On Policy and Politics and Nurse Practitioners

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At your very first gathering as an association -- now a College -- I stood on a similar platform early in a Canberra morning. I believe there were maybe 90 people in the room and you were an obstreperous crowd deservedly excited by your achievements.

And look at you now!

What could I possibly say to you that you don't already know? For it's clear to me that nurse practitioners in Australia and New Zealand for sure, and maybe in Canada are moving in interesting ways that we in the US have yet to achieve. At the same time, there are some common themes in the evolution of advanced practice nursing across the world and some even more common conceptual and operational barriers to full practice. And more to the point, I appreciate more and more how impossible it is to understand issues in professional practice without understanding the contexts in policy and politics that shape and form them.

I have come to realize how very much the market economic model of capitalism and its fractured insurance system that so characterize (or infect, in more cynical moments) the United States has affected how nurse practitioners developed in my country. In getting up to speed on nurse practitioner issues in Australia and New Zealand I think I understand better how your legal, coverage and government schemes shape your issues. In all countries, the solutions must fit the circumstances. The context is everything. Perhaps by examining parallel processes in my country and your Antipodes we may see things differently.

Let me start with this new understanding.

One of the most influential contributions to the nurse practitioner movement in the United States was the so-called Burlington Trial of Nurse Practitioners, by Walter O. Spitzer and his colleagues, published in 1974 in the *New England Journal of Medicine*. (Spitzer, Sackett, Sibley et al., 1974). It was the first randomized trial in this literature, the gold standard of evidence production. While it had some methodological flaws including not-quite-random

assignment to nurse practitioners or physicians and quite questionable locally determined standards of care as outcome measures which did not, for example, require blood pressure control as an outcome of primary care for hypertension (Diers & Molde, 1979), its findings showed no difference in outcomes between practitioner groups. That gave a boost to many of us involved in the early days of nurse practitionering.

But soon, Spitzer began to publish editorials that questioned whether nurse practitioners were really necessary, especially in pediatrics. His most outrageous one was called "Slow Death of a Good Idea" (Spitzer, 1984) also in the *New England Journal*, in which he compared nurse practitioners to thalidomide, released upon the unsuspecting public without sufficient testing and likely to produce the same kind of tragic consequences. My nurse practitioner colleague, Susan Molde, and I retorted with a lethal letter to the editor concocted over a lunch of too-spicy chili (Molde & Diers, 1984). Spitzer did not reply nor did he ever publish anything else about nurse practitioners.

Ah, but here's the context.

Dr. Spitzer had been a physician at Yale and had worked with the same interdisciplinary team that had supported our initial nurse practitioner project. We thought he was one of the good guys. But the Burlington trials were done in Canada to which he had moved. And his subsequent editorials, while published in the US professional media, were produced in the Canadian context. The nurse practitioner movement in Canada disappeared. But what I didn't know until very recently, was that Spitzer's context was a set of government policies which had produced a physician surplus in Ontario, where his work was done. (Browne & Tarlier, 2008; Edwards, Rowan & Grinspun, 2011) In the Canadian policy context, if there were too many physicians, why should the government support nurse practitioners as substitutes? Physician substitution had been the policy agenda in a physician shortage. To the US reader, not knowing about the Canadian policy context, his analysis looked like physician chauvinism and we snarled back. Because, you see, government has little role in determining physician workforce numbers in the US. Indeed, organized medicine in my country made part of its agenda support of a deliberate undersupply of physicians in order, in our market economy, to preserve incomes, and thus to make physician hegemony stronger through both scarcity and social standing.

But I'm tired of bashing organized medicine (except when they richly deserve it). I want to reach for a larger, loftier set of ways to understand the professional, policy and political life of nurse practitioners. And that means, especially in my own country, probing the intersection of economics and policy. Economics are always at work, they just happen to be revealed more transparently in the U.S.'s confluence of private actors and interests.

At the same time, as nurse practitionering has evolved in several countries now, we will find more and more need for data about the practices and the outcomes of practice. In this paper, I will try to stitch together those two themes.

U.S. administrative healthcare data systems, in hospitals and outside, are based on billing. Our electronic medical records feed the billing systems. We charge for everything we can think of – every aspirin, every hour of nursing care, every use of equipment, every suture set. Thus, there are billing and revenue coding systems which translate the work into computer readable form. Many of them are now prescribed by government but not all. The shining exception, and the one most important to nurse practitioners in my country is what are called Current Procedure Terminology or CPT Codes. CPT codes classify procedural activities of medicine and surgery. These are somewhat similar to your MBS coding scheme which is, after all, used to "bill" government for payment.

CPT codes are owned by the American Medical Association and the quite considerable income from their use (and their annual updates) supports AMA's lobbying efforts along with other income. In 2010, that was $4.2 million, up from $3.7 million the year before. (AMA, 2010, p. 17) Which helped explain to me why the American Medical Association seems to have so much power, in spite of the fact that there is a declining number of physicians who are actually members (now estimated at about 17% of all licensed physicians [Scherz, 2010]).

One of the subtleties of CPT codes that guarantees their money-making capacity for AMA is that they are updated annually but each subsequent volume is completely new, perhaps even with new codes and there is no crosswalk back to last year's version. That means every healthcare entity must purchase the new hard copy or software, every single year. It's a machine for printing money.

CPT codes were adopted by insurance companies and the government for payment for physician hospital visits and outpatient services just because they were there. CPT codes have

built in weights that determine the “difficulty” of the activity and they come with quite specific rules about definitions of service.

There is a subset of CPT codes called “E and M” for Evaluation and Management codes, not unlike your “attendance” codes. These are the ones that code whether a visit is for a new patient, a follow-up visit for a previously diagnosed problem but stable problem, a new problem in an established patient and so on.

When nurse practitioners started to get some attention, especially as they moved into private practice, the CPT folks started to play funny games. They changed the definition of the E and M codes, which are used in essentially every outpatient visit, to apply only to physician activities, thus essentially eliminating the ability of nurse practitioners to bill in their own names.

This may sound familiar to you. Except here, your codes are owned by government and you have different challenges to find the policy levers to make change. I was delighted to see that from July 1 this year, nurse practitioners have access to the attendance codes at least. And in reading through the MBS codes (an exercise that is fun only for those of us who like reading dictionaries) I see a number of other opportunities to code and capture nurse practitioner work.

MBS codes and CPT codes are service utilization measures. In a government-funded healthcare system, it is not surprising that government would wish to keep track of where its money is spent as utilization. It’s important to us in our mixed payment system too. But for understanding the nature of the work, utilization measures are not enough.

Our US capitalist system is based on a model of production in which there are inputs and outputs and in which, in advanced versions, there is a balance between efficiency and effectiveness. To create such a model requires clinical information in the form of diagnoses and reasons for visits, for these are the “inputs”. These are ICD (International Classification of Disease) codes. In the US, all healthcare occasions of service – outpatient visits, inpatient hospitalizations – must have <u>both</u> an ICD diagnosis code and a CPT or ICD procedure code.

Where this becomes important is something altogether different from government interest: creating a data system within which to find nurse practitioner practice. We need this to build up data we can mine for patterns of practice and outcomes. – who is served, by what type/kind of care, with what outcomes. My government is moving toward “pay for performance” and already testing that for hospital payment. Such efforts use standard

administrative data, especially ICD codes to detect, for example, blood transfusion incompatibility, surgical wound infection, retained surgical implements or supplies, central line blood stream infections etc. which will trigger a denial of hospital payment when they happen. The pressure will be on to extend this line of reasoning to outpatient services and it will not be possible to understand quality of care with only utilization data.

So long as data systems are driven by utilization (MBS or CPT) codes alone, it will not be possible to link NP (or anybody else's) work with the patients served nor the outcomes achieved. We will all wait for a universal electronic medical record for outcomes data. I am told here (Chris Aisbett, personal communication, July 29, 2011) that institution-specific Cerner or PAS systems can capture treating clinician and other data. But these systems here do not feed the data to government, yet. Whether data from them are even analyzed at local level is another question. A new initiative to collect non-admitted patient data in Australia has been announced to capture "instance of service provision from the point of view of the patient" (Australian Institute of Health and Welfare, 2011) but as I read it, only very superficial patient data on patient demographics will be collected, no diagnosis data and no data at all about the practitioner, only the clinic. And thus nurse practitioners (and others, for that matter) are invisible again.

In the best of all possible worlds, data systems should be descriptive , not subject to political (government or private) influence. That is generally the case of ICD codes which are governed by the World Health Organization with country-specific processes for adding, subtracting or subdividing codes with public input and discussion. The coding should describe patient condition (in the case of diagnosis codes) or provider provision. Neither should be discipline specific.

Which may lead naturally to the notion of the necessity in law or regulation including your authorization requirements which feed into the use of MBS codes, for nurse practitioners to "collaborate", if not actually to be supervised or employed by physicians. Nurse practitioners throughout the world find this requirement offensive. It's not that collaboration is offensive, it's the implication that if it isn't embedded in law or regulation, nurse practitioners will go off half-cocked and do no one knows what. One study wryly quotes a senior healthcare executive who surveyed the literature on collaboration and found that all of the citations were in the nursing

literature, none in medicine (Khoury, Blizzard, Moore & Hassmiller, 2011). We're being defensive.

The very earliest writing about what we now call nurse practitioners was done by nurse-physician teams: Charles Lewis and Barbara Resnick in Kansas and Loretta Ford and Henry Silver in Colorado. (Lewis & Resnick, 1967; Ford & Silver, 1967) The work was then called the "expanded role of the nurse" and "progressive ambulatory care" and it was in the context of partnership with physicians. Data were not the issue yet – it was too early. Lee Ford lamented what she believed is the slide of nurse practitioner work from a public health and nursing model to a medical model in the United States (Ford, 1992). It is difficult to determine when or how or even if that happened. What did happen was a change in rhetoric from partnership to competition. I contributed to that, unfortunately, fueled by feminist ways of framing issues in the '70's and '80's: casting off the oppressed group behavior. Medicine responded predictably. The medical rhetoric in the late 1970's began to talk about nurse practitioners' territory as "the worried well and the walking wounded," trivializing the work and implying that only physicians could care for the hard stuff, and that, of course would require "collaboration" if not actually referral or transfer from NP offices to physicians'.

Today, "collaboration" has become intertwined in policy and politics with employment relationships and concerns about liability (Cashin, Carey, Watson et al., 2009) and those correlations need to be taken apart. Naïve regulators and legislators have been led to believe that patient safety and quality will be compromised without legally binding collaboration (which may be legally binding only on the NP, not the physician -- that has not been tested) and physicians have been convinced by uninformed attorneys that their legal liability is increased in collaborative relationships with nurse practitioners. This morass, at least in my country, conceals what the real issues are: money and data.

It began to become clear that nurse practitioners could and did work independently of physicians in primary care, not ignoring the potentials and possibilities of collaboration but, in an economic sense, becoming the gatekeepers to specialist practice. Specialist practice (which includes internal medicine in the US but not "general" or family medicine) is highly dependent on cooperation if not actual collaboration with primary care specialists and suddenly nurse practitioners were unsafe and quality was compromised without a visible collaborative

agreement binding NPs to physicians to the referral channel. I do not think it is accident that among the first MBS codes made available to nurse practitioners were the ones for referral.

NPs now practice independently or in remote collaboration in 42 US states. There are about 140,000 nurse practitioners in the US. Twenty-three states and the District of Columbia have no requirements at all for physician involvement (The Pearson Report, 2011). Not surprisingly, the states with no requirement are all rural states. In all states, NPs have some level of independent authority to prescribe. NPs are eligible for direct Medicaid (state funding) and Medicare Part B (professional billing) reimbursement in every state. (Hansen-Turton, Ridgway, Ryan, & Nash, 2009; Fairman, Rowe, Hassmiller & Shalala, 2011). Collaborative requirements vary across states from a handshake agreement attested to by naming the collaborating physician to a state regulatory agency, to signed contracts which must be filed with a state board, to other forms in between. Eight states require some kind of on-site oversight from once every 30 days to 20% of the time including the ludicrous provision in Missouri that if the NP provides care for acute or chronic illness or injuries (what else is there?), the MD must be on-site once every two weeks. Which could be for one minute. In some states, collaboration is only in prescribing.

Nurse practitioners have been clever about attending to the law. A nurse practitioner in Connecticut, for example, has a collaborative agreement with a physician in Texas, half a country away. Yet without a collaborative agreement in states where it is required, practices must close. This is a particular issue in psychiatry where there is a shortage of psychiatrists. One psychiatric nurse practitioner I know of had a practice of 2800 chronically mentally ill people whose care she was managing beautifully. But she could not find a psychiatrist to collaborate with and she had to close the practice. Yet that state's legislature is reluctant to change the collaboration requirement because "it's only one nurse", forgetting that it's 2800 patients. Some nurse practitioners have entered into business agreements with physicians in which they hire the physician as backup and essentially buy her signature to a collaborative agreement.

At the level of interprofessional politics that influence ill-informed legislators and regulators the issue is framed as safety; but it's really all about money in our raging capitalist system. Which is why all all the data that say nurse practitioners are safe and do not need prescribed collaborative arrangements simply are tossed aside. It's not *about* safety. Further,

most of the legislative and regulatory staff who actually write legislation and regulation are economists or lawyers. Explains a lot, doesn't it?

Then I read a recent KPMG consultant report to the government of Western Australia (WA Health, Nursing and Midwifery Office, 2011, March). The report raises a worry about whether practice nurses are obliged to follow the "orders" of NPs in their own four MBS codes which are mostly about immunization and similar procedures. The KPMG report hints darkly that there will be "follow on" issues between nurse practitioners and practice nurses which I would hope you could avoid. The KPMG report is about "business models and arrangements" which, oddly, are not at all about physician collaboration. Rather, in keeping with the government's agenda, they are about service delivery options that might combine private and institutional billing and thus funding provisions.

Collaboration is, of course, the opposite of competition, which is the economic issue in a market economy. When nurse practitioners are required under law or regulation to collaborate, that means they are taken out of the economic competition arena. A recent editorial by the Editor in Chief of the *Journal of Family Practice* in the United States says, "It's time to collaborate – not compete – with nurse practitioners". The tag line said, "arguments family practitioners make against APNs sound like specialists' arguments against us" (Susman, 2010, p 672). The Editor is responding to the release of Institute of Medicine's *The Future of Nursing* report about which I will have much more to say in a bit. He goes on: collaboration is already a reality and arguments against a shift in policy to honor independence in nursing practice don't hold up anymore. "Rather than repeating the cycle of oppression that we in family medicine battle as the oppressed," he says, "let's celebrate differences in practice, explore opportunities of collaboration and develop diverse models of care."

Medicine may well have painted itself into a corner by making specialist practice more desirable and lucrative and primary care less so. There is growing recognition in my country that we face a serious undersupply of primary care physicians, a gap nurse practitioner advocates are using to try to eliminate access barriers. One study estimates that even in the most optimistic scenarios of physician specialty workforce projections and at level production of non-physicians for primary care, the US will still be 15% short of primary care clinicians in 2025 (Sargen et al.2011)

"Much of what is called collaboration is more likely cooperation or coordination of care," the *Future of Nursing* document says (IOM, p 225). Collaboration is now taking on the meaning of true teamwork, not simply having a defined leader and a set direction (Katzenbach & Smith, 1993). Teamwork cannot be prescribed, it must be built on shared responsibility and respect.

One of the loveliest examples of mature statements about practice relationships I know about comes from the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists (ACNM/ACOG, 2011) In four remarkably brief paragraphs, the two associations affirm their mutual and independent commitment to high standards of practice and education and "collegial relationships". No mention of collaboration. Indeed, this statement is notable for the transparency of the differing positions the nurse-midwives and obstetricians have about home birth: the statement merely refers the reader to their respective statements and note that "the College and ACNM hold different positions." Isn't that just grown-up?

Billing systems and employment relationships are different from payment systems.

The financing and payment for healthcare in my country is known to be a World Class mess, increasingly laughable in its policy and political complexity. Armies of junior bureaucrats, professional lobbyists from interest groups (it is estimated that there are ten lobbyists for every one Congressperson or Senator), policy wonks in professional organizations, and legislative staffers are completely occupied in Washington this year trying to write regulations to implement the Affordable Care Act, or, to its critics, "ObamaCare." This time we have some reason to hope that nursing and advanced practice nursing will be treated with more logic and understanding then they have been in the past. Nursing supported the Affordable Care Act, and nurses are working in coalitions to write and comment on regulations.

As you would know, we do have already government healthcare programs – Medicare and Medicaid – which are insurance programs. We also have the Veteran's Administration, the Indian Health Service and the Public Health Service which are hybrids of insurance and care delivery systems, and we have something called Federally Qualified Health Centers (FQHC) which serve the poor under specific payment mechanisms. Then we have a complicated set of private insurance mechanisms, most of them based on employer contributions to health insurance systems which may include historically simple coverage plans such as Blue Cross, or for-profit

plans offered by insurance companies such as Aetna and pre-paid group practice plans which would be somewhat similar to your primary healthcare organizations. Private insurance schemes are not regulated (at least not until all the ACA provisions go into place).

Thus any and all of these insurance schemes have the ability and exercise it, to set limits on what they will pay for either out of their own self-interest in cost control, or out of pressure brought by others who would wish to restrict competition in addition to whatever state law does. Our Medicare program which covers the elderly, disabled and end-stage renal disease patients, for example, will pay nurse practitioners at 85% of what they will pay physicians. Why? Because it was argued that because the education of nurse practitioners is not as long as physicians, they are therefore only "worth" 85%. Medicare has also ruled that nurse practitioners can be paid at 100% only if their work is "incident to" physician practice. Nurse-midwives have negotiated themselves out of this dilemma and are paid at 100% but that is a Pyrrhic victory since there is little midwifery practice paid for by our Medicare system.
Some insurance systems have "panels" of providers that they enroll. Individuals covered under that plan may only have their healthcare paid for if they see someone on the panel. It took nurse practitioners years in some states to become "empanelled" by the commercial insurers.

Even when nurse practitioners make it to panels or fulfill every other regulatory requirement, there can be barriers to practice. For example, a psychiatric nurse practitioner I know dealt with patients on the newer anti-psychotics which you would know can cause diabetes. This NP wanted to be able to do the diabetes management in her own practice but when she submitted a bill to the state's Medicaid program as the CPT code, it was rejected by the insurer because her clinic is registered as a psychiatric clinic and diabetes treatment is outside its scope. This is not a *legal* scope of practice issue, it's an insurance regulation. To make the story even more strange, her legal scope of practice covered diabetes management so she could bill this insurer as an individual, using the appropriate ICD codes and CPT codes. As your authorizations grow in number and kind, you may find some of these same kind of boundary concerns raised but here at least you have a process for dealing with them that isn't legislative and thus subject to organized special interests.

There is one other more subtle theme in restrictive regulations that may also apply to you. We have learned that there is a sense out there that somehow nurse practitioners are more soft

hearted than others and will therefore abuse the healthcare coverage system by over-ordering tests or scheduling too many visits. Couple this with the suspicion these same bureaucrats have that poor or marginalized people will also abuse the system with too many visits or treatments, and you have nurse practitioners caught in a conundrum difficult to unravel since it is based in fantasy.

It is not accident that our public hybrid systems such as the Veterans Administration, the Indian Health Service, the Public Health Service, and the Federally Qualified Health Centers have been the most friendly to nurse practitioners. And nurse practitioners have demonstrated that patients seen by FQHC's use fewer hospital services (Ruthkopf, Brookler, Wadhwa & Sajovetz, 2011). These are not generally where physicians like to work. These are the places where nurse practitioners have gone both out of social justice commitment and out of relatively less resistance. It is in the private practice community supported by private insurance schemes that oppressive and discriminatory rules have prevailed. Indeed, restrictions on practice contribute to the migration of nurse practitioners away from restrictive to less restrictive states. (Christian, 2007; Kaiser Commission, 2011)

As you would know, the regulation of professional practice (or all kinds) is a function of the executive branch of State governments in my country as it was here until recently. The regulatory authority in the US rests in State Boards of Nursing whose composition and membership requirements vary from state to state. In some states, the State Board is very active in advocating for nursing (New Mexico, for example). In other States including Connecticut where I live, the State Board is quite weak and concerns itself primarily with disciplinary matters. There is a National Council of State Boards of Nursing (NCSBN) which has, in recent years, assumed a more public face, becoming an active participant in intradisciplinary forums.

Nurse practitioner regulation is generally the responsibility of State Boards of Nursing under provisions of the State Nurse Practice Act although in some states such authority resides in a Public Health Board or even in shared responsibility of the Boards of Nursing and Medicine. As advanced practice nursing has rolled out across the states, each one has had to develop its own approach to legislation and regulation, sometimes in infinite complexity, and generally requiring a separate license on top of the RN as well as certification by a national specialty body. States have the capacity to regulate who, where and when and how nurse practitioners will

function, especially regarding scope of practice and prescribing, and some have taken advantage of every opportunity to be restrictive. This means that there is a quilt nearly as crazy as our insurance schemes of nurse practitioner regulation across the country. What an NP can do in Washington, he cannot do in, say, Illinois or Georgia. We even have different abbreviations from state to state: APRN, ARNP, APN and on it goes. An NP considers a move to a different state with more trepidation than a move here or to New Zealand.

In many states, the language in the initial nurse practitioner practice acts was overly restrictive and has had to be unraveled in increasingly wearying lobbying efforts. In addition, laws quite outside practice acts have had the effect of restricting advanced practice nursing both at federal and state levels, not out of malice but simply because the laws were written before there were nurse practitioners or were written in ignorance of the scope of NP practice. For example, it appears at this writing that federal law under Medicare which presently allows only physicians to refer patients to nursing homes will be changed to include nurse practitioners who, of course, are often the ones to work with families to make this determination. (Home health legislation reintroduced, 2011) Disability laws have needed to be changed to allow nurse practitioners to sign for handicapped parking stickers for their patients. (This one was resisted in one instance by a legislator who happened to be an RN but believed that this would lead to more and more handicapped parking reservations which would make it harder for her to find a parking spot). This list of such adjustments makes amusing reading: examination or certification for worker's compensation; motor vehicle disabled placards and license plates; jury service excusal; sports physicals (the NP can do them, she just can't sign the form); declaration of death; marriage health rules; alcohol and drug treatment involuntary commitment; school physicals; birth certificates. (Safriet, 2010) To show how it is obvious that scope of practice debates that characterize the issue as safety are simply silly, consider this. In Connecticut, nurse practitioners were contacted by the morticians' professional association to expand their scope of practice to include signing death certificates. Now, in this state, nurses *without* advanced practice credentials can pronounce death. But signing a death certificate means naming a cause of death. The morticians had come to realize that a good bit of their business came from nursing homes where the presiding clinicians are very often nurse practitioners, with a collaborating physician

somewhere else, often miles away. They could not remove the body without a death certificate, so an odd political collaboration was forged.

The possibility of federal licensure in nursing for advanced practice if not for basic licensure has been lofted (Safreit, 2010), having seen what Australia has done (and New Zealand always had). I will be only a sweet memory when that happens.

The "scope of practice" maneuvers have taken egregious amounts of time and effort to deal with quite small issues, practically none of which have any consequences for patient safety. Indeed, they have led to what attorney Barbara Safriet calls "scope fatigue" among legislators. That led her and others including the NCSBN, working with the Pew Foundation, to promulgate a "primer" for legislators that tries to teach them how to adjudicate arguments over scope of practice (most of which pit nursing against medical advice to naïve legislators) (NCSBN, 2007). They proposed that any questions of scope of practice should be judged against a standard of "safe and effective *abilities*" rather than "first we must start with medicine" (Safreit, 2010). Note the language: abilities. I will make more of this later.

Now add to this picture the evolution of nursing specialty organizations, some of which represent the interests of both advanced practice nurses (such as the Academy of Nurse Practitioners) and specialty nurses (the Emergency Registered Nurses Association). The emergence of this variety of nursing specialty organizations, now numbering 48 or so, can be traced to the intransigence of the American Nurses' Association in the 1950's when it refused to countenance the special interests of nurse-midwives and nurse anesthetists, who went on to create their own organization. (Diers, 1992) ANA's internal agenda until the mid-1990's was industrial (jobs) until they spun off their union to a separate organization. Only a couple of years ago did ANA hire a policy specialist in advanced practice issues.

ANA and specialty nursing organizations began to wake up to the damage being done to nursing concerns by not seeming to have our act together and took the lead to convene a series of conferences with nursing specialist organizations that eventually resulted in a "consensus" document released in 2010. It proposes a framework for licensure, accreditation, certification for specialty practice, and education, the so-called LACE framework. (APRN Consensus Work Group, 7 July 2008) For this presentation, it is not necessary (you should sigh with relief) to go into the framework that has been suggested. What is important is that the LACE framework has

been adopted by the National Council of State Boards of Nursing and thus recommended for adoption by each state Board of Nursing. This is all, of course, in a good-hearted attempt to bring American nursing to "speak with one voice."

The action by the NCSBN would write into state law national certification as requirement for eligibility for an advanced practice nursing license which in my opinion merges public and private interests in an unfortunate way, but that's the way it works in my country.

We thought we had solved the standardization problem for NP qualification by moving advanced and specialty practice nursing education to the post-baccalaureate level into master's programs. But we fell into a different kind of internal chaos when Mary Mundinger, a distinguished Dean of a distinguished School of Nursing (Columbia University in New York City), in the service of advocating for nurse practitioners in internal medicine practice, proposed that a Doctor of Nursing Practice was the proper academic preparation to make nursing education more similar to medicine with "Doctor" in the title of the terminal practice degree. Nursing has, of course, had the PhD for many years. This was seized upon by the American Medical Association which passed a resolution prohibiting anyone from calling themselves "Doctor" except M.D.s. Eight states have followed through with similar state-specific prohibitions. (The Pearson Report, 2011)

Meanwhile, for their own internecine reasons, the American Association of College of Nursing which accredits baccalaureate and higher degree programs and which itself was created by a group of Deans who were unhappy with the proliferation of associate degree (two year) nursing programs has weighed in to prescribe "Essentials" for the Doctor of Nursing Practice degree programs, for which blessing of accreditation there will be a large fee.

You still with me?

It is not at all clear how all this will settle out but it is taking a lot of attention in organized nursing away from the possibility of evolving the policy and political sophistication of the nursing discipline as we fight our internal battles. Those of us who see your authorization and endorsement processes sigh in envy.

But it's not stopping nurse practitioners there or here or in New Zealand from developing innovative, policy-grounded services nor important alliances that build to change policy and practice.

Difficult as it is to understand our 51 or so political jurisdictions, they provide state-based laboratories that can test policy reforms that, if they work, may make it into national efforts. Many of the provisions of the "Obamacare" Health Reform were tested in Massachusetts, Pennsylvania or other states.

Pennsylvania made a cornerstone of its health care policy reform the notion of *access* to care. (There were other agendas including improving palliative care, reducing hospital-acquired infections, implementing the chronic care model and ensuring smoke-free workplaces [Hansen-Turton, Ritter & Valdez, 2009]). Eventually three separate bills were passed in 2007. One covered scope of practice of nurse practitioners including ordering home health and hospice care; ordering durable medical equipment; issuing oral orders; making referrals of physical therapy, respiratory therapy, occupational therapy and dietitian services; performing disability assessments, performing and signing initial methadone treatment evaluations and issuing homebound schooling certifications. The second dealt with title recognition for Clinical Nurse Specialists (equivalent to your Clinical Nurse Consultants). The third granted prescriptive authority to nurse-midwives along with authority to order medical devices and diagnostic tests. (Hanson-Turton et al., 2009) These bills came to pass because of a series of efforts beginning in 1998 in which nursing steadily built bi-partisan political support through coalition building, public presentation and testimony. They created an Alliance of Advanced Practice Nurses which brought together the State Nurses' Association with the relevant bodies of nurse practitioners, nurse-midwives, nurse anesthetists, school nurses and psychiatric advanced practice nurses. They eventually produced a "white paper" that laid out all the areas of the law that needed to be revised in order for these nurses to practice to the "full extent of their *training*." You might note that language – it will be important shortly.

The policy agenda was to expand access to care for Pennsylvanians. The Alliance attached its agenda and argued that appropriate legal authority for nurse practitioners, nurse midwives and so on would help achieve this goal: "It is in the Commonwealth's best interest to alleviate these restraints, freeing Advanced Practice Nurses to provide care to people in a satisfying as well as cost effective way…" (Hansen-Turton et al., 2009, p 12) The Alliance had the effect of creating the capacity for nurses to speak with "high-quality, succinct, trustworthy and lucid" (Hansen-Turton et al, 2009, p 13) information. The Alliance not only built bi-partisan

relationships with the Governor and his challengers in the other party, but with legislators and others, including private sector actors such as the Chamber of Commerce. (Hansen-Turton at al., 2009)

In the US, political rhetoric confuses access to care with access to health insurance. Massachusetts learned to its distress that simply providing access to health insurance will not guarantee access to care, as Massachusetts' primary care physicians began to buckle under the strain of increased workloads. Massachusetts nurses seized on this opportunity to push for passage of a bill that would recognize nurse practitioners as providers and reimburse them at the same rate as physicians. The bill passed in 2008.

Now, take a deep breath because it gets better.

There are new forces about in the world that give one increased optimism that we can get beyond scope of practice issues that keep us down in the weeds.

In the United States, the Institute of Medicine in collaboration with the Robert Wood Johnson Foundation released a long-anticipated report, *The Future of Nursing* in 2010 (Institute of Medicine, 2010). Nearly simultaneously, the Prime Minister's Commission on the Future of Nursing and Midwifery in England delivered itself of a wonderful document, *Front Line Care*. (Prime Minister's Commission, 2010) Indeed, the Prime Minister's Commission document notes communication with the Institute of Medicine committee.

The Institute of Medicine is part of the National Academy of Sciences, a quasi-private organization that conducts studies commissioned by government. The Robert Wood Johnson Foundation is the largest healthcare private foundation in the US. It has emerged from an initial period of serious physician chauvinism into a real force for change in nursing. The Foundation's role in *The Future of Nursing* report was to provoke IOM into collaboration, provide some staff but more importantly, to provide funds for implementation of the report's recommendations.

The Prime Minister's Commission was chaired by Ann Keen, a nurse, then an MP and Parliamentary Undersecretary for State in the Department of Health. The IOM Committee was co-chaired by Donna Shalala, a former Secretary of Health and Human Services now President of the University of Miami and Linda Barnes Bolton, Chief Nursing Officer of Cedars-Sinai Medical Center in Los Angeles. Both committees/commissions were composed of distinguished

nurses and interdisciplinary colleagues. Both held public hearings, made site visits, solicited input in a variety of ways.

The US report suggests that its agenda was to try to make sense of the array of ways in which nurses are educated, practice and are regulated, so that the nursing workforce could be released to contribute to access to care and quality and speak with "one voice". The UK report deals less with regulatory barriers and more with the potential of nursing to contribute to quality of care and innovation under the National Health Service if it could be lifted from historical subservience. It makes a particular point of advocating in the strongest diplomatic terms for the return of the Ward Sister/Matron role in hospitals. (Shades of the *Garling Report* in New South Wales).

Read in tandem, these two documents lift ones nursing soul.

The UK report begins, "Nurses and midwives are responsible for so much of what we have achieved over the last 10 years [in the NHS]. They are experts who know best how the service can meet the needs of patients and their local communities. We must be bold in putting them in control and at the heart of our plans for a world-class NHS" quoting the Prime Minister, then Gordon Brown, launching the Commission. (Prime Minister's Commission, 2010, p 14)

The US report boils its 500 plus pages down to four "key messages":

- Nurses should practice to the full extent of their *education and training*.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and information infrastructure (Institute of Medicine, 2010)

The UK report has 23 recommendations under the general headings of:

- High-quality compassionate care
- The political economy of nursing and midwifery
- Health and wellbeing (preventive care but also health practitioners' own health)
- Caring for people with long-term conditions

- Promoting innovation in nursing and midwifery
- Careers in nursing and midwifery

Many of the recommendations, since they are aimed at the NHS itself, concern increasing the flexibility of service delivery, for example, having nurses follow their home care patients into hospital and back out again. With respect to advanced practice nursing, the government finds "we are unconvinced that much of what is often called 'advanced practice'...represents such a significant shift in the nature of practice that it is inadequately controlled for through current arrangements. In many cases the use of the term appears to represent progression in experience and skills that could be expected to take place as professionals develop their practice...." (Council for Healthcare Regulatory Excellence, 2009) And they are forthright that if additional regulatory intervention is undertaken, it must be "proportionate". (Their regulatory body is called the Council for Healthcare Regulatory Excellence.) (Government Response, 2011)

Both reports use the same phrase when talking about the need to develop nursing leadership: "from the bedside to the boardroom." And both talk about nurses practicing to the limits of their education and training, not what their practice act stipulates. Regulation is usually conservative rather than enabling, that's what it's for. Where our health care delivery systems need innovation now isn't, in my opinion, in the so-called licensed functions at all, it's in the care coordination, patient teaching and support for self-management and community health functions that have always been at the core of nursing. The tricky bit, in the US, is that non-licensed function can't be billed for except as E and M or attendance codes which, being created for medicine, conceal nursing practice. And recall that if something isn't billed for, no data are created.

A close second in importance is the notion that nursing is at the center of service delivery (and access to care) and the hub of quality and patient safety. This is becoming obvious as we move toward adverse event and outcome measurement. (Kurtzman & Buerhaus, 2008) Such a declaration brings nursing into the light and requires that we live up to the challenge of informing and creating humane, compassionate and excellent services, working as we will with our colleagues in other disciplines as full partners. The US *Future of Nursing* report commits nursing to a "redesign" of the healthcare delivery system. That would involve not only

innovative care delivery strategies but also the building of policy and political infrastructure to support and pay for them. That's code for political action – lobbying.

To get there we need to heed the advice of these two magnificent reports and move beyond our parochial issues to associate ourselves with the concerns of just care, justly distributed. What embarrasses the NHS is deficiencies in quality of patient care. What gets attention in the US is money – cost of care, inefficiency, waste. Nursing is right there to help out, as we have always been, if unacknowledged.

Some of my colleagues in the US have proposed a way to think about nursing's policy and political development (Cohen, Mason, Kovner et al., 1996) They suggest that there are four stages of development. In the first stage, which they call "buy in", nurses are just barely politically aware – they may vote, may appreciate their professional organizations' positions. Their policy or political concerns are local and internal, however. They do not know the language of policy and politics – the language is nursing's. Rare nurses may be appointed to policy boards or commissions but mostly out of individual achievement.

The second stage is called "self interest" and is reactive to external forces. There may be coalitions of nursing organizations and such organizations may have a role in appointing nurses to policy positions. The language of nursing in policy arenas is about caring or nursing diagnosis, internal to the discipline.

In the third stage, called "political sophistication," nurses are proactive on nurses' agendas, for example, for health reform. Nurses can now use political language and nursing coalitions form on the basis of shared commitments. Professional organizations see to it that nurses are appointed to important policy boards and commissions.

The fourth stage is "leading the way" and this seems to be the stage to which both the IOM report and the Prime Minister's report are pushing nursing. In this stage, nurses are setting the agendas on a broad range of health and social topics (access to care, smoking, obesity, quality, for example). The language introduces terms which reframe or reorder the debate. The coalitions now go beyond nursing and many nurses are sought for policy positions as nurses. (Cohen et al., 1996)

You have models of "leading the way" in your own remarkable history with advanced practice nursing and nurse practitionering. You started the latter in New South Wales with a

selection of experiments that included new nursing roles in emergency, in sexual health, in rural health and other places where you cleverly identified were short of either care or quality. It is not accident that your first census of nurse practitioners showed the highest single number in emergency care. (Gardner, Gardner, Middleton & Della, 2009) Australia's unstated health policy has long been to limit the supply of hospital beds, since hospital costs are the greatest. However, as you well know, that backs up emergency rooms, diverts ambulances and has on occasion even brought down governments.

You also have produced a remarkable document, "Primary Health Care in Australia" written "for the wider community" (Australian Nurses Foundation, 2009, p 1) which goes to the heart of "person centered, holistic approach incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of accessible, essential integrated quality care"..(p 1) even as it argues for nursing-specific fundamental change. I will be instructed to learn at this conference how that document has been received and I pledge to carry its text and promise back to the U.S.

In my country, one of the most powerful examples of fourth stage progress has been in the work to implement what is called "transitional care". Transitional care refers to an array of time-limited services and environments designed to ensure health care continuity, especially from hospital to home. It began with nurse-led models of early discharge of low weight babies from hospital to home, with nursing support. (Brooten, Youngblut, Deatrick et al., 2003) More recently, it has been tested with a variety of patient populations including cancer patients and the chronically ill elderly. Transitional care is based upon nurse practitioner practice and has been proved effective in randomized controlled trials – reductions in rehospitalization and cost savings. (Kurtzman, 2010) The evidence from these projects, combined with the considerable political and policy sophistication of Prof. Mary Naylor at the University of Pennsylvania, got transitional care embedded in the Affordable Care Act as a $500 million program specific to high-risk Medicare beneficiaries (Kurtzman, 2010).

Nurse-managed health centers are another instance of nurses being "out there" leading the way, especially in primary care services for underserved communities. There are now more than 250 Nurse-Managed Health Care Centers which record more than 2.5 million patient encounters annually. (Hansen-Turton, Nagle, et al, 2010) Most Nurse-Managed Health Centers

are operated by schools of nursing. "Convenient care centers" are arguably another form of innovation. These are retail primary care, often located in convenience stores, shopping malls, airport terminals and especially our big-box pharmacies, CVS and Walgreens. These have become very popular for minor colds, sprains, sunburn, bruises, sports physicals, blood pressure testing, insect bites and flu shots. (Hanse-Turton, Ridgway, Ryan & Nash, 2009) They are almost always staffed by nurse practitioners. Payors will cover their services, a phenomenon driven by patient demand. We are impatient and do not want to wait for care. These services have been shown to be cost effective (Mehrotra, Liu, Adams et al., 2009)

Finally, both the US and UK reports target the need for data on nursing. In the UK, the problem is in finding the nurses and their activities outside of the NHS and in determining which nurses are practicing in expanded or advanced practice roles. In the US, data on nurses come from the various State Board relicensure processes and while there are difficulties in counting nurses who hold licensure in more than one state, the larger problem is in describing practice whether in more traditional nursing roles in hospitals or in advanced practice. There are no nationwide standards for data collection about site or type or practice. Recent evidence from the states of Vermont and Washington is illuminating the importance of collecting descriptive data on nurse practitioner practice (Palumbo, Marth & Rambur, 2011) Vermont attaches a voluntary questionnaire to relicensure applications. A first study showed a marked shift in employment responsibilities for NPs since 2003 when the study began with a move away from administration into direct clinical practice. Job stress was identified as a larger issue than salary or benefits. I note that there are now attempts here to get information about nurse practitioners and their prescribing practices by survey (Middleton, Gardner, Gardner et al., 2010; Dunn, Cashin, Buckley & Newman, 2010) which will be important for you moving forward even if it is labor intensive.

The larger problem in my country and throughout the world is not so much in enumerating nurses or nurse practitioners, but in gaining an understanding of what they actually do, how many of what kind of patients they see, with what outcomes. In the US, this is because of the peculiar insurance system we have which defines billing practices which in turn define our information systems. In the UK and in Australia and New Zealand where there are no billing systems in the public sector at least, data on nurse practitioner caseloads will have to be collected

on an ad hoc basis or through surveys. It would be in your interest to develop a white paper or similar vehicle in which you might assist government in how to think about what kinds of data elements would be required to capture the work of nurses and nurse practitioners going forward. It has occurred to me that perhaps you could build such a data system from your authorization proposals.

Different as our economic structures are, there is much more commonality about nurse practitioner work across the world than difference. Your authorization processes and New Zealand's may seem a tedious form of overregulation but they allow you to skirt the scope of practice morass in which we find ourselves and they provide some form of community support.

We have much to admire about how you in Australia and New Zealand have crafted your work, your public relations and your shining professional stature.

So I thank you for letting me partake of that once again.

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