Legislative Commission on Primary Care Workforce Issues

June 22, 2017 2:00-4:00pm at the NH Medical Society Conference Room, Concord

Call in information:

866-939-8416

Participant Code: 1075916

Agenda

2:00 - 2:10 **Introductions & Minutes**

2:10 - 3:20 **Stephanie R. Richardson, Director, Government Programs & ACA Program Office, Harvard Pilgrim Health Care**

1. Improving Access to Primary Care: Recommendations from The Mayor's Task Force on Improving Access to Primary Care in Boston (2008)

2. AHCA Update

3:10 – 3:45 **Legislative Update**
*HB 322
*State Loan Repayment Program
*other workforce related legislation

3:45 – 4:00 **Updates and next meeting**

Next meeting: Thursday July 27 2:00-4:00pm

State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: June 22, 2017

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Medical Society

Meeting Minutes

TO: **Members of the Commission and Guests**

FROM: Danielle Weiss

MEETING DATE: June 22, 2017

Members of the Commission:
Laurie Harding – Chair
Stephanie Pagliuca, Director, Bi-State Primary Care Association
Cathleen Morrow, MD, Geisel Medical School
Jeanne Ryer, NH Citizens Health Initiative
Guests:
Danielle Weiss, Program Manager, Rural Health and Primary Care Section
Paula Smith, SNH AHEC
Catrina Watson, NH Medical Society
John Bunker, representing UNH & CHHS
Anne Marie Mercuri, QI Nurse, Maternal and Child Health Section
Barbara Mahar, New London Hospital
Kristine Stoddard, Esq., Bi-State Primary Care Association

Meeting Discussion:

2:00 - 2:10 **Introductions & Minutes**

- The state budget passed
    - DHHS got significant funding increases
        - Especially for mental health
    - However, there are significant tax cuts and deeper cuts to Medicaid
    - With release of the health reform bill, it currently allows states to waive key ACA provisions without legislative approval
- Our Commission's primary focuses:
    - State Loan Repayment Program
    - Workforce data collection via survey implemented during health professions boards' relicensing cycles
    - Establishing a residency
        - Challenging without Graduate Medical Education funding
        - Working with UNE for recruitment purposes
        - Working with AHEC around rural rotations
    - Looking for other possibilities in the workforce world
        - Workforce Investment Grant
        - Integration of behavioral health and substance use disorder treatment into primary care

2:10 - 3:20 **Stephanie R. Richardson, Director, Government Programs & ACA Program Office, Harvard Pilgrim Health Care**

1. Improving Access to Primary Care: Recommendations from The Mayor's Task Force on Improving Access to Primary Care in Boston (2008)
2. AHCA Update

Refer to the PowerPoint, "Improving Access to Primary Care Recommendations & AHCA Update" and the following supplemental materials: Improving Access to Primary Care Report; Improving Access to Primary Care White Paper.

- The Mayor's Taskforce in Boston was looking at the same workforce strategies
    - The report was released in 2008
    - Recommendations in the report were made from three working groups
    - The Boston Primary Care website, which was launched in 2009 to serve as a single point of entry for providers seeking primary care positions, is no longer up
- Harvard Pilgrim partnerships to address workforce shortages
    - FQHCs will be in network to fill gaps
        - Determining how to partner with other facilities that they haven't yet contracted with
    - Working with the pharmacological industry to curb the cost of prescriptions
    - When the Taskforce formed, a pressing workforce issue to address was retention – cost of living, loan debt, etc.
        - Providers were leaving the city after training
- The Taskforce's greatest success
    - The Community Health Center (CHC) Loan Forgiveness Program
        - Intended to increase the capacity of health centers to provide primary care by enhancing the availability of primary care physicians, NPs, and PAs
            - Offers school loan repayment to primary care providers who make a 2-year commitment to practice at one of the state's eligible CHC organizations
        - Managed by the MA League of Community Health Centers with private funding
        - **Possible presentation at our meeting via webinar or over the phone**
            - Stephanie Pagliuca will get contact information
- Identify those familiar with the Boston primary care website to tap into that knowledge
    - The Recruitment Center could build on their existing site for providers
        - We could improve on how to direct and move practitioners to a good practice fit
- Payment – how can we find out if the payment innovations stuck?
- The Boston Public Health Commission is involved with all public health facets
    - It's well resourced, funded, and led
    - **Reach out to a contact at Boston Public Health commission** to come speak about the primary care workforce issues that Boston still faces today
- What are major concerns in Washington?
    - Senate bill
        - If it doesn't pass, there will still be uncertainty related to CSR
            - Trump said there would be funding through June - HP got funding for June so the question is, will there be funding for July

- HP needs market stability

- If the health care bill passes as is, what will be most challenging consequence
  - States' flexibility to regulate the market
    - Because HP exists in 4 states, they could have 4 flavors of policy
- If Medicaid became a block grant tomorrow, what would happen?
  - There would be no ability to raise the ceiling as it relates to people who need the services

3:10 – 3:45 **Legislative Update**

**State Loan Repayment Program*
**HB 322*
**other workforce related legislation*

- With reduced State Loan Repayment Program funding, the limited availability of funds will have to be better prioritized
  - The hospitals that are able to match will need to cover the total repayment for their providers
- Second portion of the Joint Underwriting Association (JUA) money
  - The JUA statute, as it stands, is going to the Supreme Court
    - The language is being challenged because it all but names Bi-State as the recipient of funds and Bi-State's audit standards won't allow for the management of these funds
      - Bi-State has to apply overheads and costs evenly, so it wouldn't make sense to use the money in that capacity
        - It would disproportionately cover other grants
      - The statute currently holds that funds that were allocated for those not being insured, which weren't utilized, will go to a nonprofit to help the underserved
  - Need to identify an alternative funding recipient to manage funds that would ultimately serve the State Loan Repayment Program
    - **One of attorneys to come to a meeting to discuss options**
      - New legislation to change language could be introduced but it would still have to go to the Supreme Court
    - **Possible conference call with the DOI during an upcoming meeting**
      - They distribute the funds
    - The Endowment for Health, Charitable Association, etc. may be able to manage the funds
  - **Bill Brewster to come speak to Commission – NH manager for Harvard Pilgrim**
    - It would benefit 3rd party payors to help with funding for State Loan Repayment Program

3:45 – 4:00 **Updates and next meeting**

The NH Partnership Initiative

- A result from the State Workforce Investment Board
- Goal is to help businesses and employers address their workforce needs and workers prepare for and advance in health care careers, especially those that require more than a HS diploma but less than a 4-year degree
- Disconnected collaboration, need for integration and partnering statewide
- Report outlines key issues and recommendations
- 4 broad recommendations :
  - Develop an actionable assessment of workforce needs across subsectors
  - Expand career pathways that cross subsectors and include more entry points, workbased learning, financial and nonfinancial supports and incentives
  - Expand recruiting efforts to nontraditional populations
  - Connect to economic and community development efforts
  - Advocate for state legislative and administration policies to support hc workforce

Next meeting: Thursday July 27 2:00-4:00pm

Harvard Pilgrim Health Care

New Hampshire Primary Care Workforce Commission Presentation

Stephanie R. Richardson
Director, Government Programs
June 22, 2017

Agenda

- **Improving Access to Primary Care**: Recommendations from The Mayor's Task Force on Improving Access to Primary Care in Boston (2009 Recommendations)
- The American Health Care Act (AHCA) Update
- Questions

Mayor Tom Menino's Call to Action

- February 2008: Mayor Menino and Dr. Paula Johnson, Chair of the Boston Public Health Commission Board launched the Mayor's Task Force on Improving Access to Primary Care in Boston
  - **Goals**:
    - Evaluate state of care in Boston
    - Examine challenges associated with primary access for Boston residents
    - Make recommendations to improve primary care access
  - **Twenty Member Task Force:** leaders of premiere health care institutions, including CEOs of hospitals and community health centers, health insurance plans, deans of schools of nursing and medicine, and community organizations
  - **Three Working Groups**
    - Health Systems Working Group
    - Workforce Working Group
    - Finance Working Group

Task Force Priority Recommendations

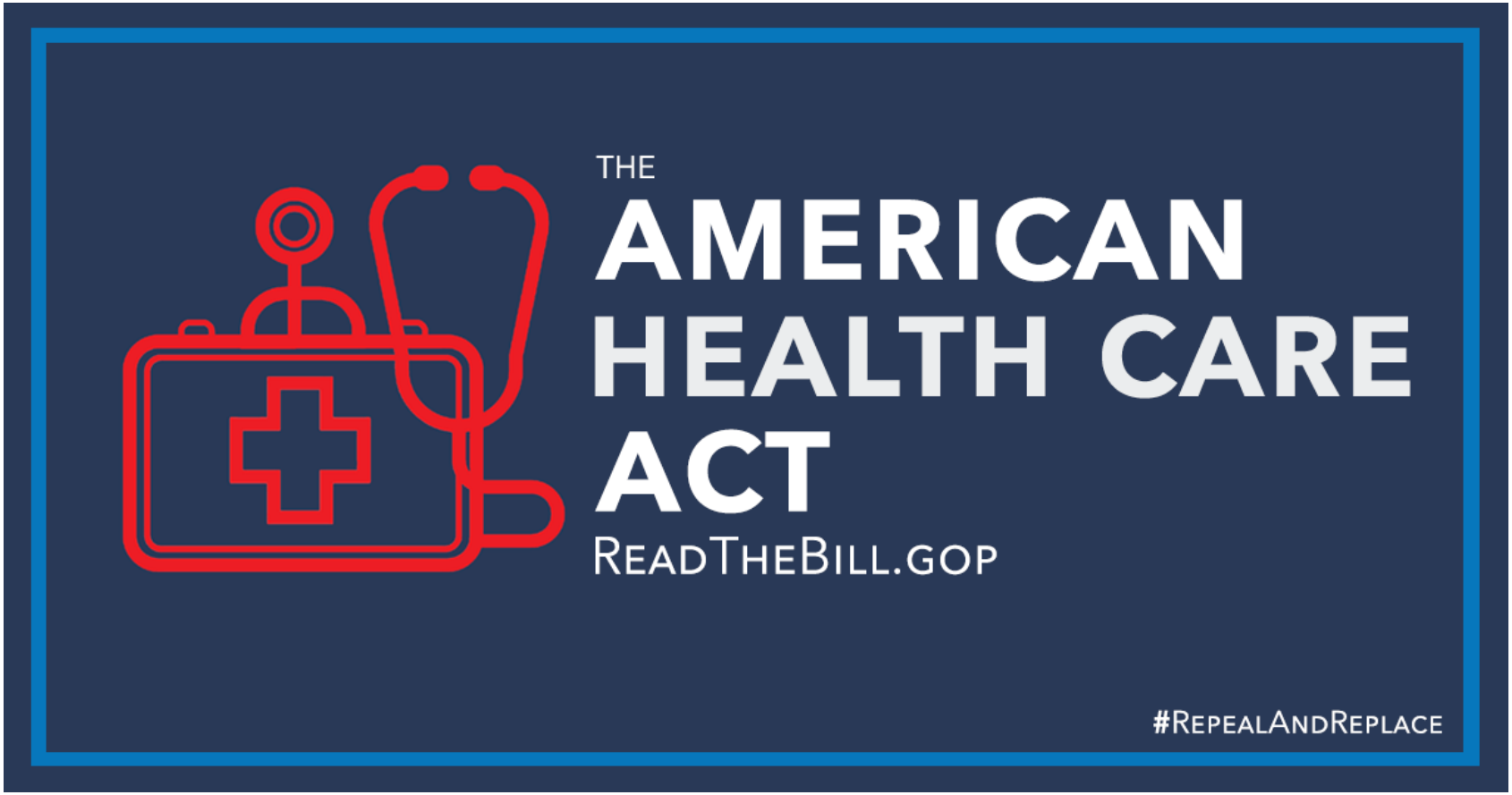
- Recommendations to improve access to quality primary care and improve health outcomes

1. **Advance** uniformity and alignment of performance measures, payment methodologies and payment incentives.
2. **Support** expanding the roles of non-physician health professionals.
3. **Promote** financial incentives to **recruit** and **retain** a robust and diverse primary care workforce in Boston.
4. **Reduce** the burden of chronic disease in Boston residents by improving access to nutritious food, increasing opportunities for physical activity and reducing exposure to environmental hazards particularly in communities of color and low-income communities.
5. **Establish** an ongoing primary care task force to monitor progress and prioritize opportunities to **improve** access to primary care.

Immediate Action Taken

- Mayor Menino immediately took the following actions:
  - Established the Boston Consortium of Health Careers Awareness and Pipeline Programs in partnership with the Private Industry Council and the Boston Public Health Commission.
    - Objective: Use primary care workforce data to identify shortages and align programs to address gaps in the healthcare system.
  - Launched the Boston Primary Care website to serve as a single point of entry for providers seeking primary care positions, loan repayment, and other incentives.
    - Objective: Highlight the advantages of living and working in Boston, and promote the benefits of primary care medicine to residents and students considering a career in primary care.
  - Created the annual Mayoral Prize for Improving Access to Primary Care that recognized promising practices at Boston institutions.
    - Four categories:
      - Innovations in healthcare delivery systems
      - Innovations in workplace settings
      - Innovations in community settings
      - Investments by philanthropic organizations

AHCA Update



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American Health Care Act

- Reconciliation Legislation
- Maintains many ACA components:
  - No preexisting condition exclusions (but potentially higher premiums)
  - Guarantee availability and renewability of coverage
  - Coverage of adult children up to age 26
  - Cap out-of-pocket expenditures
  - No lifetime and annual limits
  - No discrimination on basis of race, nationality, disability, age or sex

American Health Care Act (cont.)

- Medicaid
  - Repeals state option to expand Medicaid by 12/31/19
  - Funding for expansion would phased out starting in 2020
  - Provides $10B in safety net funding for non-expansion states
- Federal Subsidies
  - Advanced Premium Tax Credits and Cost Sharing Reduction Payments remain until 12/31/19
  - Replaced with advanceable, refundable tax credits adjusted by age (indexed to CPI+1):
    - Under age 30: $2,000
    - Between 30-39: $2,500
    - Between 40-49: $3,000
    - Between 50-59: $3,500
    - Over age 60: $4,000
  - Additive for families and capped at $14,000. Available in full up to $75,000 ($150,000 joint) & phased out for higher incomes

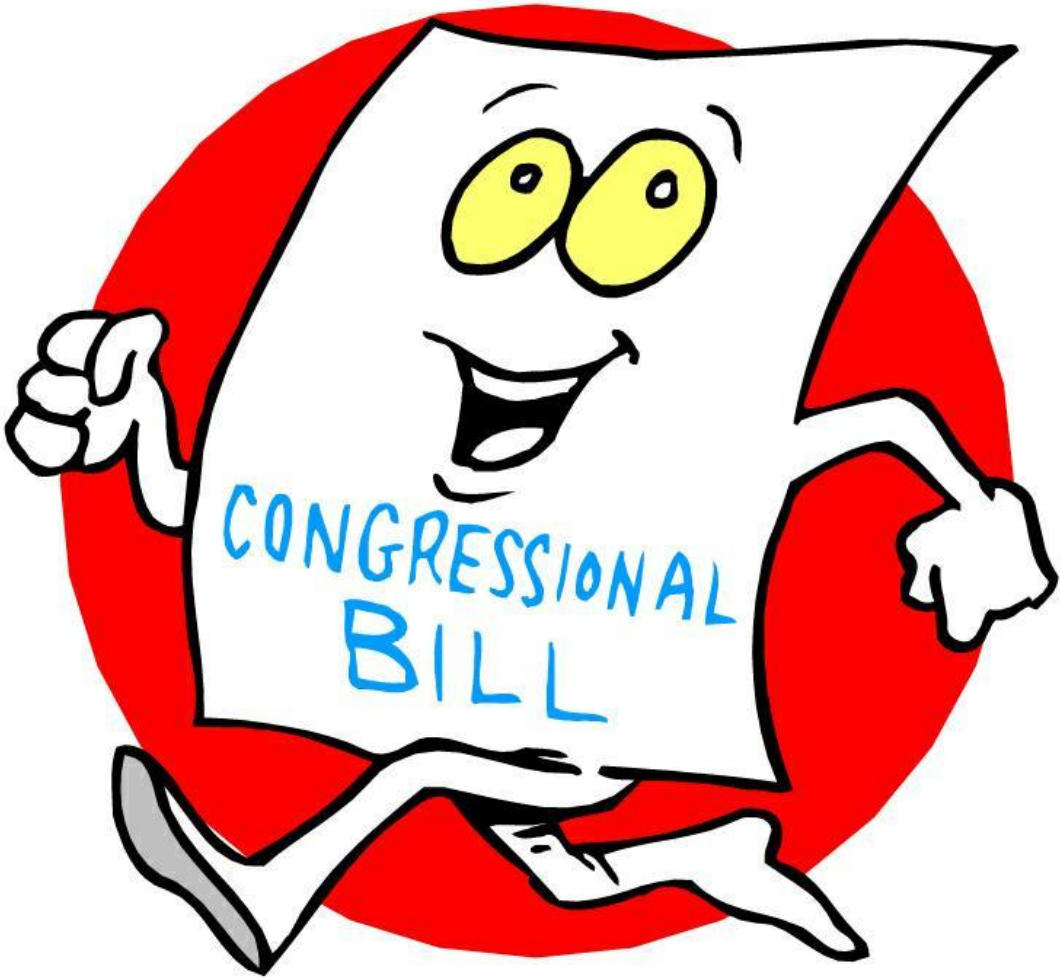
American Health Care Act (cont.)

- Patient and State Stability Fund
  - Provides states funding to stabilize premiums in the individual market. Can be used for various purposes, including invisible risk pools. In the absence of state action, defaults to a federal reinsurance program.
- Continuous Coverage
  - Repeals Individual and Employer Mandate Penalty (but reporting requirements appear to remain)
  - 30% surcharge for those without continuous coverage
- Taxes
  - Repeals many taxes (HIT, Medical Device, OTC Rx, Medicare Tax, etc).
  - Delays Cadillac Tax until January 2025
- Benefits and Rating
  - Repeals metal level requirements and allows state waivers to the essential health benefit requirements
  - Allows state flexibility in rating for individuals and small groups – including charging higher rates for pre-existing conditions in limited situations

AHCA – Repeal of Tax Provisions

- Tax penalties associated with individual/employer mandate
- Tax on branded prescription medications
- Excise tax on sale of medical devices
- ACA health insurance tax
- The Cadillac Tax (suspended through TY2024)
- Medicare tax on high-income taxpayers
- The $2,500 limit on contributions to flexible spending accounts
- The increase in level of medical expenses that must be incurred to claim a tax deduction
- Tanning tax

On to the Senate



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AHCA: Senate Version: What We Know

- **Repeals** the individual mandate, the employer mandate and ACA taxes.
- **Defunds** Planned Parenthood for one year.
- **Medicaid Expansion**: Funding continued until 2021 and then phased out over three years.
- **Medicaid Structure Changes**: States to receive a set amount of money per person as in the House bill. Annual growth rate will be tied to standard inflation and not medical inflation beginning in 2025.
- **Subsidies**: Continue under the Senate bill with changes to eligibility criteria beginning in 2020. (APTC eligibility decrease from 400% FPL to 350% FPL). CSR funded until 2019.
- **What's next?** Senate to hold a vote at the end of next week although it is unclear how this bill will reconcile with the Senate's budget rules on reconciliation. CBO score expected by early next week.

With under two weeks left until July recess, GOP senators disagree over key AHCA issues

Key issues in the fight for health care reform

The future of Medicaid

- By far, the biggest disagreement in the Senate over the AHCA is the Medicaid phase-out plan
- Moderates in the GOP want the phase out to occur over 7 or more years, whereas conservative senators want a timeline of less than 5 years
- Senators of states that have expanded Medicaid have hinted at voting no for a bill that includes Medicaid cuts at all

Repeal of Obamacare taxes

- Originally, many GOP members of Congress opposed the ACA taxes, but the Senate is looking now to keep some of the more popular provisions, like the net investment income tax
- Key conservative groups wrote a letter to Sen. Orrin Hatch to urge the Senate to repeal the taxes
- The tax most likely to be cut is the Cadillac tax on employer-provided insurance and medical devices
- Secretary of HHS Tom Price has long advocated for cutting tax on medical devices, saying it inhibits innovation and growth
- Moderates are interested in keeping some of the taxes, but it is unclear if conservatives will support a bill that includes ACA taxes

Defunding Planned Parenthood

- The only way that legislation defunding Planned Parenthood could be passed is through the AHCA is under a reconciliation bill- since it requires for a simple majority of 51 rather than 2/3rds majority
- Moderate Senators Murkowski, Capito and Collins have stated their opposition to a bill that defunds Planned Parenthood completely
- Since the Senate cannot pass the AHCA if GOP loses more than 2 votes, this clause is a crucial one for the Senate version of the AHCA

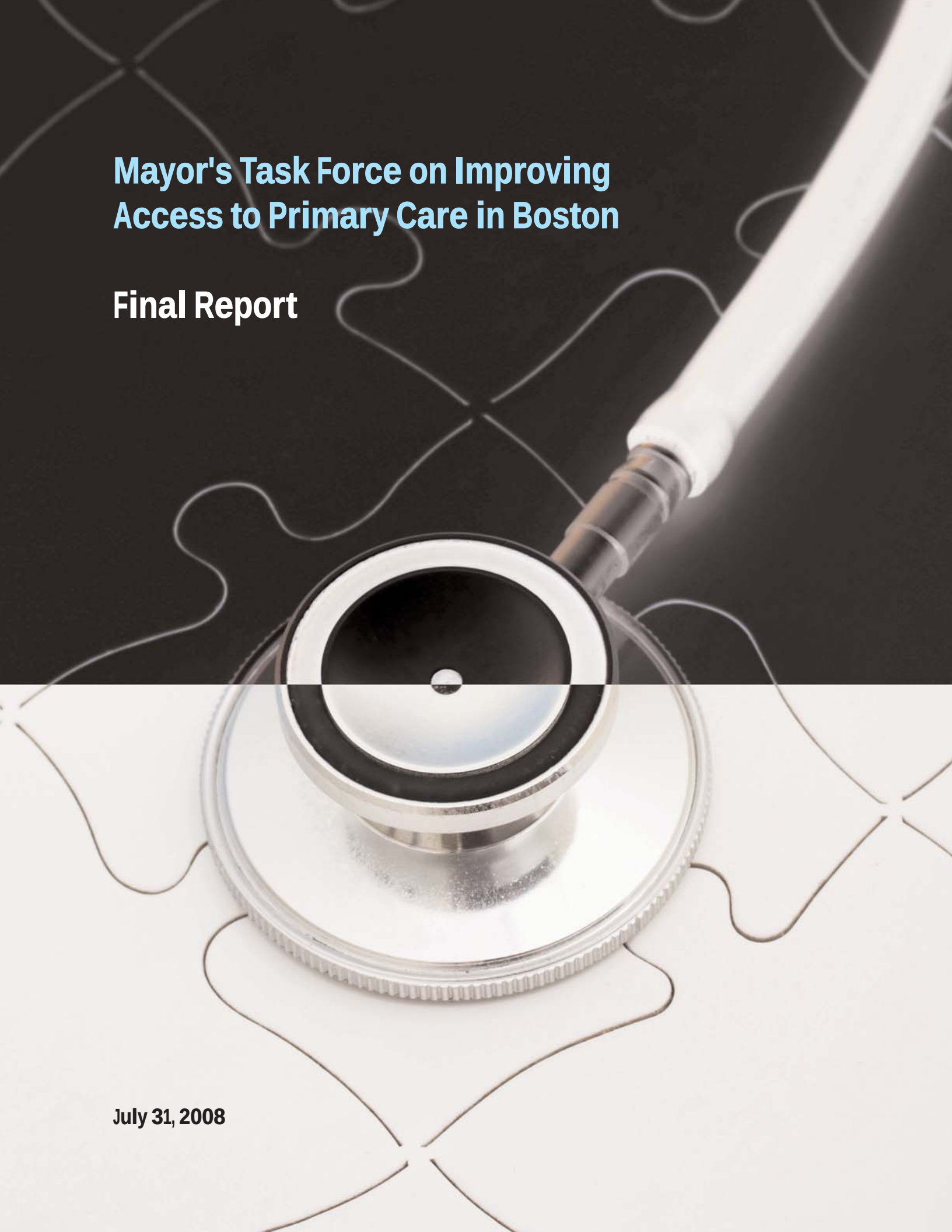
Sources: The Hill, June 19, 2017.

Questions?

Harvard Pilgrim Health Care

Mayor's Task Force on Improving Access to Primary Care in Boston

Final Report



July 31, 2008

Acknowledgments

This document is the embodiment of Mayor Thomas M. Menino's vision, leadership, and staunch commitment to improving primary care access in Boston.

Paula Johnson, M.D., chair of the Boston Public Health Commission board, took the mayor's charge and skillfully shepherded the process through its conclusion. BPHC Board members Hortensia Amaro, Ruth Ellen Fitch, and Celia Wcislo provided invaluable guidance.

This report is the culmination of the efforts of many, including members of the Task Force and Working Groups, Commission board members, and BPHC staff. The working groups were co-chaired by Bruce Auerbach, MD, Larry Culpepper, MD, Thomas Lee, MD, Robert Mandel, MD, Bill Walczak, and Ellen Zane.

The first draft of the report was authored by Jeffrey Levin-Scherz, MD. BPHC staff who contributed to the process by staffing the working groups and editing the report were Maia BrodyField, Nicole Charon-Schmidt, Barbara Ferrer, Pam Jones, Maurice Myrie, Ian Newton, Nancy Norman, MD, Debra Paul, and Gerry Thomas.

Special thanks to Judy Steinberg, MD, MPH for her contributions.

Introduction

Primary care access has been shown to improve quality of care and health outcomes, reduce inequities, and lower overall cost of care. Nonetheless, primary care is in crisis throughout the United States. Lower overall pay and demanding work requirements for primary care physicians, including general internists, family physicians and pediatricians, have led to difficulty filling residency positions, and the "pipeline" of physicians completing training in primary care is dangerously low. The American College of Physicians published an article warning of "the impending collapse of primary care," and family medicine residencies fill only half of their positions with United States graduates. There is an acute shortage of nurse practitioners and physician assistants in primary care, and nursing and many ancillary care providers are also in short supply. The state's landmark health care reform law added an additional 360,000 adults to the ranks of the insured, which is expected to further strain the supply of providers.

In February 2008, Mayor Thomas M. Menino, along with Dr. Paula Johnson, Chair of the Boston Public Health Commission Board, convened the Mayor's Task Force on Improving Access to Primary Care in Boston to evaluate the current state of care in Boston, examine challenges and make recommendations about how to improve primary care access for Boston residents. Recommendations have been developed by three working groups: health systems, workforce and finance. The Task Force included members from the provider, employer, health plan, academic, consumer and government sectors. We are grateful for their valuable contributions.

Included in this report are recommendations and suggested next steps to improve access to primary care in the city of Boston. Although the Task Force was charged with improving access, its recommendations also recognize the importance of quality and cost.

The recommendations in this report are intended to complement the efforts of the Executive Office of Health and Human Services in examining primary care access, as well as several pieces of pending state legislation. Furthermore, we recognize the need to collaborate with national efforts that address the impact of federal antitrust laws, the role of Medicare as the payment trend setter and major funder of Graduate Medical Education, and the importance of loan forgiveness programs administered through the National Health Service Corps.

Executive Summary

Though Boston is home to some of the nation's outstanding academic medical institutions, in the years ahead many Boston residents may find themselves losing access to essential primary care. Massachusetts health care reform has increased the number of insured residents, but health care costs will rise and quality will suffer if there are not enough primary care providers. This report offers recommendations intended to improve access to quality primary care and improve health outcomes.

The Mayor's Task Force on Improving Access to Primary Care in Boston has identified five priority recommendations to improve primary care access for residents. For each recommendation we review the underlying problem, lay out action steps, explain how the recommendation will improve primary care access, and discuss necessary resources, timeframes and the potential role of city government. Additional recommendations developed by working groups are listed in the Appendix and can be adopted as part of a broad agenda to improve access to quality primary care services.

PRIORITY RECOMMENDATIONS

1. **Advance uniformity and alignment of performance measures, payment methodologies and payment incentives.**
2. **Support expanding the roles of non-physician health professionals.**
3. **Promote financial incentives to recruit and retain a robust and diverse primary care workforce in Boston.**
4. **Reduce the burden of chronic disease in Boston residents by improving access to nutritious food, increasing opportunities for physical activity and reducing exposure to environmental hazards, particularly in communities of color and low-income communities.**
5. **Establish an ongoing primary care task force to monitor progress and prioritize opportunities to improve access to primary care.**

Recommendation One:
Advance uniformity and alignment of performance measures, payment methodologies and payment incentives

Underlying Problem

Many health plan "pay for performance" measures focus on the activities of primary care physicians, and health plans include varying measures and targets in their contracting conditions. Although care coordination is an essential component of primary care, numerous activities necessary for coordination are uncompensated. Fee schedules favor procedures rather than the evaluation and care management predominantly delivered by primary care clinicians. Further, each health plan differs on criteria for determining what procedures to cover, the claims and appeals process, and fees. As a result, though primary care practices may have 4 or more FTEs supporting each physician many of these staff are working on reimbursement issues, not supporting patient care.

Action Steps

1. The Boston Public Health Commission (BPHC) should review the various payment methodologies, including pay for performance measures, from health plans that contract with the City of Boston, highlighting substantive differences that create workflow difficulties in primary care practices.
2. The BPHC should engage the Massachusetts Medical Society and other parties to collect examples of prior authorization and other health plan administrative procedures that do not add value for patients, along with examples of medical home or comprehensive care models that enhance patient care.
3. Health plans should identify ways to streamline claiming processes to reduce administrative waste.
4. The City should evaluate the possibility of including criteria in the bidding process that would require health plans to remove unnecessary administrative barriers and improve alignment of performance incentives and payment methodologies.

How This Will Improve Primary Care Access

Identifying payment methodologies which advance the concept of a medical home will improve care for patients while also streamlining the administrative process for clinicians. Freed from the burdens of duplicative and conflicting administrative processes, primary care practices will be able to increase resources to care delivery. Practices will also have much clearer expectations for how performance and outcomes-based incentives can be aligned across the medical sector. Ultimately, this will have the added effect of improving job satisfaction and improving retention of primary care providers by eliminating non-essential clinical work requirements.

Examples

Across the country there are new payment models being piloted and implemented. Bridges to Excellence, a *medical home payment initiative*, has been implemented by many states and employers. The program gives primary care physicians $125 per patient per year for providing certified medical homes. Prometheus Payment, Inc., with support from Robert Wood Johnson and the Commonwealth Fund, advocates system reform through a new model of *evidence-based care rates* (ECR). ECR covers all care given in a set period of time. Prometheus is using "expert opinion" to build the rates from the ground up based on appropriate evidence-informed services. There are also plans that are using *blended payment models*. The North Carolina Community Care Program is using a blended payment with their 750,000 Medicaid members. Approximately 3,000 physicians in 15 networks statewide participate. Payment is 95% of Medicare rates and providers receive $3 per member per month (PMPM) for case management and a $2.50 PMPM for care and disease management. Tufts Cigna's prospective payment model pays a fee for service and providers receive a monthly care management payment and performance bonus for quality and reducing costs.

In addition, the state of Maryland is considering expanding its hospital-based all-payer system to providers in out-patient settings. Many international financing systems models exist, but are premised on universal government sponsored health insurance.

Resources Required

This recommendation will require project management at the BPHC, as well as collaboration with various outside organizations including the Massachusetts Medical Society and local health plans. Further, this recommendation requires the engagement of the Health Benefits and Insurance Department, which procures health insurance on behalf of the City of Boston.

Timeframe

The City of Boston negotiates its contracts with health plans in early fall for the following fiscal year. Therefore, efforts to inventory opportunities for change would have to begin immediately so that they could be used in establishing the bidding requirements and selection criteria for 2010 or 2011 health insurance coverage.

Role of the City Of Boston

The City of Boston, with 18,000 employees, has leverage as a major health insurance purchaser. In this initiative, the City can also play an important role as an advocate and a convener.

Recommendation Two:
Support expanding the roles of non-physician health professionals

Underlying Problem

Few new graduates of internal medicine training programs intend to practice general internal medicine. Over the past decade, family medicine training programs have also suffered a substantial decline in enrollment. Virtually all estimates suggest that there will not be enough primary care physicians to take care of our aging population. While strategies that increase the number of primary care physicians are essential, the projected shortfall of physicians is serious enough to warrant an expansion in the roles, responsibilities and training of physician assistants (PAs) and nurse practitioners (NPs). Efforts are needed that will also make it attractive for PAs and NPs to practice primary care within the city. This is not possible without modifying rules and regulations that limit their scope of practice, even if they have appropriate training. As these professions are also experiencing workforce shortages, more effort should go into recruiting.

Historically, various professional societies have objected to expanding the scope of practice for clinicians outside of their membership. The primary care shortage should be seen as an opportunity for professional societies (both medicine and nursing) to collaborate in identifying ways of enhancing access and capacity by changing the scope of practice of non-physician primary care providers while continuing to ensure the highest quality of care.

Action Steps

1. Increase current capacity at Physician Assistant training programs (Northeastern University) and Nurse Practitioner training programs (Boston College, Northeastern University, Simmons College, University of Massachusetts Boston); this will require creative solutions that address the shortage of qualified instructors in these programs.
2. Expand pipeline programs with local high schools that are designed to increase the racial and ethnic diversity of the healthcare workforce.
3. Expand training opportunities for other clinicians who support the provision of primary care, including more training of current medical assistants to become Licensed Professional Nurses.
4. Support legislation that allows for expanded scope of practice for non-physicians, elimination of regulations that restrict the scope of practice for medical assistants, and insurance reimbursement for care provided by licensed non-physicians. In addition, the BPHC should work with the Massachusetts Department of Public Health and other state agencies to identify changes that can be made within existing law.
5. Convene health care providers to share best practices in implementing "team care" that supports the expansion of non-physician roles.

How This Will Improve Primary Care Access

Physician Assistants and Nurse Practitioners should play a larger role in primary care delivery. Allowing expanded scope of practice for non-physicians with appropriate training will increase primary care capacity.

Examples

With the use of nurse practitioners, Urban Medical Group is able to provide home and institutional care for many more severely ill and elderly Boston residents than it otherwise could. Harvard Vanguard offers its medical assistants tuition support and on-site classes toward becoming an LPN through a partnership with a community college.

Resources Required

This initiative will require project management within the BPHC. To achieve full success, the City will also need to engage the State Boards of Registration in Medicine, Nursing and Pharmacy and the colleges and universities providing training for health professionals.

Timeframe

It is likely that some changes can be made within primary care practices immediately, as these will not require any change in regulation or legislation. Increases in PA and NP training will take a number of years to have an impact, and regulatory or legislative effort will require a long lead time.

Role of the City Of Boston

The City can play a positive role through advocacy and by convening representatives of educational and health care institutions.

Recommendation Three:
Promote financial incentives to recruit and retain a robust and diverse primary care workforce in Boston

Underlying Problem

Too few health professionals across the country are choosing disciplines in primary care, general internal medicine, family medicine or pediatrics. Research shows clinicians of color are more likely than their White counterparts to stay in primary care and serve vulnerable populations, and that Blacks and Latinos have better health outcomes when clinicians share their ethnic background. Achieving a diverse workforce is critical to access and quality of care. The reasons for the shortage of primary care providers and the limited diversity within primary care are numerous and interconnected. While carrying the same debt, primary care clinicians receive substantially lower pay and recognition than other disciplines. They often work long hours and shoulder heavy responsibilities. Nurse practitioners and physician assistants face similar issues, and are also in short supply. Finally, steep housing prices and the high cost of living make it difficult for primary care clinicians with significant debt to live in the Boston area.

Given the current shortage of primary care clinicians, various hospital systems are offering signing bonuses and enhanced payments. While this is often an effective recruitment strategy for hospitals, it has made it harder for safety net providers such as community health centers to recruit clinicians. This in turn has made it difficult to expand clinic hours, resulting in a continued reliance by patients on emergency room services in the evenings and on weekends.

Action Steps

1. The BPHC should convene Boston safety net and other providers to identify opportunities to offer recruitment and retention incentives for primary care clinicians, particularly those who treat the most vulnerable populations.
2. Request the assistance of philanthropic partners in supporting incentive programs that can help make primary care practice in community health centers attractive for those professionals with substantial student loan debt.
3. Encourage community agencies involved in creating mixed-income housing to identify opportunities that include health care professionals in these plans.
4. Provider organizations should consider housing aid (such as forgivable loans or guaranteed housing at affordable rates) when they are making their recruitment plans.
5. Support legislation and voluntary efforts to increase loan forgiveness programs for primary care health care clinicians, including physicians, nurse practitioners, and physician assistants.

How This Will Improve Primary Care Access

Financial incentives to recruit and retain primary care clinicians will lead to improved access through increased capacity.

Example

Together, the state primary care loan forgiveness program and the Bank of America loan forgiveness program, both of which began in 2007, have been instrumental in hiring or retaining 64 primary care physicians and nurse practitioners over the past 15 months. The Massachusetts League of Community Health Centers administers both of these programs.

Resources Required

The BPHC will provide project management to convene provider and philanthropic organizations to identify financial incentives that can improve recruitment and retention.

Timeframe

The BPHC can convene providers to develop an inventory of potential financial incentives over 90 days. Many provider organizations could initiate new programs in their next fiscal year.

Role of the City Of Boston

The City can convene provider and philanthropic organizations to develop strategies for ensuring the availability of an adequate number of primary care clinicians in the most underserved Boston communities.

Recommendation Four:
Reduce the burden of chronic disease in Boston residents by improving access to nutritious food, increasing opportunities for physical activity and reducing exposure to environmental hazards, particularly in communities of color and low-income communities.

Underlying Problem

Chronic disease care accounts for 30-40% of primary care visits and 75% of overall health care costs in the US. Tobacco use, poor nutrition and lack of physical activity are the contributing causes of chronic disease. Asthma and other chronic respiratory conditions are exacerbated by many preventable environmental factors. Locally and nationally, we are facing a chronic disease epidemic, driven by increasing obesity rates. In Boston, an estimated 46% of Boston Public School students are at an unhealthy weight; among adults, 52% are overweight or obese. There are significant racial and health disparities among risk factors and prevalence of chronic disease, with 66% Black Bostonians considered overweight/obese and both Blacks and Latinos suffering from diabetes at rates more than double that of Whites. Ultimately, building support for healthier lifestyles can complement efforts to improve primary care access by improving health status and decreasing mortality.

Action Steps

1. Business, schools, public and community-based organizations, and elected officials should work together to establish a compact to support efforts that establish Boston as a national model for promoting resident health and well-being. Many elements of this partnership are already in place, including efforts to make the city more amenable to bicycle transportation and pedestrian traffic, as well as efforts to increase access to healthy and affordable foods.
2. Identify and promulgate health regulations in the areas of nutrition, tobacco, environmental hazards, and others that promote good health and prevent disease (such as the transfat ban).
3. Amend or adopt City ordinances that can improve population health (such as restricting tobacco sales).
4. Implement policies or programs city-wide that can improve and/or protect the health of the City's employees (such as the Take the Stairs campaign).
5. The BRA and city planner should coordinate the various City department programs and policies that impact the walkability, bikability, and availability of recreational and park spaces, ensuring that these issues are given high priority in development, public works, and transportation projects.
6. The BPHC should track efforts to improve population health across the city and include this information in its annual Health of Boston report.

How This Will Improve Primary Care Access

Healthier residents require fewer primary care visits, thus reducing demand on existing primary care capacity.

Examples

The Mayor and the BPHC Board have been very active in advocacy and implementation of regulations that affect the "built environment" and social determinants of health. The Mayor's advocacy for bike trails and the recent prohibition of transfats in restaurants are two such examples.

The BPHC's NeighborWalk program has engaged more than 1700 residents annually in neighborhood walking groups. These groups have provided opportunities for people to safely engage in physical activity with their neighbors, colleagues, friends and families. The BPHC partnered with Project Bread and the Boston Public Schools to pilot the Healthy Meals Initiative. The pilot features a professional chef cooking in two schools and educating cafeteria managers about healthier ways to prepare and present breakfast and lunch options that are both nutritious and delicious.

Resources Required

Implementation will require project management and analytical support for tracking and developing annual reports. This effort will require collaboration of multiple municipal agencies, including the Environment Department, the Boston Public Schools, and the Transportation Department. Various components of this initiative include capital improvements that will require substantial resources.

Timeframe

Nutritional and wellness programs can be designed and implemented 90-180 days after funding is secured and projects are approved. Exercise promotion that requires "built environment" investments will take 2-10 years to fully put into place.

Role of the City Of Boston

The City of Boston can help reduce risk factors for residents through concerted efforts in schools and municipal workplaces – as well as through capital infrastructure investments that make it easier for city residents (and those who work in the city) to adopt and maintain healthy lifestyles. The Mayor can also advocate for improved infrastructure investments that support healthy lifestyles throughout the state.

Recommendation Five:
Establish an ongoing primary care task force to monitor progress and prioritize opportunities to improve access to primary care

Underlying Problem

This Task Force has identified a number of recommendations which can be carried out in Boston in the short and long term. At the same time, there is a great deal of effort being made at the state and federal level to improve access to primary care. There will be a need to monitor progress on the recommendations as well as coordinate with concurrent governmental, legislative, and private sector activities.

Action Steps

1. The Mayor should appoint a Task Force to Improve Primary Care Access with the following charges:

- Monitor progress on the initiatives in this report.
- Present regular reports to the Mayor describing efforts to improve primary care access.
- Develop a database of primary care providers (physicians, nurse practitioners, and physician assistants) within the city, including discipline, specialty, race, ethnicity, gender, linguistic capacity, and clinical full-time-equivalency. This database would be used to measure capacity and identify gaps in service.
- Collaborate with academic institutions to track the entry, completion and career path of medical, nurse practitioner and physician assistant students. Data collected should include number of students, race, ethnicity and gender demographics to assess success at meeting workforce capacity and diversity goals.
- Encourage community health centers, hospital based ambulatory primary care practices, and private primary care practices to report on efforts they are making to improve the efficiency and effectiveness of their practices. This information will be collated and shared with all participants.
- Develop a centralized system for consumers and residents to report difficulties obtaining primary care and advocate for redress.
- Identify funding opportunities for hiring operations management engineers to offer consultation to participating practices.
- Establish a Mayoral Prize for innovations to improve access and quality of primary care. This will encourage advances in primary care and promote dissemination of innovation across the community.
- Make recommendations about how health information technology and other innovations can be used to improve primary care access, especially to the medically underserved community.

- Collaborate with health plans, purchasers, and primary care providers to explore new payment methods that would increase pay rates for primary care clinicians and provide 'quality incentives' through patient-centeredness and care coordination.

2. The Task Force should work closely with ongoing statewide and federal efforts to improve primary care access.
3. The Task Force should be made up of representatives from consumer, provider, payer, academic and government sectors.

Example

In 2004, Mayor Thomas M. Menino convened the Mayor's Task Force to Eliminate Racial and Ethnic Disparities in Health. Members were leaders from multiple sectors – business, community coalitions, health centers, higher education, hospitals, and insurance – and were charged with developing a comprehensive blueprint to eliminate racial and ethnic health disparities. The blueprint's recommendations and accompanying reports not only contributed to major changes in Boston's healthcare institutions but in the manner we talk about health inequity and the social determinants of health. The recommendations continue to be implemented through the work of the BPHC Disparities Project.

How This Will Improve Primary Care Access

The Task Force will help identify and disseminate information about effective strategies that can be implemented to improve access to quality primary care for Boston residents.

Resources Required

The BPHC will provide project management and staff support for this Task Force. An effective task force will also need a dedicated chairperson and committed task force members, along with assistance from staff at various institutions with data collection, research, and data base development activities.

Timeframe

This Task Force could meet 60 days after it is appointed.

Role of the City Of Boston

The Mayor would convene this Task Force. The Task Force efforts, including a Mayoral Prize, are likely to play an important role in promoting innovation.

Appendices

A. Working Group Membership
B. Principles from Working Groups
C. Full list of Working Group Recommendations
D. Bibliography

Appendix A: Working Group Membership

HealthCare Systems

- Mr. John Auerbach, Massachusetts Department of Public Health
- Ms. Ashley Barrington, Massachusetts League of Community Health Centers
- Ms. Jennifer Bennet, The Family Van
- Mr. John Droney, Caritas Physician Network
- Mr. William Halpin Jr., South Boston Community Health Center
- Dr. James Heffernan, Beth Israel Deaconess Medical Center
- Ms. Sally Iles, Massachusetts General Hospital
- Ms. Deb Joelson, Tufts Medical Center
- Dr. Rich Kalish, Boston Medical Center HealthNET, Boston University School of Medicine
- Dr. Barbara Kelley, Northeastern University School of Nursing
- Dr. Raj Krishnamurthy, Boston Medical Center
- **Dr. Thomas Lee, Partners Community Healthcare, Inc.**
- Dr. Jeff Levin-Scherz, Harvard School of Public Health
- Ms. Adela Margules, Bowdoin Street Health Center/BIDMC
- Dr. Paul Mendis, Neighborhood Health Plan
- Dr. Meyechia Minter-Jordan, Dimock Community Health Center
- Mr. Christopher O'Connor, Caritas St. Elizabeth's Medical Center
- Dr. Dan O'Leary, Caritas Carney Hospital
- Dr. Zeev Neuwirth, Harvard Vanguard Medical Associates
- Ms. Joan Pernice, Massachusetts League of Community Health Centers
- Dr. Mark Schuster, Children's Hospital Boston
- Dr. Namita Seth Mohta, Brigham & Women's Hospital
- **Mr. Bill Walczak, Codman Square Health Center**
- Ms. Lisa Whittemore, Brigham & Women's Hospital

Workforce Development

- **Dr. Bruce Auerbach, Massachusetts Medical Society**
- Ms. Leslie Bailey, Massachusetts League of Community Health Centers
- Ms. Kate Bilsborrow, Massachusetts Association of Health Plans
- Ms. Linda Cragin, Massachusetts AHEC Network
- **Dr. Larry Culpepper, Boston University School of Medicine**
- Dr. Peter Davidson, Boston Medical Center
- Ms. Julia Dyck, Massachusetts Department of Public Health
- Ms. Susan Edgman-Levitan, Stoeckle Center for Primary Care Innovation
- Ms. Ediss Gandelman, Beth Israel Deaconess Medical Center
- Ms. Kristin Garcia, Greater Boston Interfaith Organization
- Dr. Robert Master, Commonwealth Care Alliance
- Dr. Margaret McAllister, UMass Boston, College of Nursing and Health Sciences
- Dr. Angela Nannini, Northeastern University School of Nursing
- Dr. Angelleen Peters-Lewis, Brigham & Women's Hospital
- Dr. Joyce Pulcini, Boston College School of Nursing

- Dr. Leslie Schwab, Harvard Vanguard
- Dr. Theodore Sectish, Children's Hospital Boston
- Ms. Paulette Shaw Querner, Harbor Health Services
- Dr. Pat Tabloski, Boston College School of Nursing
- Dr. Marion E. Winfrey, UMass Boston, College of Nursing and Health Sciences
- Ms. Harriet Tolpin, Partners Healthcare
- Ms. Lisa Vinikoor, Greater Boston Interfaith Organization

Financing

- Dr. Marylou Buyse, Massachusetts Association of Health Plans
- Dr. Peggy Chou, Boston Medical Center
- Ms. Kim Damokosh, Tufts Medical Center
- Ms. Patricia Edraos, Massachusetts League of Community Health Centers
- Ms. Deborah Enos, Neighborhood Health Plan
- Dr. David Fairchild, Tufts Medical Center
- Ms. Ruth Ellen Fitch, Dimock Community Health Center, BPHC Board Member
- Ms. Diane Gilworth, Beth Israel Deaconess Medical Center
- Dr. Peter Greenspan, Massachusetts General Hospital
- Ms. Ellen Haffer, Massachusetts League of Community Health Centers
- Ms. Christie Hager, Massachusetts House Speaker's Office
- Ms. Jean Haynes, BMC HealthNet Plan
- **Dr. Robert Mandel, Blue Cross Blue Shield**
- Ms. Patricia McMullin, Beth Israel Deaconess Medical Center
- Dr. Susan Jo Roberts, Northeastern School of Nursing
- Ms. Karen Quigley, Community Catalyst
- Dr. Judith Steinberg, Harvard School of Public Health student ('08)
- Ms. Jessica Taubner, Joint Committee on Health Care Financing
- Dr. Greg Young, Children's Hospital
- Mr. Eugene C. Wallace, Harvard Vanguard Medical Associates & Atrius Health Foundation
- Ms. Celia Wcislo, 1199SEIU United Healthcare Workers East & Mass Connector Board, BPHC Board Member
- **Mrs. Ellen Zane, Tufts Medical Center**

Names in **bold** indicate co-chairs.

Appendix B: Working Group Principles

Mission

To develop and promote policies and practices that increase the availability (supply) of primary care providers, promote greater equity in health, achieve better health outcomes (*or prevent unnecessary illness and death*) and lower (*or control*) costs.

Goals:

- Adequate supply of well-trained primary care providers (meet HP2010 provider/patient ratio)
- Every person/individual has a regular source of care (further refine patient-centered medical home, advanced medical home, medical home, etc) (HP2010)
- 100% health insurance coverage for all residents (HP2010)
- Eliminate racial and ethnic disparities in health access and health outcomes (HP2010)
- Support efforts to increase workforce diversity

Combined, the three work groups drafted a total of 21 separate principles. These principles were used by each group to guide the development and/or prioritization of recommendations. While there was little redundancy or repetitiveness there were common categories that provided a means to logically group them—Access, Quality, and Cost.

Access

- Primary care should be recognized and promoted as a specialty with a body of expertise specific to it.
- The primary care workforce should reflect the diversity (racial/ethnic/linguistic) of the populations to be served.
- Retaining the existing supply of primary care clinicians should be a priority, along with recruitment.
- Workforce development strategies should be tailored to be responsive to demographics, geography, practice settings, and political and economic environments.
- Models and strategies should embrace and promote entry and re-entry and shorten the pipeline.
- Recommendations about the primary care workforce should be inclusive of all qualified providers, i.e. physicians, nurse practitioners, and physician assistants; the term “provider” should encompass all of these groups.
- Primary care, like all medical care, should be focused on the individual patient and his/her needs. This patient-centeredness requires access to culturally competent care, good communication between patient and provider, evidence-based care delivery and care coordination. Payment methodologies should be tailored to foster these key characteristics of excellence.
- A comprehensive, patient-centered standard of care that is delivered by a multi-disciplinary team should apply across all health care settings and for all

individuals, across the life span, regardless of ability to pay, or whether they have public or private insurance and as such, payment methods should provide consistent incentives across these payer types.

Quality

- Recommendations about the primary care workforce should promote the full and effective utilization of all members of the primary care team.
- Recommendations should recognize the importance of addressing professional and lifestyles challenges.
- Safe – avoiding injuries to patients from the care that is intended to help them.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- Effective – providing services based on scientific knowledge to all who benefit, and refraining from providing services to those not likely to benefit.
- Patient-Centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Cost

- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy. (STEEEP)
- The payment system should provide incentives for primary care to focus on the management of patients with chronic diseases as well as the prevention of disease and disease progression.
- Payment should support a comprehensive view of primary care encouraging the management of physical and behavioral health conditions and the psychosocial components of both.
- The payment system should recognize that primary care services are best delivered by a multidisciplinary team[1]. Team members and size should be customized based on the patient's needs. Payment should reward effective teams that communicate and coordinate care.
- Primary care practices should have systems in place to support an excellent standard of care. These may include electronic medical records, clinical decision support, patient registries, etc. Payment should reflect the need to use these types of tools to achieve expected outcomes and the payment system should reward achieving desired outcomes.
- Payment system reform and compensation should reflect the value added and critical role primary care can play in increasing quality, equity[2] and

[1] Multidisciplinary teams may include nurses, social workers, nutritionists, alternative or complimentary care providers, etc.
[2] Equity also includes reducing racial and ethnic health disparities

affordability of care, as seen in primary care based health care systems internationally.

- Primary Care payment reform should support changes in practice patterns that will reduce the rising rate of growth in medical costs over time, not increase them.
- Purchasers, payers, providers and patients have a shared responsibility in improving health care quality, outcomes, affordability and equity. Incentives should be aligned across each of these health care system participants. Primary care payment methodologies should reflect aligned incentives.
- Payment reform should support changes in systems and payment to improve transparency in quality and pricing.

Appendix C : Full List of Working Group Recommendations

Training and Education

1. Expand role of non-physicians by working with Boston health educational institutions to identify training capacity, enrollment, and challenges in training non-physicians for roles in primary care.
2. Link health care delivery systems with schools to expose students to opportunities in primary care fields.

Organizational Structure

1. Establish on-going primary care task force to monitor progress and prioritize opportunities to improve access to primary care.
2. Create primary care workforce registry and use information to set targets for increasing capacity and diversity.
3. Create venues to share best practices in improving ambulatory care.
4. Document non-value added work to inform health plan requirements.
5. Encourage "team approach" in primary care setting, including increased utilization of non-physicians for health care delivery.
6. Improve coordination with non-traditional sites of care by creating a working group (with representatives from Boston Public Schools, BPHC, mobile clinics, college clinics and community based organizations that employ community health workers) to make structural and functional recommendations about aligning services.
7. Use incentives to promote use of e-technology for improving communication between providers and patients.
8. Address lifestyle and professional concerns that affect retention and recruitment by replicating existing "job doability" pilot programs.

Finance/Reimbursement

1. Add a monthly payment for care coordination to the current Fee for Service (FFS) system.
2. Establish uniform payment methodologies across payers.
3. Pilot payment models that support integrated care.
4. Require primary care physician designation for all patients enrolled in a health insurance plan.
5. Create innovative financial incentives to keep primary care clinicians in Boston (such as expanded loan forgiveness programs and housing subsidies).
6. Pilot model programs that receive reimbursement (through insurance) for non-traditional members of primary care team (patient navigators, case-managers and community health workers).
7. Provide financial incentives to primary care providers who use e-technologies to enhance communication with their patients.

Legislative/Regulatory

1. Support advocacy that increases pay rates for primary care clinicians.
2. Support legislation that recognizes NP and PA scope of practices as primary care providers.
3. Support identification and elimination of regulations that restrict moving medical tasks to the most appropriate professional.
4. Identify possible board of health regulations and city ordinances that support healthy lifestyles, access to nutritious foods (including school breakfasts and lunches), and reduce exposures to environmental hazards.
5. Advocate for licensing boards and/or other agencies to conduct a workflow analysis that can inform recommendations for addressing obstacles and expediting the licensure process.

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Mayor Thomas M. Menino, Mayor

Dr. Barbara Ferrer, Executive Director

Boston Public Health Commission

The Mayor's Task Force on Improving Access to Primary Care in Boston

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Role Maximization of Nurse Practitioners and Physician Assistants in Boston: A Position Paper of the Workforce Capacity Subgroup

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Executive Summary

In a continuation of the work of the Mayor's Task Force on Improving Access to Primary Care in Boston, the Workforce Capacity subgroup developed this position paper on the maximization of the roles of Nurse Practitioners (NPs) and Physician Assistants (PAs) in order to improve access to primary care. The subgroup was comprised of nurse practitioners, physician assistants, physicians, policy experts and representatives from the Boston Public Health Commission. The charge of this subgroup was to make recommendations for full utilization of Nurse Practitioners (NPs) and Physician Assistants (PAs) and thus improve access to primary care in the city of Boston.

The paper provides background information on NPs and PAs and current primary care capacity; describes challenges to NP and PA practice, including statutory and regulatory restrictions; and makes recommendations to more fully utilize these practitioners in primary care practice. With implementation, the proposed recommendations should increase primary care capacity, and increase access to primary care for residents of the City of Boston.

The Workforce Capacity subgroup made the following specific recommendations:

1. Monitor primary care enrollment data (physician, NP and PA) for the City of Boston and report annually to the Mayor's Office, the Massachusetts Coalition of Nurse Practitioners, the Massachusetts Association of Physician Assistants and the Massachusetts Medical Society.

2. Leverage existing data from the Office of Patient Protection, Board of Registration in Nursing and the Physician Assistant Board of Registration to establish standards and mechanisms to monitor the inclusion of NPs and PAs in the primary care workforce in Boston.

3. Ensure that any health care reform or payment reform models recognize and directly reimburse NPs and PAs, based on quality measures and outcome data.

4. Revise statutory language that stipulates physician oversight and the performance of quarterly chart reviews for NP practice.

5. Revise current NP state legislation (Nurse Practice Act and M.G.L c 94c.) to remove mandated physician supervision for prescriptive practice.

6. Change the oversight of NP practice from dual oversight by the Board of Registration in Nursing (BORN) and the Board of Registration in Medicine to oversight by the BORN only.

7. Eliminate the restriction specifying the number of PAs a physician can supervise

8. Eliminate unintended barriers in statute by adopting statutory language such as "health care providers" for future legislation.

9. Develop a communications strategy to educate the public about the role of NPs and PAs in the delivery of primary care; partner with existing state and national NP and PA organizations to develop and institute a media campaign.

10. Include PAs in loan repayment programs currently only available to physicians and nurses/NPs.

11. Support the recruitment and retention of NP and PA faculty.

12. Support increasing the number of primary care sites that participate in NP and PA clinical education.

NPs and PAs make significant contributions to the health care system. Increasing access to these providers within primary care is at least a partial solution to shortage of primary care physicians. Change in statutory and regulatory requirements for the licensure and practice of NPs and PAs are necessary to expand their scope of practice and fully utilize their skills and training. Financial incentives for all health professionals working in primary care should be supported in order to increase access to a heavily burdened healthcare system.

The primary care team is fundamental to primary care and enhances the delivery of high quality health care. Within primary care, the notion of "team" is fluid—where members from different specialties and varying levels of expertise contribute. The "team" may be comprised of physicians, NPs, nurses, PAs, medical assistants (MAs), social workers, and allied health professionals. As the structure of the health care system changes, it is critical that the team care model be preserved and strengthened. These reforms would fortify the ability of primary care teams to provide high-quality, cost-effective primary care in the city of Boston and throughout the state.

Introduction

In a continuation of the work of the Mayor's Task Force on Improving Primary Care Access in Boston, the Workforce Capacity subgroup developed this position paper on the maximization of the roles of Nurse Practitioners (NPs) and Physician Assistants (PAs) in primary care. The goal is to improve access to primary care. The subgroup was comprised of nurse practitioners, physician assistants, physicians, policy experts and representatives from the Boston Public Health Commission.

Although the focus of the paper is NPs and PAs, the subgroup strongly supports the concept of team care, and recognizes the important role of all members of the primary care team. Within the team care model, the role of each member should be optimized in order to provide the most effective care possible. Given the membership and expertise of this subgroup, however, this paper has focused on the roles of NPs and PAs as members of the primary care team.

Both NPs and PAs are committed to delivering high quality health care as health care professionals and strive to meet the needs of their patients in an effective, caring, and efficient manner. Although NPs and PAs are trained differently, many of their professional responsibilities and job functions are similar. NPs are independently licensed health care providers who are generally educated and certified to provide primary care as well as other clinical services. They are registered nurses with advanced degrees and education that prepare them to diagnose and treat patients. NPs practicing primary care are nationally certified and are able to provide all primary care services that physicians provide, as well as some specialty care. A significant number of NPs work in underserved areas with vulnerable populations. Many work in urban and rural settings, in public housing communities, community health centers, school based clinics, nursing homes, hospitals, physician offices and in occupational health.

PAs are health professionals licensed or credentialed (in the case of those employed by the federal government) to practice medicine with physician supervision. PAs practice medicine as part of a physician/PA team. The scope of practice for a PA is defined by four parameters - state law, institutional policy, education and experience, and physician delegation. PA education and training mirrors that of the physician. It includes rigorous coursework in medicine and is followed by over 2,000 hours of supervised clinical practice in diverse health care institutions and medical practices. State laws allow physicians broad delegatory authority which allow PAs to practice in all areas of medicine, surgery, and the sub-specialties.

Nationally, there are about 125,000 NPs (American Academy of Nurse Practitioners, 2009) and 75,000 PAs (American Academy of Physician Assistants, 2009a). In Massachusetts, there are about 5,900 NPs and 1,700 PAs (Kaiser Family Foundation, State Health Facts Online). Extrapolating from national data that indicate that about 66% of NPs and 40% of PAS practice some primary care, it is estimated that 3,900 NPs and 700 PAs practice primary care in Massachusetts. Data also suggest that PAs see patients in about 2.5 million internal medicine out-patient visits annually (American Academy of Physician Assistants, 2009a).

Current Access to Primary Care

Expanded roles for NPs and PAs that more fully utilize their backgrounds and training could help address the shortage of primary care physicians in Massachusetts and, more broadly, in the United States. In 2006, the Massachusetts Medical Society (MMS) demonstrated that the primary care system in the Commonwealth was in crisis, with a serious shortage of primary care physicians (Massachusetts Medical Society, 2008). According to the MMS survey, the number of family practice physicians not accepting new patients increased from 25% in 2006 to 35% in 2008. Similarly, the percentage of internal medicine physicians not taking new patients increased from 31% in 2006 to 48% in 2008. Patients in Massachusetts also waited an average of 50 days for a primary care appointment (ACP Advocate, 2008; Kowalczyk, 2008).

The primary care shortage is due in large part to a decreased supply of primary care physicians as fewer residents choose to practice primary care. Many graduates who are interested in primary care ultimately secure positions in medical and surgical subspecialties or in tertiary care facilities. This is due to economic concerns, such as significant student debt load and higher salaries available in other specialties. In Massachusetts, there has also been a recent increase in the demand for primary care services.

Since Massachusetts implemented its health care reform initiative in 2006, which includes health insurance coverage for many previously uninsured patients, many newly insured persons have sought primary care. Since the passage of Chapter 58, Massachusetts' landmark health care legislation, 439,000 formerly uninsured people have received coverage (Commonwealth of Massachusetts, Division of Health Care Finance & Policy, 2008). According to the Urban Institute, Massachusetts' uninsured rates fell from 13% to 7% after the implementation of Chapter 58, with rates decreasing most with young adults, whose uninsured rates fell from 23% to 13% (Long and Masi, 2008).

The primary care shortage is especially troubling considering the importance of primary care and its relation to health outcomes. A study done conducted by John Hopkins looked at the relationship between the supply of primary care physicians and health outcomes (using the number of primary care physicians per 10,000 population) and found that the supply of primary care physicians was significantly associated with lower all-cause mortality, and that areas with higher concentrations of primary care physicians had lower total health care costs than did other areas (Starfield et al, 2005).

Models of Primary Care

According to the Institute of Medicine, primary care is defined as:

> "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Institute of Medicine, 2001)

If this definition is to be fully realized, new models of primary care are needed. One of the important elements of these new models is full utilization and maximization of NPs and PAs and other primary care providers and resources. Other elements include changes in incentives to discourage high cost and unnecessary care, increased emphasis on prevention and patient care outside of highly expensive health care facilities, and special attention to the aging populations, as well as those with chronic illnesses.

Many states, including Massachusetts, are actively assessing different models of primary care service delivery, with costs being an important part of these assessments. Although additional research and evaluation are needed, there is evidence that non-traditional models of care that fully utilize professionals, such as NPs and PAs, are cost-effective, as well as safe and efficient. For example, the Association of American Medical Colleges reported on an innovative nurse-managed health care delivery system developed at the Purdue School of Nursing (Wilson, 2008). These Indiana clinics provide acute and episodic illness care, health promotion, disease prevention, health education and chronic care management. In this model, annual health care costs for 10,000 patients were $800,000, compared to $3.0 - $5.0 million in annual costs for these patients if they had been cared for in a traditional model.

Using data from the Medical Expenditure Panel Survey, the RAND Corporation estimated the average cost of an NP or PA visit to be 20% to 35% lower than the average cost of an office visit with a physician, and the Massachusetts Division of Health Care Finance and Policy ranked better utilization of NPs and PAs as 7th in its list of 12 policy changes that would impact health care spending (Eibner et al, 2009). A recent report by the Medical Group Management Association also showed that for every dollar of charges a PA generates for the practice, the employer pays on average 30 cents to employ the PA (Medical Group Management Association, 2009). These findings are important because it has been estimated that NPs and PAs can appropriately care for patients in as many as 80%-90% of their primary care visits (Hooker, 2000; Venning et al, 2000). Quality may also be improved with a provider mix which includes NPs and PAs. A study of Medicare spending found higher costs and lower quality in states with higher use of more expensive providers (Baicker and Chandra, 2004).

Research also has shown that patients are generally accepting of care provided by NPs and PAs (Atwater et al, 2008). NPs have been found to be well-accepted as primary health care providers and to provide quality, cost-effective care **(**American Academy of Nurse Practitioners, 2007a, 2007b; Chenowith et al, 2005; Lenz et al, 2004; Mundinger, et al, 2000; Paez & Allen, 2006). Studies by the Kaiser Permanente Center for Health Research also found very high satisfaction levels for services provided by PAs, ranging from 89% to 96% (AAPA 2009b).

Challenges to NP and PA Practice

Legal and Statutory Restrictions

Nationally and in Massachusetts, there are statutory and regulatory restrictions to NP and PA practice that many believe needlessly limit the practice (Safriet 2002). Many of these restrictions have been in effect for more than 30 years. The current primary care shortages present an opportunity to take a fresh look at the existing laws and regulations to identify changes that could

improve access. In the same way that the PA profession first emerged in the United States more than 40 years ago when the country was facing similar workforce issues - a shortage of primary care (and other) physicians and a mal-distribution of providers, the current shortage presents an opportunity to make other significant changes. The Bureau of Health Professions analyzed the state practice environments for PAs, NPs, and certified nurse midwives and concluded that the elimination of practice restrictions for PAs, NPs, and certified nurse midwives is a strategy to increase practitioner supply and to increase access to health care services (Sekscenski et al, 1994).

One of the areas to specifically examine is the mandated supervision of NPs and PAs by physicians, particularly around prescriptive practice. Many states have already removed the supervision requirements (See attached map). Eliminating these requirements would allow NPs and PAs to more fully engage with primary care patients.

Another requirement that needs to be re-examined is the number of PAs a physician may supervise. A RAND Corporation study found that restrictions on the number of PAs that one physician may supervise are a barrier to increased utilization of PAs (Eibner et al, 2009). Although a growing number of states have no laws limiting the number of PAs that one physician may supervise, (AAPA Issue Brief, 2009c), Massachusetts law limits the number to four. The intent of this provision was to ensure that whenever a PA was practicing, the supervising physician was available to provide adequate oversight and direction to the PA.

The American Medical Association (AMA) has officially supported the principle that the appropriate ratio of physician to PA should be determined by physicians at the practice level, as long as it is consistent with good medical practice (American Medical Association, 1998). It is important that a supervising physician be available for consultation as needed, but the supervising physician is in the best position to make that determination, based on the levels of experience of the PAs and the complexity of the patient population. This subgroup believes that this requirement should be re-examined and changed to be consistent with the AMA principle.

Another issue in Massachusetts that needs to be addressed is the current licensure structure for NPs. This subgroup believes that the current dual oversight[1] by both the Board of Registration in Nursing (BORN) and the Board of Registration in Medicine (BORM) creates unnecessary administrative burdens and limitations to autonomous practice. This subgroup proposes that NP practice be solely under the purview of the BORN. A change in this structure would require that the current language in the Nurse Practice Act (see appendix) be changed as well.

[1] Mass General law 112 section 80B refers to the joint oversight. This was written in the 70's when NPs were relatively new to the marketplace and there was very little research to support the quality and effectiveness of NP practice.

Other Issues

Education and Awareness about the Roles of NPs and PAs

If the roles of NPs and PAs are to be expanded, it will be important to create public knowledge and awareness of their backgrounds and roles. In recent years, the Massachusetts Coalition of Nurse Practitioners has worked with various legislative and regulatory partners to develop an understanding of the value and capabilities of NPs. These efforts helped to create legislation that recognized NPs as primary care providers (Chapter 305 of the Acts of 2008). Although the new Massachusetts health care reform legislation now requires third party payers to recognize NPs as primary care providers and offer their services to patients, increased awareness is needed. The public has been largely unfamiliar with the role of the NP in primary care and should be educated about this discipline. Data about the state of the NP workforce, including the number of NPs in primary care, are not currently available, but would be very helpful in public awareness efforts.

PAs and Loan Repayment

Through Chapter 305 of the Acts of 2008, the Health Care Workforce Center was created at the Massachusetts Department of Public Health to study and address health care workforce shortages. The Workforce Center was tasked with addressing workforce shortages in part through loan repayment programs and support for institutional recruitment efforts for physicians and nurses who serve in primary care and underserved areas. In order to attract more PAs to primary care settings, loan repayment programs and institutional recruitment efforts, such as those pursued by the Health Care Workforce Center for physicians and nurses, should also include PAs.

Like physicians and nurses, PAs enter the workforce with significant debts due to the high costs of their education. On average, the total educational costs for PAs exceed $60,000 (Physician Assistant Education Association, 2009). Moreover, PAs entering primary care are paid less than those entering subspecialties. PA salaries, like physician salaries, are higher in subspecialty practices than they are in primary care. Whereas the average PA salary in this country in 2008 was about $90,000, the average for those in family practice was only $84,000, while the average salary for PAs in emergency medicine was about $100,000 (American Academy of Physician Assistants, 2009a).

Reimbursement and Payer Issues

In recognition of an expanded role for NPs and PAs, it is important to address reimbursement across payers, and where possible, to have some consistency in the reimbursement strategies. For example, a study of PA practice patterns found similar patterns across the fifty states except in the area of reimbursement, which was attributed to differences in the policies of individual third party payers (Wing et al, 2004).

One of the issues in current fee-for-service systems are that the bills are often submitted under the supervisory physician, with payment received based on the higher (than NP and PA)

physician reimbursement rates. This results in an inability to identify the care provided by the NP and PA, an inability to track outcomes and quality for NPs and PAs, and potentially higher payments than would be provided to NPs and PAs.

Movement towards global payment and the patient-centered primary care home (also referred to as the medical home), which rely on a primary care provider to care for a panel of patients for a set fee for a determined amount of time, presents an opportunity to increase the recognition of NPs and PAs as primary care providers. In these models, accurate outcome and quality data will be crucial to controlling health care costs. Therefore, it is important that payment reform recognize the involvement of NPs and PAs within the Accountable Care Organizations (ACOs) that are being proposed as part of national health care reform. As defined in the Recommendations of the Special Commission on the Health Care Payment System, ACOs

> will be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need. ACOs could be real (incorporated) or virtual (contractually networked) organizations—potentially including, for example, a large physician organization that would contract with one or more hospitals and ancillary providers

With Chapter 305 mandating that all health insurance plans recognize NPs as primary care providers, many have begun to credential NPs and offer NP services to their enrollees. Principles of health care reform necessitate value-based competition among health care providers and state that a reformed system should embrace patient choice (Porter and Olmsted-Teisberg, 2006). This subgroup believes that primary care practices which employ NPs should allow their patients to choose NPs as their primary care provider by credentialing them as such and allowing them to manage their individual panel of patients. This subgroup believes that insurers should similarly recognize PAs. In the current fee-for-service system, the PA practices under the supervising physician.

As the shift is made from fee-for-service to models that align payment with quality and access, reimbursement rewarding the quality of care delivered, not the credentials that deliver it, is the first step to creating a cost effective, affordable and accessible health care system and alleviating the shortage of primary care providers. Studies have consistently shown that NPs and PAs extend access to care. Research suggests that PAs can safely assume 83% of all primary care visits without input from the supervising physician (Hooker, 2000) and similar data has also been found for NPs (Venning, Durie, Roland, Roberts & Leese, 2000). Therefore this subgroup recommends that any payment reforms that include ACOs and Patient Centered Primary Care models fully recognize and reimburse NPs and PAs.

Education and Training

There is a shortage of primary care clinical sites for PA and NP students in the Commonwealth. The reasons given by clinical sites for not participating in training or precepting these students include concerns about provider productivity, lack of time and institutional support for teaching

students (Ippolito, 1994). Strategies need to be developed to address these concerns, and provide support. All the schools as well as the national organization of NP faculties are working on the issue of faculty shortage. There also have been some incentives at the federal level for tuition repayment if one enters into graduate training for nursing with the intent of becoming faculty.
In addition to the shortages of training sites, recruitment and retention of qualified faculty has increasingly become a challenge in educating both NPs and PAs. Lack of faculty impacts the ability of nursing and PA programs to accept students and ultimately affects the number of NPs and PAs in the workforce. This subgroup supports the investigation of ways to recruit and maintain faculty positions.

Recommendations

To address the issues identified in this paper, the Workforce Capacity subgroup makes the following recommendations:

1. Monitor primary care enrollment data (physician, NP and PA) for the City of Boston and report annually to the Mayor's Office, the Massachusetts Coalition of Nurse Practitioners, the Massachusetts Association of Physician Assistants and the Massachusetts Medical Society.

   These data can then be used to identify barriers and to develop further strategies for recruitment and utilization of these providers.

2. Leverage existing data from the Office of Patient Protection, Board of Registration in Nursing and the Physician Assistant Board of Registration to establish standards and mechanisms to monitor the inclusion of NPs and PAs in the primary care workforce in Boston.

   These data should include monitoring the enrollment of NPs as primary care providers and the utilization of PAs in the primary care setting within all health plans.

3. Ensure that any health care reform or payment reform models recognize and directly reimburse NPs and PAs, based on quality measures and outcome data.

   The final recommendations from the Payment Reform Commission in Massachusetts include payment transition from a fee for service system to a global payment system with the formation of ACOs**.** In light of these recommendations, it is important to assess how NPs and PAs will fit into this type of system. According to the RAND analysis (Eibner, et al, 2009), provider payment options such as these would encourage the utilization of PAs and NPs as well as encourage all providers to accept risk with financial incentives.

4. Revise statutory language that stipulates physician oversight and the performance of quarterly chart reviews for NP practice.

5. Revise current NP state legislation (Nurse Practice Act and M.G.L c 94c.) to remove mandated physician supervision for prescriptive practice.

   This change will allow autonomous practice, recognize and preserve the current collaborative NP/physician relationship, and more accurately reflect the nature of the interaction. It will also bring Massachusetts in line with many other states that do not have this supervisory requirement.

6. Change the oversight of NP practice from dual oversight by the Board of Registration in Nursing (BORN) and the Board of Registration in Medicine to oversight by the BORN only.

7. Eliminate the restriction specifying the number of PAs a physician can supervise

8. Eliminate unintended barriers in statute by adopting statutory language such as "health care providers" for future legislation.

   The use of "physician" language in regulation and statute creates unintended barriers. This language allows insurers and others to create rules and internal policies that discriminate and limit the ability of NPs, PAs and other health professionals from being recognized and reimbursed. The term "health care providers" is more inclusive and would represent all health care professionals equally.

   With the implementation of Chapter 305 and its recognition of NPs as primary care providers, great strides have been made in eliminating discriminatory language in statute and regulation. For example, the Division of Insurance and the Department of Public Health have updated their regulations to reflect this change in order to be in compliance with Chapter 305. This subgroup recommends that any future legislation or regulation remain consistent with current law and continue to include provider neutral language.

9. Develop a communications strategy to educate the public about the role of NPs and PAs in the delivery of primary care; partner with existing state and national NP and PA organizations to develop and institute a media campaign.

   Involvement of state agencies, such as the Health Connector and Division of Insurance, would ensure widespread information that would increase consumer knowledge and allow for informed choices.

10. Include PAs in loan repayment programs currently only available to physicians and nurses/NPs.

11. Support the recruitment and retention of NP and PA faculty.

12. Support increasing the number of primary care sites that participate in NP and PA clinical education.

Conclusion

NPs and PAs make significant contributions as health care providers within the system. Increasing access to these providers in primary care is at least a partial solution to addressing the shortage of physicians within primary care. Change in statutory and regulatory requirements for the licensure and practice of NPs and PAs are necessary to expand their scope of practice and fully utilize their skills and training. Financial incentives for all health professionals working in primary care should be supported in order to increase access to a heavily burdened system.

The team relationship is fundamental to primary health care and enhances the delivery of high quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened. These reforms would fortify the ability of primary care teams to provide high-quality, cost-effective primary care in the city of Boston and throughout the state. The challenges that face health care demand bold solutions, including changed roles and models of care. NPs, PAs and other providers are all working towards the same goal - health care reform that contains costs, increases access, and maintains high quality care.

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Appendix A: Massachusetts General Laws Chapter 94C.

PART I. ADMINISTRATION OF THE GOVERNMENT

TITLE XV. REGULATION OF TRADE

CHAPTER 94C. CONTROLLED SUBSTANCES ACT

Chapter 94C: Section 9. Administering and dispensing of controlled substances in course of professional practice; records, inspection

[Text of section effective until April 15, 2009. For text effective April 15, 2009, see below.]

Section 9. (a) A physician, dentist, podiatrist, optometrist as limited by sections 66 and 66B of chapter 112 and paragraph (h) of section 7, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by paragraph (g) of said section 7 and section 80E of said chapter 112, physician assistant as limited by said paragraph (g) of said section 7 and section 9E of said chapter 112, a certified nurse-midwife as provided in section 80C of said chapter 112 or a veterinarian when registered pursuant to the provisions of said section 7 and acting in accordance with the provisions of applicable federal law and any provision of this chapter which is consistent with federal law, in good faith and in the course of a professional practice for the alleviation of pain and suffering or for the treatment or alleviation of disease, may possess such controlled substances as may reasonably be required for the purpose of patient treatment and may administer controlled substances or may cause the same to be administered under his direction by a nurse.

A practitioner, as defined in section 1, may cause controlled substances to be administered under his direction by a licensed dental hygienist, for the purposes of local anesthesia only.

(b) Notwithstanding the provisions of section 17, a physician, physician assistant, dentist, podiatrist, optometrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist or veterinarian who is registered pursuant to the provisions of section 7, when acting in good faith and in the practice of medicine, dentistry, podiatry, optometry, nurse-midwifery or veterinary medicine or a nurse, when authorized by a physician, dentist, podiatrist, optometrist, nurse practitioner, physician assistant, certified nurse-midwife, psychiatric nurse mental health clinical specialist or veterinarian in the course of such nurse's professional practice, may dispense by delivering to an ultimate user, a controlled substance in a single dose or in such quantity as is, in the opinion of such physician, dentist, podiatrist, optometrist, nurse practitioner, physician assistant, certified midwife, psychiatric nurse mental health clinical specialist or veterinarian, essential for the treatment of the patient; provided, however, that such amount or quantity of such controlled substance shall not exceed the amount needed for the immediate treatment of the patient and that all such controlled substances required by the patient as part of such treatment shall be dispensed by prescription to such ultimate user in accordance with the provisions of this chapter.

For the purposes of this section, the words "amount needed for the immediate treatment of the patient" shall mean the quantity of a controlled substance which is necessary for the proper

treatment of the patient until it is possible for such patient to have a prescription filled by a pharmacy.

This section shall not be construed to prohibit or limit the dispensing of any prescription medication that is classified by the department of public health as schedule VI and that is provided free of charge by the manufacturer as part of an indigent patient program or for use as samples if such prescription medications are: (1) dispensed to the patient by a professional authorized to dispense controlled substances pursuant to this section; (2) dispensed in the package provided by the manufacturer; and (3) provided at no charge to the patient.

The department shall promulgate rules and regulations governing the dispensing of medication pursuant to this section. Said rules and regulations shall include, but not be limited to, the types and amounts of medications that may be dispensed and the appropriate safeguards for the labeling and dispensing of such medications.

(c) A nurse who has obtained from a physician, dentist, physician assistant, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist or veterinarian, a controlled substance for dispensing to an ultimate user, pursuant to the provisions of paragraph (b) or for administration to a patient pursuant to the provisions of paragraph (a), during the absence of such physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist or veterinarian shall return to such physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist or veterinarian any unused portion of such substance which is no longer required by the patient.

A licensed dental hygienist who has obtained a controlled substance from a practitioner, as defined in section 1, for dispensing to an ultimate user pursuant to paragraph (a) shall return to such practitioner any unused portion of the substance which is no longer required by the patient.

(d) Every physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner or psychiatric nurse mental health clinical specialist or veterinarian shall, in the course of a professional practice, keep and maintain records open to inspection by the commissioner during reasonable business hours, which shall contain the names and quantities of any controlled substances in Schedule I, II or III received by such practitioner; the name and address of the patient to whom such controlled substance is administered or dispensed; the name, dosage and strength per dosage unit of such controlled substance and the date of such administration or dispensing.

(e) Notwithstanding the provisions of paragraph (b), a physician, nurse practitioner, physician assistant, or certified nurse-midwife, when acting in good faith and providing care under a program funded in whole or in part by 42 USC 300, or in a clinic licensed by the department to provide comparable medical services or a registered nurse, registered pursuant to the provisions of section seventy-four of chapter one hundred and twelve and authorized by such physician, nurse practitioner, physician assistant or certified nurse-midwife, may lawfully dispense controlled substances pursuant to Schedule VI to recipients of such services in such quantity as needed for treatment, and shall be exempt from the requirement that such dispensing be in a single dosage or as necessary for immediate treatment; provided, however, that such registered nurse shall not so dispense except as provided in section seventeen. The department may

establish rules and regulations controlling the dispensing of said medications including, but not limited to, the types and amounts of medications dispensed and appropriate safeguards for dispensing.

Chapter 94C: Section 9. Administering and dispensing of controlled substances in course of professional practice; records and inspection

[Text of section as amended by 2008, 528, Sec. 1 effective April 15, 2009. For text effective until April 15, 2009, see above.]

Section 9. (a) A physician, dentist, podiatrist, optometrist as limited by sections 66 and 66B of chapter 112 and subsection (h) of section 7, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section 80E of said chapter 112, physician assistant as limited by said subsection (g) of said section 7 and section 9E of said chapter 112, certified nurse-midwife as provided in section 80C of said chapter 112, pharmacist as limited by said subsection (g) of said section 7 and section 24B 1/2/ of said chapter 112, or veterinarian when registered pursuant to said section 7, may, when acting in accordance with applicable federal law and any provision of this chapter which is consistent with federal law and in good faith and in the course of a professional practice for the alleviation of pain and suffering or for the treatment or alleviation of disease, possess controlled substances as may reasonably be required for the purpose of patient treatment and may administer controlled substances or may cause the same to be administered under his direction by a nurse.

A practitioner may cause controlled substances to be administered under his direction by a licensed dental hygienist, for the purposes of local anesthesia only.

(b) Notwithstanding section 17, a physician, physician assistant, dentist, podiatrist, optometrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist, pharmacist as limited by said subsection (g) of said section 7 and section 24B1/2/ of said chapter 112, or veterinarian registered pursuant to said section 7, may, when acting in good faith and in the practice of medicine, dentistry, podiatry, optometry, nurse-midwifery, pharmacy or veterinary medicine or as a nurse, as the case may be, and when authorized by a physician, dentist, podiatrist, optometrist, nurse practitioner, physician assistant, certified nurse-midwife, psychiatric nurse mental health clinical specialist or veterinarian in the course of such nurse's professional practice, dispense by delivering to an ultimate user a controlled substance in a single dose or in a quantity that is, in the opinion of such physician, dentist, podiatrist, optometrist, nurse practitioner, physician assistant, certified midwife, psychiatric nurse mental health clinical specialist, pharmacist or veterinarian, essential for the treatment of the patient. The amount or quantity of any controlled substance dispensed under this subsection shall not exceed the quantity of a controlled substance necessary for the immediate and proper treatment of the patient until it is possible for the patient to have a prescription filled by a pharmacy. All controlled substances required by the patient as part of his treatment shall be dispensed by prescription to the ultimate user in accordance with this chapter.

This section shall not prohibit or limit the dispensing of a prescription medication that is classified by the department as schedule VI and that is provided by the manufacturer as part of an indigent patient program or for use as samples if the prescription medication is: (i) dispensed to the patient by a professional authorized to dispense controlled substances pursuant to this

section; (ii) dispensed in the package provided by the manufacturer; and (iii) provided at no charge to the patient. The department shall promulgate rules and regulations governing the dispensing of medication pursuant to this section. These rules and regulations shall include, but not be limited to, those concerning the types and amounts of medications that may be dispensed and the appropriate safeguards for the labeling and dispensing of such medications.

(c) A nurse who has obtained from a physician, dentist, physician assistant, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist, pharmacist or veterinarian a controlled substance for dispensing to an ultimate user pursuant to subsection (b) or for administration to a patient pursuant to subsection (a) during the absence of the physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist, pharmacist or veterinarian, shall return to the physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist, pharmacist or veterinarian any unused portion of the controlled substance which is no longer required by the patient.

A licensed dental hygienist who has obtained a controlled substance from a practitioner for dispensing to an ultimate user pursuant to subsection (a) shall return to such practitioner any unused portion of the substance which is no longer required by the patient.

(d) Every physician, physician assistant, dentist, podiatrist, certified nurse-midwife, nurse practitioner, psychiatric nurse mental health clinical specialist, pharmacist or veterinarian shall, in the course of a professional practice, keep and maintain records, open to inspection by the commissioner during reasonable business hours, which shall include the following: the names and quantities of any controlled substances in schedules I, II or III received by the practitioner; the name and address of each patient to whom such controlled substance is administered or dispensed; the name, dosage and strength per dosage unit of each such controlled substance; and the date of such administration or dispensing.

(e) Notwithstanding subsection (b), a physician, nurse practitioner, physician assistant, pharmacist as limited by subsection (g) of section 7 and section 24B1/2/ of said chapter 112 or certified nurse-midwife, when acting in good faith and providing care under a program funded in whole or in part by 42 U.S.C. 300, or in a clinic licensed by the department to provide comparable medical services or a registered nurse, registered pursuant to section 74 of said chapter 112 and authorized by such physician, nurse practitioner, physician assistant, pharmacist as limited by said subsection (g) of said section 7 and section 24B1/2/ of said chapter 112, or certified nurse-midwife, may lawfully dispense controlled substances pursuant to schedule VI to recipients of such services in such quantity as needed for treatment and shall be exempt from the requirement that such dispensing be in a single dosage or as necessary for immediate and proper treatment under subsection (b). A registered nurse shall dispense under this subsection only as provided in section 17. The department may establish rules and regulations controlling the dispensing of these medications, including, but not limited to, the types and amounts of medications dispensed and appropriate safeguards for dispensing.

Appendix B: Massachusetts Nurse Practice Act

244 CMR 3.00: REGISTERED NURSE AND LICENSED PRACTICAL NURSE

Section

3.01: Definition - Registered Nurse

Registered Nurse is the designation given to an individual who is licensed to practice professional nursing, holds ultimate responsibility for direct and indirect nursing care, is a graduate of an approved school for professional nursing, and is currently licensed as a Registered Nurse pursuant to M.G.L. c. 112. Included in such responsibility is providing nursing care, health maintenance, teaching*, counseling, planning and restoration for optimal functioning and comfort, of those they serve.

**Defined as assignment consistent with the education, experience and demonstrated competence of the assignee and consistent with the needs of the patient(s).*

3.02: Responsibilities and Functions - Registered Nurse

A registered nurse shall bear full and ultimate responsibility for the quality of nursing care she/he provides to individuals and groups. Included in such responsibility is health maintenance, teaching, counseling, collaborative planning and restoration of optimal functioning and comfort or for the dignified death of those they serve. A registered nurse, within the parameters of his/her generic and continuing education and experience, may delegate nursing activities to the registered nurses and/or health care personnel, provided, that the delegating registered nurse shall bear full and ultimate responsibility for:

(1) making an appropriate assignment;

(2) properly and adequately teaching, directing and supervising the delegatee; and

(3) the outcomes of that delegation. A registered nurse shall act, within his/her generic and continuing education and experience to:

(a) systematically assess health status of individuals and groups and record the related health data;

(b) analyze and interpret said recorded data; and make informed judgments therefrom as to the specific problems and elements of nursing care mandated by a particular situation;
(c) plan and implement nursing intervention which includes all appropriate elements of nursing care, prescribed medical or other therapeutic regimens mandated by the particular situation, scientific principles, recent advancements and current knowledge in the field;
(d) provide and coordinate health teaching required by individuals, families and groups so as to maintain the optimal possible level of health;
(e) evaluate outcomes of nursing intervention, and initiate change when appropriate;
(f) collaborate, communicate and cooperate as appropriate with other health care providers to ensure quality and continuity of care;
(g) serve as patient advocate, within the limits of the law.

3.03: Definition - Practical Nurse

Licensed practical nurse is the designation given to an individual who is a graduate of an approved practical nursing program, and who is currently licensed as a practical nurse pursuant to M.G.L. c 112. The licensed practical nurse functions within the framework specified by the nursing statutes and regulations of the Commonwealth.

3.04: Responsibilities and Functions - Practical Nurse

A licensed practical nurse bears full responsibility for the quality of health care s/he provides to patients or health care consumers. A licensed practical nurse may delegate nursing activities to other administratively assigned health care personnel provided; that the delegating licensed practical nurse shall bear full responsibility for:

(1) making an appropriate assignment,

(2) adequately teaching, directing and supervising the delegatee(s), and

(3) the outcome of that delegation: all within the parameters of his/her generic and continuing education and experience.

(4) A licensed practical nurse participates in direct and indirect nursing care, health maintenance, teaching, counseling, collaborative planning and rehabilitation, to the extent of his/her generic and continuing education and experience in order to:
(a) assess an individual's basic health status, records and related health data;
(b) participate in analyzing and interpreting said recorded data, and making informed judgments as to the specific elements of nursing care mandated by a particular situation;

(c) participate in planning and implementing nursing intervention, including appropriate health care components in nursing care plans that take account of the most recent advancements and current knowledge in the field;
(d) incorporate the prescribed medical regimen into the nursing plan of care;
(e) participate in the health teaching required by the individual and family so as to maintain an optimal level of health care;
(f) when appropriate evaluate outcomes of basic nursing intervention and initiate or encourage change in plans of care;
(g) collaborate, cooperate and communicate with other health care providers to ensure quality and continuity of care.

3.05: Delegation and Supervision of Selected Nursing Activities by Licensed Nurses to Unlicensed Personnel

The qualified licensed nurse (Registered Nurse/Practical Nurse) within the scope of his/her practice is responsible for the nature and quality of all nursing care that a patient/client receives under his/her direction. Assessment/ identification of the nursing needs of a patient/client, the plan of nursing actions, implementation of the plan, and evaluation of the plan are essential components of nursing practice and are the functions of the qualified licensed nurse. The full utilization of the services of a qualified licensed nurse may permit him/her to delegate selected nursing activities to unlicensed personnel. Although unlicensed personnel may be used to complement the qualified licensed nurse in the performance of nursing functions, such personnel cannot be used as a substitute for the qualified licensed nurse. The following sections govern the licensed nurse in delegating and supervising nursing activities to unlicensed personnel. Delegation by Registered Nurses and Licensed Practical Nurses must fall within their respective scope of practice as defined in M.G.L. c. 112, § 80B, paragraphs 1 and 2. Said delegation must occur within the framework of the job description of the delegatee and organizational policies and procedures and also must be in compliance with 244 CMR 3.05(4) and (5).

(1) Definitions

Delegation - The authorization by a qualified licensed nurse to an unlicensed person as defined in 244 CMR 3.05(1) to provide selected nursing services.

Supervision - Provision of guidance by a qualified licensed nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity.

Unlicensed Person - A trained, responsible individual other than the qualified licensed nurse who functions in a complementary or assistive role to the qualified licensed nurse in providing direct patient/client care or carrying out common nursing

functions. The term includes, but is not limited to, nurses' aides, orderlies, assistants, attendants, technicians, home health aides, and other health aides.

(2) General Criteria for Delegation. Delegation of nursing activities to unlicensed persons shall comply with the following requirements:

(a) The qualified licensed nurse delegating the activity is directly responsible for the nursing care given to the patient/client, and the final decision as to what nursing activity can be safely delegated in any specified situation is within the specific scope of that qualified licensed nurse's professional judgment.

(b) The qualified licensed nurse must make an assessment of the patient's/client's nursing care needs prior to delegating the nursing activity.

(c) The nursing activity must be one that a reasonable and prudent nurse would determine to be delegatable within the scope of nursing judgment; would not require the unlicensed person to exercise nursing judgment; and that can be properly and safely performed by the unlicensed person involved without jeopardizing the patient's/client's welfare.

(d) The unlicensed person shall have documented competencies necessary for the proper performance of the task on file within the employing agency; an administratively designated nurse shall communicate this information to the qualified licensed nurse(s) who will be delegating activities to these individuals.

(e) The qualified licensed nurse shall adequately supervise the performance of the delegated nursing activity in accordance with the requirements of supervision as found in 244 CMR 3.05(3).

(3) Supervision. The qualified licensed nurse shall provide supervision of all nursing activities delegated to unlicensed persons in accordance with the following conditions:

The degree of supervision required shall be determined by the qualified licensed nurse after an evaluation of appropriate factors involved, including, but not limited to, the following:

(a) the stability of the condition of the patient/client;

(b) the training and capability of the unlicensed person to whom the nursing task is delegated;

(c) the nature of the nursing task being delegated; and

(d) the proximity and availability of a qualified licensed nurse to the unlicensed person when performing the nursing activity.

(4) Delegation of Nursing Activities. By way of example, and not in limitation, the following nursing activities are usually considered within the scope of nursing practice to be delegated, and may be delegated provided the delegation is in compliance with 244 CMR 3.05(2):

(a) Nursing activities which do not require nursing assessment and judgment during implementation;

(b) The collecting, reporting, and documentation of simple data;

(c) Activities which meet or assist the patient/client in meeting basic human needs, including, but not limited to: nutrition, hydration, mobility, comfort, elimination, socialization, rest and hygiene.

(5) Nursing Activities That May Not Be Delegated. By way of example, and not in limitation, the following are nursing activities that are not within the scope of sound nursing judgment to delegate:

(a) Nursing activities which require nursing assessment and judgment during implementation;

(b) Physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up;

(c) Formulation of the plan of nursing care and evaluation of the patient's/client's response to the care provided;

(d) Administration of medications except as permitted by M.G.L. c. 94C.

(6) Patient/Client Health Teaching and Health Counseling. It is the responsibility of the qualified licensed nurse to promote patient/client education and to involve the patient/client and, when appropriate, significant others in the establishment and implementation of health goals. While unlicensed personnel may provide information to the patient/client, the ultimate responsibility for health teaching and health counseling must reside with the qualified licensed nurse as it relates to nursing and nursing services.

REGULATORY AUTHORITY

244 CMR 3.00: M.G.L. c. 112, § 80B.

Appendix C: Nursing Map—Prescriptive Authority