Past Event: 2024 NCSBN Scientific Symposium - Scope of Practice Reform for Nurse Practitioners and Population Health Video Transcript

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2024 NCSBN Scientific Symposium

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Presenter
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- [Dr. Bhai] I'd like to thank the National Council of State Boards of Nursing for funding this project. So, this was the start of my research in full practice authority and scope of practice. So, this is kind of my earlier work, and now I've started using claims data to kind of build upon this work.

So, I'll start with this project first. All right. So, I came to study nurse... So, I'm a trained health economist. I came to see the value of nurse practitioners because disparities was...disparities in the United States were kind of alarming to me when I saw them. And I was thinking about what are tangible policy solutions to reducing disparities in the U.S. So, why should we care about scope of practice and nurse practitioners?

So, nurse practitioners grow at 9.4% a year. So, NPs are growing substantially faster than physicians. So, we know physicians can only grow at 1% a year because CMS caps residencies. So, our population is getting older, has a lot of comorbidities, and needs requirement for care.

NPs are part of the solution because they grow faster. Kaiser Permanente has a study that like 85% to 90% of the tasks that an MD physician in primary care performs, an NP can also perform. All right. So, we talk a lot about "let's improve insurance," and that is part of the solution of reducing disparities. But if you expand health insurance, if you give people Medicaid, just having an insurance card doesn't mean you can actually see a provider.

So, insurance is part of the solution, but we also need to make sure that there are enough providers, especially in rural areas. Even in urban areas. So, even in, like... So, I come from Chicago. So, if you're in the lower SES neighborhoods, there are still shortages, even in urban areas. All right.

And so many states still maintain these restrictions. These restrictions seem to be arbitrary and idiosyncratic. And so I explore what happens. I'm going to kind of skip this slide. So, we know nurse practitioners came out in the 1965 because we've had a history of shortages in this country. So, we know

NPs are well trained, they have additional qualifications beyond the bachelor's, they have additional clinical hours.

So, and they're increasing to be a sizable part of the primary care infrastructure in the United States. All right. So, this is the map that I find very compelling on why we need to look at NPs. All right?

So, this is health professional shortage areas in the United States. All right? So, this is 2022, this is very recent. So, dark is bad. So, like if you see a darker shade of blue, that's pretty bad. But if you look at most of the country, most of the country is a healthcare provider shortage area. So, there's little pockets of light blue.

So, most of the counties in the country contain a healthcare provider shortage area. So, even in Chicago. Like suburban Chicago is doing well, but Cook County has portions of healthcare provider shortage area. If you look at the South, if you look at the Mountain West, the whole county is a shortage area. All right?

So, I think this is kind of problematic. So, when we think about disparities, reducing disparities, it's hard to do that when we have these broad healthcare shortage areas. So, not enough providers for patients. So, I think this is part of the reason why we need to think about full practice authority. All right? So, these scope of practice restrictions limit tasks that nurse practitioners can perform.

Oftentimes, they have to engage in collaborative practice agreements. In one of the states that I'm working to do policy change in, Pennsylvania, a nurse practitioner not only needs one physician, but they need two physicians to sign off on a collaborative practice agreement.

And it's completely arbitrary. All right? So, if you look at the geography of the U.S., if you look at full practice authority, it's done in an arbitrary and idiosyncratic manner. So, the nice thing about the fact that we actually have certain states that have full practice authority and others that don't, that actually lets us have a counterfactual. Right?

So, when people say, "When we get rid of...when we implement full practice authority, quality is going to go down," we've actually seen states pass full practice authority and we didn't see quality going down. And in fact, we see access to care improving, and we see certain improvements on patient outcomes. So, we actually know what happens when you get rid of scope of practice restrictions, and patients seem to benefit.

All right? So, it's not a hypothetical scenario, what happens when we get rid of scope of practice and implement full practice. We've seen it happen. And historical evidence kind of provides us a guidance for states that still maintain these restrictions. All right? So, a lot of components are, you know, physician supervision, chart review. There's multiple articles in the Journal of Nursing Regulation that talks about how chart review is not really systematic, it's arbitrary.

Physicians, when they have time, they'll kind of review charts. So, in many ways, a lot of the restricted scope of practice is not tied to patient outcomes. All right. So, before I motivate the study, so there's RCT evidence. So, I'm going to kind of steal some of Dr.

Carthon's presentation. It's like we have plenty of evidence from previous studies that show that NPs are as effective as primary care providers. So, there's a randomized control trial. We also have surveys on

how much time is spent with patients. We generally know NPs spend more time with patients. And there's a lot of population evidence.

Ed Timmons finds that Medicaid costs actually go down. When we have full practice authority, Medicaid costs go down. Morris Kleiner shows that well-cared child visit prices go down. And Danny Hughes and the Journal of Rural Health, they find that debridements go down. So, I actually have a working paper that's going to come out in Contemporary Economic Policy that shows that when you...

So, this is using commercial claims data from one of the large insurers in the U.S. When you have full practice authority, costs for diabetics go down and their non-primary care visits go down. So, NPs are likely, you know, to do more primary care because they're not... Physicians are constrained by the RVU model. Right? So, it is kind of...

Sometimes, you know, it's part of the fact that they're part of a practice that wants them to have enough RVUs. It's not the physician, they're constrained by their work environment. And so NPs don't have similar constraints. So, we have a national study that shows that diabetics are much better off when you do full practice authority. And this is using very expensive commercial claims data.

All right? So, there's a whole emerging body of evidence that's showing that full practice authority generally either improves patient outcomes or has no effect on patient outcomes. Either of those scenarios makes the case that we should have full practice authority. Right? So, even if you don't see any harm to patients, then why do we have scope of practice restrictions if you don't see any harm?

All right? So, there's a considerable body of research. If you do a lit review, 80% to 90%...I would say more like 95% of the studies generally show full practice authority is very good. And those other 5% of the studies are kind of...make a lot of assumptions. All right? So, tons of studies on mental health. So, Diane Alexander talks about when states pass full practice authority, we see a reduction in suicides.

So, and survey data from the Behavioral Risk Factor Surveillance System shows improvements in mental health. All right? So, this is a big population-level study using CDC data which samples about, like, 400,000 Americans a year that shows prescriptive authorities associated with improvements in mental health.

We see reductions in emergency care and so forth. So, there's tons of high-quality studies using population data that generally shows that full practice authority is associated with improvements in health. All right. So, this study has...it's a two-part study. So, I'm going to look at how full practice authority affects children's health using survey data. So, children are a very interesting group because children are generally fully insured because of CHIP.

For the most part, nearly all children have full insurance. And children are an interesting group because unhealthy children go up to become unhealthy adults. So, if we can invest in kids, that's a good way of potentially reducing disparities. The other thing about kids is that if you improve their health, you probably can improve their schooling, also, human capital.

So, the biggest reasons kids miss school is, like, you know, uncontrolled asthma. So, just getting them an inhaler, having them see a provider. So, when we engage in full practice authority, it might not just be a health policy, but it might also be a human capital policy...or educational policy. All right? So, the study with kids is very limited. Again, any positive or zero effects suggest that scope of practice should be expanded.

Negative effects suggest we should rethink scope of practice. All right. So, this is the second part of my paper here. So, if you look at children's health over time, as children get older, their self-reported health...or parentally-reported health worsens over time.

All right? So, you could also do this by racial status and you'll see similar patterns, or a similar gradient if we did it by race. You know, African-American children have worse reported health, and those gaps increase over time. All right?

So, I'm going to... So, for one part of my paper, I'm going to use the National Survey of Children's Health. So, this is a large, repeated cross-section of kids in America, age 0 to 17. So, I'm going to... So, there's two parts to this survey. I'm going to use the most recent one because that incorporates sampling with cell phones. All right?

So, the survey asks a parent like, you know, "Could you please report about your child's access to healthcare, how they're doing, and so forth?" The nice thing about this is that this survey actually samples small states very well. So, in Wyoming, Arkansas, the Dakotas, you actually have enough observations in those states. Because a lot of times, if there's a survey, a lot of the observations are going to be based on like California or New York.

So, the nice thing about this is that it's making sure that we have enough observations in our low-population states. All right? So, it's a very nice survey. So, keep in mind, this is a survey. So, it's not claims, but it's survey. But it can kind of still enlighten us. All right?

So, this was the start of the agenda, we started with this survey. So, there's actually not very many good surveys for children that contain lots of observations. So, we chose the National Survey of Children's Health because it has enough statistical power for us to kind of do our analysis. Since then, I've actually also have a claims project. So, but this was a start.

All right? So, we're going to use Ben McMichael and Sara Markowitz's database on full practice laws. So, this is probably the most comprehensive. And they've gone through the statutes. And so we're going to use McMichael and Markowitz for full practice authority. We're going to also pull in some state-level covariates to kind of condition on economic...potentially economic confounders.

And what I'm doing is I'm going to use a quasi-experimental method, I'm going to use differences in differences. So, the idea there is, since we can't really do a randomized controlled trial here, we're going to assume that when a state passes full practice authority, like when Arkansas...which recently passed full practice authority, we're going to consider that the treatment group.

And we would consider, like, a neighboring state, such as Tennessee or Oklahoma, as our control group. So, this is a way of trying to emulate RCT. So, it's a way to kind of try to reduce confounders. It's not perfect, but it might be an improvement. All right? So, I'll ignore the equation. All right?

So, there are certain assumptions that go with these models. All right. So, before I look at children, my other part of the project was to look at the American Community Survey. So, how are the ways that full practice authority could improve health? So, one way is that full practice authority could make the existing nurse practitioners more efficient. Right?

So, they don't have to spend time on preparing notes for physicians, they don't have to engage in chart review, they don't have to do a lot of administration. So, one way full practice authority could improve

health is that it makes NPs more efficient because they don't have this administrative task. The other way is that it could mean that nurse practitioners maybe work more. Maybe they start becoming entrepreneurial, they start their own practice. There's limited evidence for that, but they are starting.

So, once they get full practice... There's very few self-employed nurse practitioners. But there's evidence that once they have full practice, some of them are going to move out to rural areas and start their own practices. So, what I actually see is when full practice authority happens, we see earnings for nurse practitioners go up. Part of this could be that they don't have to pay a large sum to physicians for collaborative practice agreements.

The other thing is that once you do become an independent nurse practitioner, you could start your own practice and you will also get billed under RVUs. Right? So, we see some evidence that, you know, nurse practitioner... We see robust evidence earnings go up. And this is very much an estimate of what an NP has to pay for a collaborative practice agreement. We also see, like, some evidence they start working more.

So, you know, they might work more because they have more agency. So, there's some evidence that full practice authority would improve population health because NPs might shift from the salary model to becoming their own...or moving towards a more independent approach where they determine their own hours, they see their patients, and so forth.

So, this is some evidence why full practice authority should improve health, because nurse practitioners can now, you know, start their own clinics, can see more patients. So, there's some evidence that they will work more. So, there's two ways then how full practice authority could improve health. Increased labor supply, more efficiency of the existing medical care system. And there's a third way which we don't test, is that when you have full practice authority, if you're an NP and you just graduated, do you want to live in a state that has full practice authority or restricted practice?

So, the other way is, of course, nurse practitioners could migrate to full practice authority states. Or if you're a nurse and you're thinking whether you should... A lot of nurses think about becoming an NP. And so, like, full practice authority could kind of motivate you to take that step. So, that's the third way we don't test. But, so, there's at least three mechanisms that we can think of why full practice authority is going to be good for population health.

All right? So, I wanted to show you the results of full practice authority on physicians. So, when states implement full practice authority, there's no change on physician earnings. There's no change on their labor supply. There's a small change, but it doesn't hurt their bottom line, it doesn't hurt physician earnings.

We don't see any change on their work behavior or how they work. So, this is part of why... Like, the big roadblock to implementing full practice authority is the state AMAs. They're concerned that, you know, full practice authority is going to harm physicians. So, if you look at the American Community Survey, which is a 1% sample of all Americans, we don't see harm to physicians on...in their pocketbooks.

You know? So, full practice authority doesn't hurt them. We have enough disparities and we have enough people in America who lack access to care. So, NPs aren't taking their business. So, this is 2005 to 2019 American Community Survey. All right.

So, let me go to my child health visit piece. So, we show that once there's full practice authority, we see reductions in hospitalizations. We also see a potential change of, like, no ER visits, but the estimates are noisy. I also had another table on, like, time spent with the child. And that also goes up, but I did not include that here.

So, there's strong evidence that once you have nurse practitioners, they are providing full practice authority, they are providing more primary care, and they are spending more time even with kids who already have insurance. And so on some of these effects, we don't see any changes. But the overall evidence suggests that NPs don't harm patients.

So, when we think about policy change, full practice authority is a very cost-effective policy change. I will say this. When you talk to state legislators, they're very concerned about cost. Like when you privately talk to them, they're concerned about cost. And my story, I think, is that, look, this is actually good for state policy.

Because, for example, with my diabetes patients, it's much easier to treat people and put them on metformin than it is to perform an amputation. It's bad for the government and it's bad for patients. Right? So, it's much easier for us to treat chronic conditions than to perform heavy operations. So, I think in due time, we will see evidence that, you know, having full practice authority leads to more primary care and we are reducing these heavy chronic procedures.

Which are not good for patients and which are not good for taxpayers. All right? So, it just makes sense to do this. Because it doesn't cost anything, we already have well-trained professionals. If we have restricted scope of practice, we're not using our resource, which is NPs that are well trained, to fully practice to their training.

So, lots of economic and policy significance. So, NPs are likely to improve...are likely to work more. They're also likely to improve children's access to healthcare. At the core, we don't see any harm. All right? So, we need to think about beyond physicians, because, you know, physicians just aren't going to grow very fast.

When you look at even physicians, their burnout rates are increasing. There is a study in the Journal of General Medicine that talks about that the average physician would need 27 hours in a day to adequately take care of all the chronic conditions that the patients have. So, we're in a country where lots of people have chronic conditions and we need to think about how we could better manage that.

All right? So, and I'll also talk about physician policy. So, there's a lot of policies that work to increase physicians in rural areas. My understanding of the literature is that these just don't work. So, a lot of incentives that say, "Sell, if you stick around for five years, we'll pay off a portion of your loan."

First, the amount is trivial. And therefore, you don't see a lot of responsiveness. So, there's lots of policies that try to get physicians to rural areas, but they don't seem to be very effective. So, we need to think out of the box. And my disclaimer is, you know, any research on NPs is not, like, anti-physician. The whole point is, like, you know, we have well-trained providers, such as NPs.

And in a functioning medical care system, we'll have NPs do a lot of these tasks that they are trained to do. And then we'll have a system of referrals, you know. So, this is one of the things that people talk about for, like, patient safety, is like, "Well, NPs aren't trained to do everything." But neither are primary care providers.

We have a system of referrals, we have a system of malpractice. So, we actually have ways for the system to work with full practice authority. All right? So, we should think about NPs more, and in their role of managing, like, you know, chronic conditions. All right? So, this is cost-effective. The FTC, the Hamilton Policy Project, and lots of scholars, the National Academy of Medicine, and there's various op-eds in even the New England Journal of Medicine that talk about how, look, we're going to have to go give NPs full practice authority.

And I'll talk about Dr. Carthon's point, too. I mean, there's also proposals that we need to let nurses do more and just be more involved. Because, you know, they're at the forefront and they can kind of build relationships with patients. So, we need to think about reform to fully use our healthcare workforce, human capital. All right?

So, I will stop here. Thank you.

- [Monica] Hi. Thanks for a great presentation. I'm Monica Riley-Jacob at Columbia University, an NP researcher. And a theory that I just wanted to offer you that could be behind the physician salaries not changing once they get full practice authority and revenue of practices potentially staying the same, or getting better.

The admin time that NPs and physicians spend together, it can be cumbersome. And when that expectation gets taken away, both physicians and NPs now have more time to see more patients, get reimbursed more. So, just one thought.

And then I think we need to be really careful about assuming that more NPs means more primary care, because it's not a direct link. We have some evidence that only 40% of NPs that... In claims, everybody just kind of assumes that all NPs are primary care providers. And it's really hard to tease out who's doing what in Medicare claims.

But only about 40% of NPs seem to be actually providing primary care. So, I think it's... You know, as a profession, we can sort of put ourselves into a tricky situation when we just always assume, "Churn out the NPs, we can improve the primary care workforce," when it's much more lucrative, as most of the people in the room can tell you if you're an NP, it's much more lucrative to go into a specialty and you can still be trained as a primary care provider.

And you get trained on the job or orientation or things like that. Anyway, it's just this disconnect between what's going on in the research and what's going on in the real world.

- Yeah, thank you so much. So, I agree with your first point, that it actually...full practice authority is also better for physicians in the sense that they are also no longer engaging in this administration or monitoring. And so it should add an efficiency component for them, too. And to your second point, yeah, thank you. So, I will look into that.

So, that is one of the things that we're trying to work on with our commercial claims, just to see, like, what do NPs bill...or what claims are assigned to NPs and what claims are assigned to CNMs. And yeah, so, I will keep that in mind, about kind of, you know, looking at the roles and the NP involvement in non-primary care, as well.

But, yeah, thank you.

- [Dr. Lyon] Hi. Karen Lyon, I'm the CEO of the Louisiana State Board of Nursing. I really appreciated your presentation. My entire state, as your slide showed early on, is a health professional shortage area. I came from Texas, entire state is a health professional shortage area. And then Mississippi, our neighbor to the east, is the whole state.

But, so, you have lots of really good information and I appreciate all that. An early slide of yours inferred that boards of nursing are responsible for scope of practice restrictions and full practice authority restrictions. That is absolutely not true.

It's legislatures. We've been fighting for 10 years, introduced five different bills over the course of the 10 years I've been there. And it's... As you pointed out, it's the Louisiana Medical Society, in Texas it was the Texas Medical Association that fight so hard against full practice authority for nurses. So, I just caution you to be careful about statements that you make like that.

Because I think boards of nursing in our jurisdictions across the United States for states that are striving very hard to get full practice authority for our APRNs, all APRNs, not just nurse practitioners, work hard, you know, with a lot of collaborating organizations. And we have been working that way for a long time.

And it seems like the wind is always coming at us, rather than behind us. So, but thank you. Really excellent study.

- Yeah, no, thank you so much. Yeah. So, that was one of the issues, like, in my involvement in Arkansas, is that, you know, legislators were a roadblock. And ultimately, one of the doctors who was fighting very hard in the legislature realized when he retired that, you know, he wouldn't have...his constituents wouldn't have any care and that kind of tipped him over.

But yeah, you're right. So, that was a bad sentence on the slide. Yeah.

- [Audience Member] When you're talking about pediatrics and child healthcare, if you look at the Pediatric Nursing Certification Board, they will be able to tell you which pediatric nurse practitioners are taking acute care versus primary care certification exams. And it is separate for us.

If you get primary care, I can't work in acute care. If you get acute care, you can't work in primary care, unless you get dual certification. So, that's one way you'll be able to extract some of that information.

- Yeah. Thank you so much. So, my next project is kind of looking at pregnancy episodes using commercial claims. So, we will be able to look at NPIs, and hopefully we'll be able to kind of unpack the mechanism and look at what kind of NPs are involved. But thank you, that will be very helpful for our next project. All right, thank you.