Healing Arts Scope of Practice Task Force

Meeting Minutes
October 13, 2016

Opening
The third meeting of the Healing Arts Scope of Practice Task Force was called to order at 10:00 am on 10-13-2016 in Executive Conference Room of State Capitol by B. Massey.

Present

Introduction/Opening Remarks
B. Massey explained that there would be three presenters from each side and each will be allowed 10 minutes to speak.

Nurse Presentations

C. Myers opened by reminding members of the Task Force that Tennessee has poorer health outcomes than most other states and stating that she believes there is inadequate access to providers particularly in rural areas. She stressed that these are the problems that the task force has been commissioned to address.

April Bryant, FNP from a rural East Tennessee Federally-Qualified Health Center, explained the role of Nurse Practitioners (NPs) in primary care and how they can be utilized to fill gaps in access. Evidence about the cost-effectiveness, quality, acceptability, and equivalency of patient outcomes of NP-provided was presented. Copy of slides attached.

Linda Hill, Director of the UT-Chattanooga CRNA program and practicing CRNA, explained the role of Certified Registered Nurse Anesthetists (CRNAs), their specialized training and education, and how they differ from other APRNs. Evidence about the cost-effectiveness, quality, acceptability, and equivalency of patient outcomes of CRNA-provided care was presented. Copy of slides attached.

Mavis Schorn, a CNM and Associate Dean for Academics at Vanderbilt University and practicing CRNA, explained the practice of midwifery and concerns about access to care of patients with issues related to women’s health, childbirth, premature birth, and health outcomes. Evidence about the cost-effectiveness, quality, acceptability, and equivalency of patient outcomes CNM-provided care was presented. Copy of slides attached.
Physician Presentations

J. Hale gave introductory remarks and introduced presenters for the Physicians.

Yarnell Beatty, staff attorney with the TMA, provided an overview of a U.S. Department of Veteran’s Affairs evidence brief questioning the conclusiveness of many studies on patient outcomes where APRNs are unsupervised by physicians. *Copy of brief attached.*

J. Daniels explained his “unique” personal perspective and knowledge regarding the differences in education, training and licensure between nurses and physicians. He described his personal experience that there is a lack of standardization in APRN training and that some APRN clinical training is substandard. *Copy of slides attached.*

N. Shumaker explained a physician’s perspective on the role of NPs and insurance and quality concerns about scope of practice expansion. *Copy of slides attached.*

Post-presentations discussion:

When J. Alliman asked what task force member could agree on, it was suggested that access to care is an issue of common concern. However not all physician members agreed that there is an access problem. M. Sethi did say “access issues are very real”. He suggested that task force “look at this as a trauma case”, asking is there something we can agree upon to increase access? What can be done to address the most acute problems?

J. Faison reiterated need for “doing a good job for Tennesseans”. Suggested that task force members “stick with the facts”.

J. Favors said: 1) we have access problems, 2) we need to improve the quality of care, and 3) “we have the resources needed in this room” to improve care.

Brainstorming

B. Massey led a brainstorming session organized according to eight categories of issues raised during the past two meetings and recommendations submitted by nursing and physician groups in advance of the meeting and absent task force members: 1) Qualifications/Training; 2) Prescribing Authority; 3) Supervision/Oversight; 4) Governance; 5) Delivery Methods; 6) Specialty; 7) Costs; and 8) Other.

K. Moore suggested adding Access as a category.

Qualifications/Training:
B. Earwood presented major points of nursing recommendations, including: 1) initial transition to prescribing system of a 2-year supervised “internship” or “residency” for APRNs with prescribing authority for all controlled and non-controlled drugs, 2) after 2-years, APRNs graduated to a system where a physician supervisor is required only for controlled drugs, 3) need for revised supervision parameters stressed, and 4) after another two-year period, APRNs can petition the BON to be released from regulated physician supervision for all prescribing.

Discussion:

C. Myers suggested that the use of the word “residency” has specific connotations that may not apply to the transition periods being discussed. She did, however, acknowledge support for a transition to prescribing period of time based on the evidence presented by Liz Sherfey from the BON that showed 40% of disciplinary hearings for APRN prescribing occur in the first 20 months of practice.

J. Alliman suggested that supervision could be provided by an experienced APRN instead of an MD, due to limited availability of qualified and willing physicians.

N. Shumaker and other physicians expressed intrigue with the transitional system concept to address any inconsistency in APRN training, but objected to variations of the concept which would lead to the cessation of collaboration with physicians.

Prescribing Authority/Supervision and Oversight:

Physician recommendations included suggestions that: 1) BME/DOH set fees for physician supervision, 2) chart reviews can be accomplished via telemedicine, 3) supervision be changed to collaboration, 4) the BME would assemble a pool of available physician supervisors, and 5) there be a 5-year moratorium on for further practice authority/regulation bills was suggested by J. Hale.

Discussion:

B. Earwood commented that over-prescribing was bigger than the committee and should not be the committee’s primary focus when making recommendations.

J. Faison suggested modeling opioids prescribing after the Accutane model, requiring prescribers to take courses and jump through hoops in order to be able to prescribe.

J. Hensley suggested that APRN’s should not be allowed to prescribe any Schedule II or III drugs.

K. Setser said verbiage would have be included allowing for APRN’s to prescribe short-term 5-day supply/ limited supply of opioids and other scheduled drugs so that APRN’s would not have to send patients to the ER for pain, etc.
M. Modrcin also disagreed, stating everyone needs to be able to prescribe limited supplies of opioids and all drugs, such as testosterone.

J. Favors objected to 5-year moratorium given the uncertainty about the upcoming elections and ongoing ACA implementation and issues.

J. Hale mentioned going toward collaboration and a team-based approached and inquired about defining the term “full practice authority”; clarified that medicine will not be able to agree to anything resembling “independent practice” or without a formal, written relationship between an MD and an APRN.

K. Setser described what full practice authority would mean to her: doing exactly what she is doing now, but without a physician being required to look over her charts or make clinic visits. She requested no legal relationship between an APRN and an MD. She believes she doesn’t need supervision and that suggesting that there is a need to have a formal relationship with an MD sends an underlying message that she is not skilled, capable and qualified.

C. Myers explained that full practice authority means that the regulation of nursing practice was solely under the jurisdiction of the BON with no provisions for physician supervision. She emphasized that evidence that shows that supervision does not improve patient outcomes and that it may increase costs and impeded access. She stressed that with relatively poor outcomes and poor access in certain areas and with certain populations, given the evidence, new models of primary care, including better utilization of APRNs, should be considered.

C. Myers also stated that APRNs are able to diagnose and treat without a supervisor and only need one if they are prescribing. J. Daniel asked Legal staff to read aloud the definition of the practice of medicine from the BOM statutes. C. Myers claimed that diagnosis and treatment are in both the medical practice act as well as the nursing practice. J. Daniel requested the nurses show in the statute where they have the authority to diagnose and treat. J. Hensley said he did not feel that this was something he could agree to change.

B. Massey reiterated that the Task Force is looking for the way they want the law to be and that maybe diagnosis and treatment should be added to the nursing practice act. J. Hensley stated that he didn’t believe the physicians would agree to that.

C. Myers indicated that an NP can handle many of the items that a family physician handles routinely and that practice and roles have changed in the past 40 years in response to a question from J. Hensley.

J. Daniel spoke up to disagree with the assertion that primary care physicians are over-qualified, stating that he has a unique perspective after completing both APRN and DO training programs and believes MDs/DOs are trained to look for ‘zebras’ and not miss outlying diagnosis.
N. Shumaker spoke up to address concerns about the lack of APRN clinical training. She stated that that lack of training justifies the need for physician supervision, again expressing that medicine would not agree to go forward with anything less than some type of formal supervisory relationship between APRNs and physicians.

J. Alliman suggested that young APRNs could be supervised by more experienced APRNs to increase access and to address oversight concerns.

N. Shumaker objected to any transitional system using APRNs instead of physicians for supervision.

J. Daniel suggested replicating a program in which he had participated in another state, where a physician interested in supervision pays to take a course and a test. The class educates the physician on proper supervision techniques and the fees collected go toward enforcement of physician supervision rules. He indicated that he believes that this type of program would combat the problem of physicians who supervise “in name only”.

C. Myers said, “But we don't need a supervisor.”

B. Earwood said the need for supervision has not been satisfied and the “supervision system in Tennessee is a failure”.

J. Allman agreed, saying, “The current situation is not working.” Suggested that the state implement the tiered system recommended by nursing members and set-up a study to closely track outcomes.

Governance:

C. Myers pointed out that APRNs are currently under indirect rule of the BME and that they want to be solely governed by the BON. She thinks the current supervision model is not working, nor does it improve patient outcomes.

M. Modricin stated that the nursing profession is already heavily regulated and doesn’t need more regulation or supervision.

Costs:

N. Shumaker urged members to keep payment reform and MACRA implementation requirements in mind.

Other:

Access:
K. Moore said that access is the number one issue he keeps hearing. “An NP is not an MD, and a MD is not an NP.”

J. Alliman said she is also concerned about access, and doesn’t believe the suggested transitions to prescribing helps to increase access.

J. Hensley expressed that he did not tolerate the assumptions being made. He expressed that no one knew for sure where APRNs would be located and that is was only an assumption that they would relocate to rural Tennessee.

M. Sethi agreed that there were a lot of assumptions being made and suggested adding pilot programs in full practice authority in rural zip codes to incentivize APRNs to relocate there and serve the underserved populations. He said that what Sen. Hensley was expressing had validity and that to increase access, there needed to be a way to expedite rural access to care.

B. Earwood spoke up urging the group to realize that would create a two tiered system. Lower quality care for rural Tennesseans and higher quality care for others.

N. Shumaker reminded the group the both the military and physicians groups have incentives programs to relocated physicians to rural areas which work well and could be replicated.

M. Modricin said that there are already existing loan forgiveness for going to rural Tennessee and that this was not the problem, physician oversight was the problem.

J. Hale offered to help increase access by addressing the concerns expressed by the nurses. Medicine would no longer require an onsite visit by the physician, but instead have physician oversight via telehealth. He also suggested that the BME or Health Department might consider creation of an online pool of physicians willing to supervise APRNs at a reasonable price. He said he had had discussions with a representative of State Volunteer Mutual Insurance Company, the state’s largest health care liability insurer, who confirmed that it offered liability coverage for full-time physician policyholders who supervise for no additional cost. He also asked that no further legislation to be brought for the next 5 years in order to give this time to work. He also mentioned giving the BME more power to come down on physicians who are not properly supervising.

C. Myers spoke up saying telehealth is not scalable and that there was not enough technology available for such a plan to work, especially in rural areas with no access to the internet. She stressed that modifying the current system of physician supervision was not warranted based on the evidence.

B. Massey emphasized things to consider for going forward were: 1) the Tennessee General Assembly want “less regulation”, 2) what needed to be written versus unwritten (i.e., formal supervision agreements), and 3) what should be handled in law vs. rule.
Concluded with statement, “we are here to make transformative change”; looking for “better outcomes, better access”.

B. Massey also suggested that the Task Force hire a facilitator for the next meeting. After some discussion, it was determined by a majority of the members that it would be challenging for a facilitator to come in this late in the process and that there was hope that agreement could be reached without a professional facilitator.

C. Myers and J. Hale agreed to look for things that can be agreed on going forward.

**Adjournment**

Meeting was adjourned around 3:00pm by B. Massey. The next general meeting will be at 10:00am on December 2, 2016, in Room 30 of Legislative Plaza.

Minutes submitted by: Logan Grant

Approved by: [Name]