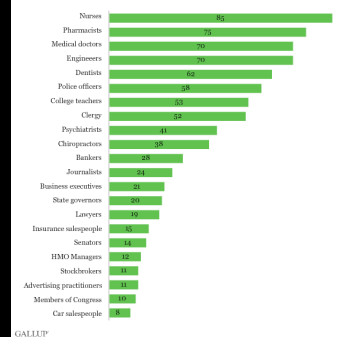
- Requires long-term dedication to the community
- Remote rural residents are older and poorer
  - Heart disease, diabetes, asthma, hypertension, mental health issues
  - Have worse health outcomes
  - Rural residents less likely to be offered health benefits by employer (59% vs. 70% urban)
- Remote rural dwellers are more likely to be uninsured

The Center for Rural Affairs, 2012 [www.cfra.org/](http://www.cfra.org/)

Please tell me how you would rate the honesty and ethical standards of people in these different fields – very high, high, average, low or very low?

Nov. 26-30, 2012

■ % Very high/High



## National Governors Association Report: *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care (2013)*

What would be the effects of changes to current state scope of practice laws on health care access?



## NGA findings:

- “Easing current scope of practice restrictions and reimbursement policies will encourage and incentivize greater NP involvement in primary care.
- None of the studies in the NGA literature review raise concerns about the quality of care offered by NPs.
- Expanded utilization of NPs has the potential to increase access to health care, particularly in historically underserved areas.”

## Nurse Practitioners and Primary Care

- Most important to have a usual source of care
- Patients report having higher levels of satisfaction with NPs
- Patient-centered, emphasis on care coordination, counseling, prevention.
- NPs order fewer tests and procedures
- NP workforce more nimble, fill the growing shortage more quickly (6 vs. 12 years)
- Less educational debt
- In states with full NP Scope of practice, no higher:
  - malpractice rates
  - medication diversion
  - safety violations
- No patient safety crisis in Arizona

## Center to Champion Nurses at AARP A Review of Southern U.S. Practice Laws

***“ we are over-regulating a highly skilled workforce that costs taxpayers money, limits consumer access and choice, and places undue time restraints on professional nurses and physicians”***

- Restrictions on APN practice threaten consumers' access to affordable quality care.
  - Access that enhances quality of life
  - Keep employees in the workplace
  - Restrictions result in poorer health outcomes
  - Cost taxpayers and employers

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/01/access-to-care-and-advanced-practice-nurses.html>

## The Human Story

- Child with fracture with uncontrollable pain is taken by ambulance to the ER Mariana County.
- Psychiatric NP had full prescribing authority in the Army, can't practice on return to Melbourne
- Patient in Pinellas County with toothache goes to ER to get pain relief.
- Hardee County patient sees an NP for migraines and diabetes but can't get treatment for debilitating anxiety disorder.

## Modernizing Nurse Practice Acts will not solve all the problems

- NPs are more willing to relocate to rural underserved areas where MDs are unwilling to live and practice.\*
- NPs are expert at health promotion, chronic disease management
- Removing barriers that have no evidence-base or rationale will increase opportunities for innovation
- Professional turf battles:
  - Are not in the public interest
  - Do not protect patient safety
  - Do not promote consumer choice.
- Glen Steele, MD, CEO Geisinger Health System:

*“ I need all professionals practicing at the top of their licenses”*

\*DHHS, HRSA Office of Shortage Designation

## Concerns from MDs

2012 Analysis

***“There was no variation on MD earnings between states that have expanded SOP and states that have not”***

Pittman, P. & Williams, B. (2012). *Physician Wages in States with Expanded APRN Scope of Practice*. *Nursing Practice and Research*. Article ID 671974, 5 pages.  
<http://www.hindawi.com/journals/nrp/2012/671974/cta/>

## NP barriers impede the effectiveness of NPs delivering rural health care

- Thwarts innovation
  - Home delivered primary care
  - Transition care
- Lack of opportunity to contract with insurers
- Legal linkages to MDs
- Lack of authority to:
  - diagnose
  - prescribe
- order services
  - physical therapy
  - home care
  - mammography



## Unleashing the Nation's Nurse Practitioners

- Considerable segment of the workforce is under-utilized
- Wide variation across state practice acts suggest a lack of evidence
- A new regulatory model for NPs provide a strong framework for states

O'Grady, ET, Hanson, CM, Lugo, NR & Hodnicki, D. (2010). Unleashing the Nation's Nurse Practitioners, The Journal of Rural Health, Vol 28(1): 1-3.

Pohl, J, Hanson, C., Newland, J & Cronenwett, L. (2010). Unleashing Nurse Practitioners: Potential to Deliver Primary Care and Lead Teams, Health Affairs 29 (5): 900-5.

## The National Standards from the Nursing Profession

- L.A.C.E.
  - Consistent NP Licensure standards across states
- Accreditation of NP programs
- Certify all NPs
- Education standardized
- Arizona and Wyoming State Nurse Practice Acts
- Allows the rapidly growing NP workforce to be fully and safely utilized

## Why I can't tell you more on rural NPs

- Adequate data on NPs is not available
  - Myriad of licensing configurations
  - Many NPs have multiple state licenses
- The identification of practice location is not available
- It is currently impossible to identify with certainty, the providers of service to underserved populations
  - often tagged with MD
- 24 states have interstate RN compact

## The US Primary Care Workforce (2010)

Primary Care Workforce	Estimated Number
Nurse practitioners	155,000
Physicians Assistants	84,000
Family Medicine Physicians	88,000
General Internist Physicians	94,000
Pediatricians	50,000
Geriatric Physicians	3,000
<b>TOTAL</b>	<b>483,000</b>

Agency for Healthcare Research and Quality Primary Care. (2011). Workforce facts and stats no. 1. The number of practicing primary care physicians in the United States.

## Graduates of Masters NP Programs 2011-2012

Clinical Track	Graduates
Family NP	6,550
Adult NP	1,600
Pediatric NP	1,000
Geriatric NP	125
Women's Health	400
<b>Total Primary Care NP graduates</b>	<b>9,700</b> (6,000 in 2004)

American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties. (2012). Annual survey. Washington, DC: Authors.

## NP Growth Estimates

- Expected to double by 2025 (245,000)
- NPs are expected to fulfill a substantial amount of future demand for primary care.
- Bureau of Labor Statistics cites NPs as one of the highest demand professions
  - due to MD shortages in rural areas

Auerbach, D. (2012). Will the NP workforce grow in the future? *Medical Care*, 50(7): 606-10. Bureau of Labor Statistics (2012) Bureau of Labor Statistics, May 2011/ <http://www.bls.gov/oes/current/oes291071.htm>.

## Likely Future

- APNs workforce will expand dramatically
  - Alleviate access problems
  - Bend the cost curve
  - More consumer choice
- May be difficult to recruit Advanced Practice Nurses in over-regulated states
- “Fee for Doing things” shifts to “Meaningful Patient care across the Care Continuum”



Modernizing Nurse Practice Acts is a wise mechanism for states that anticipate health care demand surges

Full Practice Authority  
Follow LACE Guidelines

# ANNA SMALL PRESENTATION

## Quality of Care Provided by ARNPs

Anna G. Small, C.N.M., J.D.  
Vice President of FNA  
asmall@allendell.com

**Question:** Is there a difference in the level of quality of care provided by ARNPs v. physicians?

**Answer:** There is no significant difference in outcomes by provider type. Research suggests that patient satisfaction is greater with nurse practitioner care.

## Comparison of Educational Levels

- What is the ARNP educational level?
  - ARNPs (NPs, CNMs, CRNAs) have bachelors degrees in nursing
  - Advanced degrees– Masters or higher
  - National Certification
  - Continuing education requirements for licensure and for maintenance of certification
  - Licensure requirements in Fla. Stat. §464.012

## Point by point comparison is not appropriate

- NPs have formal health care education and experience prior to entering graduate program
- NPs tailor their educational experience to a specific patient population
- NP education is competency based, not time based

## Quality of NP practice

- 1974: New England Journal of Medicine: “a nurse practitioner can provide first-contact primary care as safely and effectively as a family physician.”
  - sample of 2796 patients over a two year period
  - Randomized to one of 2 physicians or 1 NP
- Spitzer, W.O. et al. (1974) The Burlington randomized trial of the nurse practitioner. *New England Journal of Medicine*, 290(3), 252-256.

## Care provided has a holistic focus

- 1980: Review of 26 studies done determined NPs scored higher in many areas:
  - Discussion of preventative health, child health
  - Amount of advice
  - Completeness of history and physical
  - Completeness of physical exam
  - Resultant patient knowledge of the management plan
- Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner*, 1(1), 28-32.

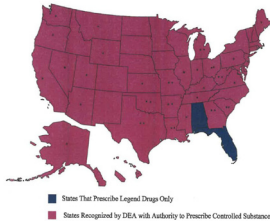
## U.S. Government Agrees

- The office of Technology Assessment determined:
- “NPs appear to have better communication, counseling, and interviewing skills than physicians.”
- Malpractice rates and premiums support patient satisfaction with NP care.
  - Office of Technology Assessment. (1986). *Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis*. Washington DC: US Government Printing Office.

## Recent studies confirm

- Article by a medical economist shows how goals of health care reform can be met with the use of NPs
  - Substitution of NPs reduces cost without diminishing quality
  - **Every** study reinforces OTA initial conclusions: NPs can be substituted for physicians in a significant portion of medical services
    - 25% in some specialties
    - 90% in primary care
  - Not a single study has found that NPs provide inferior services within the overlapping scopes of licensed practice
    - Bauer, JC Nurse Practitioners as an Underutilized Resource for Health Reform: Evidence-Based Demonstrations of Cost – Effectiveness. *J Am Acad Nurse Pract.* 2010; 22:228-231.

### NURSE PRACTITIONER PRESCRIPTIVE AUTHORITY





Are 48 other states wrong?

## Q&A

Anna G. Small  
asmall@allendell.com

# SANDY RYAN PRESENTATION

Nurse Practitioners Part of the Solution to Improving Healthcare

Sandra Ryan, Chief NP Officer and Clinical Advocate Take Care Health Systems

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### Agenda

- Walgreens and Convenient Care Industry/Retail Clinics
- Role of Convenient Care and the NP in the Retail Clinic
- Florida Facts
- Future Role of the Nurse Practitioners in Healthcare



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### Walgreens Mission and Vision

**MISSION**  
To be the most trusted, convenient multichannel provider/advisor of innovative pharmacy, health and wellness solutions, and consumer goods and services in communities across America...  
A destination where health and happiness come together to help people get well, stay well, and live well.


**VISION**  
To be "My Walgreens" for everyone in America, the first choice for health and daily living


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### The Problem-A Broken Healthcare System





Primary Care — Will It Survive?  
*Thomas Bodenheimer, M.D.*



**"Family Medicine cannot fully succeed, nor will the needs of the public be met, without fundamental changes in the U.S. health care system."**

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### Decreased Provider Supply

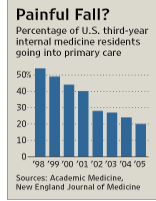
*The US healthcare system is fundamentally broken -- Mike Leavitt, Health and Human Services Secretary, November 2007*

**"Doctor Shortage Hurts A Coverage-for-All Plan"**

"They will be seeking care in a state with a 'critical shortage' of primary-care physicians, according to a study by the Massachusetts Medical Society released yesterday [November 14, 2007], which found that 49% of internists aren't accepting new patients. Boston's top three teaching hospitals say that 95% of their 270 doctors in general practice have halted enrollment."




**Painful Fall?**  
Percentage of U.S. third-year internal medicine residents going into primary care



Sources: Academic Medicine, New England Journal of Medicine

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### Difficulty with Access to Care

**"Where to Turn for Immediate Care"**

**"A new survey found that 73 percent of people said they had difficulty getting access to their doctor when they needed to. Thirty percent reported that it was hard to get a next-day appointment when they were sick; twice that number said it was difficult to get care on weekends or in the evening from their regular doctor. More than 40 percent of respondents said that, even during regular business hours, they had trouble getting advice from their doctor on the telephone. So they end up at the ER patients often shell out a copayment of \$100 or more for a visit that might cost them just \$20 elsewhere -- US News & World Report**

\*Commonwealth Fund Survey: Public Views on US Health System Organization: A Call for New Directions -- August 8, 2008 (Harris Interactive Survey of 1,004 People)

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## The Harsh Reality

- **50 million Americans** are uninsured, including 1 in every 8 children.
- **70% of Americans** report they can't get same-day appointments with their PCP.
- **29% of Medicare recipients** (11.6 million people) have a hard time finding a PCP who accepts their insurance.
- **30% of Americans** lack a regular source of primary care.
- **Almost half of all emergency room visits** were non-emergent in nature or otherwise treatable in primary care settings.

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## Industry Facts: over 1400 clinics in 35 states, 17+ Million cared for, over 5000 NP's



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## Industry Growth

- Growth in the number of clinics is anticipated in the coming years (Deloitte Center for Health Solutions, 2009).
- Scope of services is being expanded with an eye towards disease prevention and chronic disease monitoring.
- More hospitals and health systems now operate clinics than non-hospital companies, though the majority of individual clinics are still operated by non-hospital companies.
- Growth among hospitals is largely due to perceived benefits of the relationship in supplementing and extending existing care (RAND, 2010).

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## Take Care Clinics: Quality Family Healthcare, Made Easy

- Walk-Ins Welcome and Appointments Available**
- Open 7 Days a Week and Weeknights, Too**
- Most Insurance Accepted**
- Board-Certified Family Nurse Practitioners and Physician Assistants\***
- On-Site Pharmacy**
- Treatment for Patients 18 Months and Older**

\* Physician Assistants provide patient care in Nevada and Texas clinics

**Prevent**  
 Vaccines  
 Physicals  
 Screenings

**Treat**  
 Illnesses  
 Minor Injuries  
 Skin Conditions

**Manage**  
 High Blood Pressure  
 Injection and Infusion Services

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## Delivering a Patient Centric Experience

- **260+ square feet**
- **Two exam rooms, with exam tables**
- **Restroom facilities nearby**
- **Most clinics conveniently located across from the pharmacy**



- **Professionally outfitted with state-of-the-art technology and medical equipment**
- **Electronic sign-in kiosks/LCD**
- **Patient queue, with wait time visibility**
- **Electronic Health Records**

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## Well Experience: Transforming the Patient Experience



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## Growing Range of Services

### Prevent

Vaccines  
Physicals  
Screenings

**Examples**

- Flu shots
- Hepatitis A & B
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Tdap (Tetanus, Diphtheria, Pertussis)
- Varicella (Chicken Pox)
- Zostavax (Shingles)
- Physicals (camp and sport)
- Health screenings HRA's
- Medicare Wellness Exams

### Treat

Illnesses  
Minor injuries  
Skin Conditions

**Examples**

- Strep throat
- Sinus infection
- Bronchitis
- Ear infections
- Urinary tract infections
- Seasonal allergies
- Minor burns
- Sprains/strains
- Skin rashes
- Cold and mouth sores
- Tick/insect bites and stings
- Wart removal

### Manage

High Blood Pressure  
Injection Services

**Examples**

- High Blood Pressure Screening and Monitoring
- Specialty Injection Services

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## An Exceptional Patient Experience

### ACCESS

- Take Care Clinic locations in the Florida market will serve as a cost-effective alternative for overflow, after hours, and non-emergent needs
- All clinics are open 7 days a week, including weeknights - no appointment necessary

### TRANSPARENCY

- Wait time, patient satisfaction, and quality metric transparency via TakeCareHealth.com to guide patient choice
- Cash prices, as well as insurance plans accepted, available via in-clinic signage and website
  - Most insurance plans accepted, including Medicaid
  - Affordable costs for cash paying patients

### SIMPLICITY

- A simple, paperless check-in process and clear information about estimated wait times
- E-prescribing to allow access to patients' pharmacy of choice
- Online appointment scheduling available for both patients and <Health System> staff

### PATIENT SATISFACTION

- Take Care Clinic's patient satisfaction is in the top 10% of Gallup Consulting's consumer database
- Patients receive a follow-up phone call within 48 hours of their visit, except those receiving immunizations
- Trending of patient complaints reveals less than two complaints per 1,000 encounters

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## Clinical Excellence

### BEST-IN-CLASS PROCESSES

- Use of evidence-based frameworks and expert review of clinical policies
- Quality benchmarked against national standards, such as HEDIS
  - Clinic exceeds national HEDIS benchmarks in measured categories
- Chart review process, facilitated by EMR, includes both peer review and Collaborating Physician review

### WELL-TRAINED CLINICAL STAFF

- Clinicians credentialed in accordance with NCQA guidelines
- Enhanced certification and education of our clinicians

### EVIDENCE-BASED RESOURCES

- ADAM Encyclopedia (2011)
- DynaMed Online (2011)
- Epocrates Online Premium (2011)
- Clinical Guidelines in Clinical Practice, C. Uphold, M.V. Graham (2003)
- Sanford Guide to Antimicrobial Therapy (updated yearly)
- Griffith's Education to Patients (8<sup>th</sup> Edition, 2011)
- Skin Disease: Diagnosis and Treatments by T. Habif (2005)

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## Quality of Care at Take Care Clinic

Quality of care delivered in Take Care Clinic for treatment of pharyngitis, upper respiratory infections and bronchitis meets or exceeds the quality of care delivered in other settings\*\*

	Appropriate Testing for Children with Pharyngitis	Appropriate Treatment for Children with Upper Respiratory Infection	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
2010 National Benchmarks	86.0%	91.0%	37.0%
Take Care Clinic Avg. FY 2012*	98.2%	98.4%	75.5%

\*Take Care Clinic numbers reflect September 1, 2011 through June 30, 2012  
\*\*American Journal of Medical Quality, Jefferson School of Medical Quality, September 2010

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## Improving Access--An Alternative to the ED

By Robert M. Shorrock, Rachel M. Burns, and James W. Meyers

**Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics**

**13.7-27.1% of all ED visits could take place at alternative sites.**

**Potential \$4.4 billion in annual cost savings.**

ABSTRACT Americans seek a large amount of nonemergency care in emergency departments, where they often encounter long waits to be seen. Urgent care centers and retail clinics have emerged as alternatives to the emergency department for nonemergency care. We estimate that 13.7-27.1 percent of all emergency department visits could take place at one of these alternative sites, with a potential cost savings of approximately \$4.4 billion annually. The primary conditions that could be treated at these sites include minor acute illnesses, strains, and fractures. There is some evidence that patients can safely direct themselves to these alternative sites. However, more research is needed to ensure that care of equivalent quality is provided at urgent care centers and retail clinics compared to emergency departments.

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## Improving Access

- As many as 40% of clinic patients report not having a PCP (Mehrotra et al. 2011).
- Some hospital systems report their retail clinics are the largest entry point into their healthcare system. (Mehrotra et al. 2011)
- ~12 to 14% of all ED visits can be seen at convenient care clinics (Weinick et al. 2010; Mehrotra et al. 2008).
- 93% of patients report highly on the convenience (Wall Street Journal/Harris Interactive 2008).
- Nearly 30% of the U.S. population lives within a ten-minute drive of a clinic (Rudavsky et al. 2008).

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## Decreasing Costs

Retail clinics **reduced ER use and costs** for pediatric population, and **reduced admissions and outpatient costs** for patients with chronic illnesses (Parente n.d.)

**Costs of care at a convenient care clinic are significantly lower** than those at an urgent care center, primary care office, or emergency department (Mehrotra et al. 2009; Thygeson et al. 2008).

Blue Cross and Blue Shield of Minnesota eliminated co-pays for enrollees who used a clinic, citing **\$1.2 million in cost savings** (Minneapolis/St. Paul Business Journal 2008).

**After-hours Access of Convenient Care Clinics and Cost Savings** (Patwardhan, Davis, Murphy, Ryan) *Journal of Primary Care and Community Health*, 2012

- 44.6% of convenient care clinic visits occurred on weekdays, 5 pm or later, or on weekends. Savings from avoided encounters with the emergency room, urgent care, and primary care physician were estimated at **\$135.53 million**

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## Peer Reviewed Quality Outcomes

- Convenient care clinic providers adhere to evidence-based practice guidelines and exceed national benchmarks (Jacoby et al. 2010; Woodburn et al. 2007).

- Quality scores and rates of preventive care offered are similar for convenient care clinics as for other delivery settings (Mehrotra et al. 2009).

- 92.72% compliance with quality measure for appropriate testing of children with pharyngitis vs HEDIS average of 74.7%; they also had an 88.35% compliance score for appropriate testing of children with URI vs HEDIS average of 83.5%. (Jacoby et al. 2010)

- Quality of routine care in walk-in clinics is comparable to, if not better than, treatment in traditional physician practices, *National Center Policy Analysis Retail Clinics Convenient and Affordable Care* (Brief Analysis 686, Herrick, 2010)

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**Q: Do you know that there are 140,000 solutions to the Primary Care Shortage?**

**A: Yes, Nurse Practitioners**

Dear President Obama and Members of Congress:

Nurse Practitioners (NPs) have been providing primary care in the United States for nearly half a century. As leaders in primary health care, the 400,000 NPs stand ready to enhance the provision of primary care to patients across the nation. NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans – including prescribing medications. They provide primary acute and chronic care to patients of all ages and walks of life.

The 2010 Institute of Medicine report, *The Future of Nursing*, recommends utilizing the health care provider group to its fullest potential. Four decades of research have established that NPs provide high-quality, cost-effective, comprehensive, personalized patient-centered health care with excellent outcomes. In addition to diagnosing and managing acute and chronic illness, NPs

place a strong emphasis on health promotion and disease prevention. They are skilled clinicians who include teaching and counseling individuals, families and communities as major parts of their practice.

NPs practice autonomously and in coordination with health care professionals and patients to manage their health problems and needs. They serve as direct care providers, health care researchers, interdisciplinary consultants and patient educators.

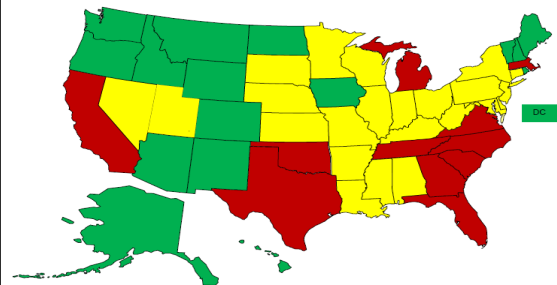
The American Academy of Nurse Practitioners (AANP) and the undersigned organizations, on behalf of the 140,000 NPs licensed to practice in the United States, offer our extensive resources to you as you continue your important work to establish a reasonable health care agenda for our nation.

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AANP | American Association of NURSE PRACTITIONERS

## 2013 Nurse Practitioner State Practice Environment



## Nurse Practitioner State Practice Environment

- **Full Practice**
  - 16 states and the District of Columbia allow NP's to practice completely independently-under the exclusive licensure authority of the state board of nursing. This is the model recommended by the IOM and the National Council of State Boards of Nursing
- **Reduced Practice**
  - State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. Requires a regulated collaborative agreement.
- **Restricted Practice**
  - State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. Supervision and delegation of team management by an outside health discipline—Florida

State Nurse Practice Acts, AANP, 2013

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## Florida Facts

- **A physician who practices primary health care may only oversee four (4) offices in addition to the physician's primary office.**
  - The limit on the number of clinics that the physician can oversee hinders the ARNP's ability to be flexible and cover all clinics within a given market. Most states do not have a limit on the number of sites a physician can oversee, in addition to not limiting the number of NP's or full time equivalents a physician can oversee. Most states permit the physician to exercise his/her judgment with regard to geographic proximity and advise to not oversee an excessive number of NPs that would affect the quality of the collaborative relationships
- **FL Requirement that the "Written Protocol"** (Collaborative Practice Agreement or "CPA") be filed with the state in original ink signed form. This is a departure from most other states. Most states require that the agreement be available for inspection, and are not required to be filed with the Boards directly.

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## Florida Facts

- **The CPA filing requirements are such that if any changes are made to the agreement, an entirely new original agreement must be filed with the Board.**

– This is labor intensive from a business perspective in changing service offerings or opening new clinics. It is magnified exponentially since TCH ARNPs have a CPA with every physician (average of 3 physicians) in their market to ensure that they are able cover all locations in a given market).

- **ARNPs do not apply for prescriptive privileges.** Writing of the protocols and approval of the collaborative practice physician grants ARNPs' prescriptive privileges. Most other states have prescriptive privileges granted through separate licensure, or have a separate process with the NP notifying the Board of Nursing of any changes in Collaborating Physician delegating the prescriptive authority to the NP. Florida does not permit ARNPs to prescribe controlled substances.

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## Florida Facts—Clinic Licensure

- **Licensure requirements in Florida are onerous and expensive**

– Additional licenses necessary in the State of Florida that are not required for most other states. **Health Care Clinic License** - \$2000.00 bi-annual fee per clinic and each clinic is required to have an onsite survey prior to launch and upon bi-annual renewal. Regulated by the Agency for Health Care Administration (AHCA).

– Each site must have a "Clinic Director" who is required to conduct chart reviews on a monthly basis. Clinic Directors may only oversee a maximum of 5 sites so we have to go beyond the Market Managers and recruit other colleagues (typically, the Clinic Co-coordinator) to complete this requirement with time/travel costs being incurred. .

– **Health Care Clinic Establishment Permit** - \$255.00 biannual fee per clinic. Required to order vaccines. Florida is the only state that requires this permit.

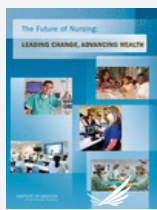
– **Waste Generator Permits** are required in Florida (\$85.00 per clinic annually, though some of our sites are fee exempt due to low volume).

– **Level 2 Background Screenings—Florida is the only state that requires**

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## Leveraging the NP as a Powerful Resource



INSTITUTE OF MEDICINE  
OF THE NATIONAL ACADEMIES

### Future of Nursing IOM

- **Nurse practitioners should practice to the full extent of their education and training.**

### 2012 Gallup Integrity Ratings

- **Since 1976 Gallup has been surveying Americans to rank professionals based on honesty and ethical standards. The nursing profession was added to the poll in 1999 and has ranked the highest in 13 out of 14 annual surveys. The only exception came in 2001 when firefighters ranked higher following the events of 9/11**

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## Current Legislative Environment: What it means to the Patient and role of NP's

- **Need for increased access: 30 +million more insured lives**

– Innovative models to address Physician shortage

- More Nurse-Managed Healthcare Centers

- Innovative models with all electronic, interoperable processes

- **NPs are positioned to educate and implement wellness and preventive medicine – holistic care**

- **Quality: Accountable Care organizations (ACO's)**

– Rewards provider-led organizations that take responsibility for the costs and quality of care received by their patients over time.

– Will see increased partnering between health groups, including collaboration with NPs

- **Retail clinics engage in creative partnerships (employers, community health centers, private sector, payors**

- **Federal Funding: Nursing education grants and loan programs to strengthen nurse training programs**

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## Change is the Future

From fee for service to value based programs, from face to face and the potential for telemedicine, from independent primary care practices to systems and from encounter based medicine to person based health.

We need to:

- Use Health Information to manage and coordinate care
- **Utilize all health professionals to their fullest extent**
- Collaborate to integrate services
- Help other to Navigate the Change-Stay Patient Centered
- Strive for Healthy communities
- Innovate to accelerate the pace of change
- Tipple Aim
  - Better Care
  - Better Health
  - Lower Cost



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## Questions?

## Thanks

**Sandra.Ryan@Walgreens.com**

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## ABOUT FLORIDA TAXWATCH

As an independent, nonpartisan, nonprofit taxpayer research institute and government watchdog, it is the mission of Florida TaxWatch to provide the citizens of Florida and public officials with high quality, independent research and analysis of issues related to state and local government taxation, expenditures, policies, and programs. Florida TaxWatch works to improve the productivity and accountability of Florida government. Its research recommends productivity enhancements and explains the statewide impact of fiscal and economic policies and practices on citizens and businesses.

Florida TaxWatch is supported by voluntary, tax-deductible memberships and private grants, and does not accept government funding. Memberships provide a solid, lasting foundation that has enabled Florida TaxWatch to bring about a more effective, responsive government that is accountable to the citizens it serves for the last 33 years.

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The Florida TaxWatch Center for Health and Aging (CHA) conducts research and analysis that quantifies the fiscal and economic impacts of current and proposed policies across the health care and aging spectrum to help shape policy discussions. As a Florida TaxWatch Center of Excellence, the CHA identifies and promotes the appropriate, effective, efficient, and accountable delivery of taxpayer-funded health care and aging services and works with stakeholders and policymakers to drive improvements within the system.

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The findings in this summary are based on the data and sources referenced. Florida TaxWatch research is conducted with every reasonable attempt to verify the accuracy and reliability of the data, and the calculations and assumptions made herein. Please feel free to contact us if you feel that this paper is factually inaccurate.

The research findings and recommendations of Florida TaxWatch do not necessarily reflect the view of its members, staff, or Board of Trustees; and are not influenced by the individuals or organizations who may have sponsored the research.

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All Florida TaxWatch research done under the direction of: Dominic M. Calabro, President & Publisher; and Robert E. Weissert, VP for Research & General Counsel

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