

To: Obama Transition Team
From: Susan Wysocki, WHNP-BC, FAANP
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National Association of Nurse Practitioners In Women's Health (NPWH)

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RE: Follow-up to meeting December 18 on women's health

Nurse Practitioners and Women's Health Care

Nurse practitioners (NPs) are registered nurses with additional specialized education at the graduate level. Education for nurse practitioners includes advanced nursing and selected medical studies as well as intensive clinical experiences specific to the NP's area of practice. There are a number of different specialties of nurse practitioners. This memo focuses on the services provided by nurse practitioners in women's health.

Nurse practitioners perform many kinds of health services from physical exams, screening for health problems, treating illness, and prescribing medications. In women's health, for example, nurse practitioners provide cervical cancer screening, physical exams, treat infections and sexually transmitted infections (for women and men), and other problems. They prescribe medications such as contraception and menopause therapies, provide care to pregnant women, evaluate and treat common pelvic pain disorders, and urinary problems, and evaluate for mental health issues, signs of sexual or domestic abuse, and other issues that have an impact on the woman's health, safety, or well-being.

It has been estimated that nurse practitioners can provide 85% of all health care needs. In the reproductive health setting, nurse practitioners are the backbone of providing care in family planning clinics and Planned Parenthood clinics. In fact, the vast majority of the care in these settings is provided by nurse practitioners.

In the early 1970's through 1995, the Title X Family Planning Program, included funding to educate nurse practitioners specifically to work in Title X programs. That funding is no longer available. Subsequently, the pipeline of community based nurses who were educated by the Title X program to return to their communities is no longer supplying the work force. The nurse practitioners who are still practicing in those settings are beginning to retire and finding replacements has been difficult. Attention needs to be paid to the supply of NPs for these settings as much as keeping these programs funded. We suggest working with NPWH, the National Family Planning and Reproductive Health Association (NFPRHA) and Planned Parenthood Federation of America (PPFA) to develop solutions for this demand for qualified nurse practitioners who will provide family planning services in Title X clinics.

Disruptive Innovators

There are many other settings in which nurse practitioners can have an even more active role in women's health. In an article titled *Will Disruptive Innovations Cure Health Care*, Harvard Business Review, October 2000, Clayton M. Christensen et al, makes some important points that merit consideration for the new administration.

Christensen's ideas include **"Creating a [healthcare] system that matches clinicians' skill levels to the level of medical difficulty."** In this suggestion, he specifically mentions nurse practitioners (NPs) who can focus on the diagnosis and treatment of predictable problems and reserving more complicated care to physicians.

In women's health, in addition to addressing reproductive and pregnancy care, nurse practitioners focus on a woman's well being and the prevention of future health problems. Access to nurse practitioner care is critically important for a number of reasons. Consumer and government studies have shown that nurse practitioners are both skilled clinicians and patient educators. Consumers value the nurse practitioner's sensitivity to their needs and their ability to decrease the mystery surrounding health care. Consumers frequently comment that they prefer nurse practitioners for their care for the time they spend with the patient; because they do not feel rushed; and because they feel the NP is treating them as an individual and is listening to them.

As early as 1986 the Office of Technology Assessment stated: "Within their defined area scope of competence NPs and CNM is [equivalent to MDs]. NPs/CNMs are more adept than many physicians at communicating effectively with patients and managing patients who require long-term and [continuity of] care." □ A 1995 meta analysis demonstrated that patients of NPs are more likely to take medications correctly, keep appointments, and follow behavioral changes. In addition, this report demonstrated that patient satisfaction with NPs is high.

Yet, despite the fact that NPs care has been consistently shown to be equal to that of care provided by a physician, reimbursement rates for the same procedure or service performed by a nurse practitioner is 15% less than it is for a physician. This differential for the same procedure or test, for example cervical screening, is not differentiated if the test is performed by a family physician versus a gynecologic oncologist. Either the procedure is worth what the procedure is worth, or there is something wrong with the system. The relative value of the NPs service versus the physician is not grounded in evidence and should be reevaluated. NPs providing these services are not charged 15% less for supplies or overhead required for providing their care.

A second point from Christensen's article is **"to invest in technologies that simplify complex problems, and less in high-end technologies."**

Because nurse practitioners do not perform surgery, they seek non-surgical (less high tech) approaches to solving a health care issue. Rather than resolving the problem with a costly surgical procedure, that has a more profound effect on the woman, NPs opt for the simpler medical solution first. However, when a problem becomes more complicated or a medical strategy fails to work, the nurse practitioner will refer a woman to the most appropriate specialist.

There are currently technologies available that are less expensive to address certain health issues. However, when these lower cost technologies compete with higher reimbursements for a more complex procedure provided by a health care professional trained at a more complex level, the more highly reimbursed (often a surgical procedure) may be chosen. For example, women with severe menstrual bleeding can often be managed by prescribing hormonal contraceptives or a medicated intrauterine contraceptive versus a surgical approach such as an endometrial ablation or hysterectomy.

Using hormonal contraceptive drugs and devices for the medical management of bleeding are “off-label” indications for these products. However, they have been shown to work and are far less expensive and invasive than surgery. Efforts should be made to encourage a hierarchy of lower tech less expensive choices for managing common problems. It is also important that alternative options be reimbursed at adequate levels that not only consider the time and effort spent on the procedure itself, but the time required to counsel the patient to make an appropriate choice. Far less value is given to counseling and educating patients than procedures.

As another example, a 66 year old woman who had classic mixed (both urge and stress) urinary incontinence symptoms approached an NP colleague who had her own practice in Pennsylvania. This nurse practitioner works with patients to find non-surgical management approaches for incontinence. Her success rate with managing these symptoms is quite good. However, the woman’s insurance would not pay for her visits to the NP. Instead, the woman was given the insured option of surgery that not only was costly, but did not help with her symptoms with urge incontinence. Ultimately, she paid out of pocket to see the NP for both the medication she needed for the urge incontinence and for the pelvic muscle rehab she needed after the surgery. As I understand it, the services the patient wanted in the first place are a Medicare carve out. Clearly, thousands of dollars could have been saved if the surgery was not the first approach used, not to mention how the non-surgical approach might have affected the patient’s quality of life dealing with this issue.

There should also be parity among health insurers so that each plan is required to pay for health promotion/disease prevention services, including, as an example, all available methods of contraception. Offering a limited menu of contraceptive choices to both the patient and clinician is penny wise and pound-foolish as women are not the same whether it comes to their biology or their personal preferences. There is no one size fits all in women’s health. Having one formulation of an oral

contraceptive on the formulary will not be acceptable to all women. The woman who is unhappy with her oral contraceptive stops using it.

Additionally, in the current system, insurers are often concerned that if they provide a method that costs more initially, even if it offers long-term pregnancy protection, and the patient moves out of the plan, the insurer paying for the method, won't reap the long term benefit of the method's amortized cost over time. If all plans covered all methods, this would not be an issue.

The majority of reproductive aged women as well as menopausal women *only* see their gyn provider for all their care. This is true of women who seek care in family planning clinics and Planned Parenthood clinics as well as in the private sector. Women should be able to receive all their primary care needs through the provider *they* view as their primary care provider. Currently, some systems do not reimburse gyn care providers, whether in the private sector or the clinic setting, for even simple primary care screening beyond those screening tests for breast or cervical health. It is only common sense that gyn providers be reimbursed for ordering cholesterol testing, diabetes screening, etc., and the subsequent counseling to prevent those diseases. While in the majority of cases, a gyn practice would not manage diabetes, those providers should be encouraged to screen and counsel those patients—and be reimbursed for it.

Encouraging technologies that can be appropriately used by a wide range of health care professionals to either diagnose problems or address solutions to those health problems will increase access to care. The nurse practitioner's skill at counseling and education is a perfect fit as we learn more about predictive medicine and can teach people how to avoid future problems. The lowest cost "technology" available to patients is teaching them about how to stay healthy and to avoid disease whether that health issue is an unplanned pregnancy, or the sequelae of diseases such as diabetes and hypertension. Yet, these services are under-reimbursed. The pay off, however, can be huge.

The last two ideas from Christensen include: **"Don't be afraid to invent the institution that could put you out of business"**. This is not to suggest that nurse practitioners replace physicians. Rather, it means to critically analyze what kind of institutional and health care professional mix can do best the job of keeping Americans healthy throughout their life span. As the article further discusses, the idea is to maximize the competencies of all caregivers and the technologies that can maximize the skills of the health care professional in an accessible way to patients.

Finally, he suggests, **"Overcome the inertia of regulation"**. Currently, regulations for nurse practitioners are different in all 50 states and some of the regulations make little sense in providing quality patient care. For example, in one state, nurse practitioners who are trained to do so, are allowed to perform colonoscopy (a visual diagnostic test as a follow-up to an abnormal cervical screening test) , but they aren't allowed to confirm their visual findings with a simple biopsy. The

regulation results in both costs to the patients and the system if this exam needs to be repeated to do a simple test that could have been done in the first place. Further, this restrictive regulation does not even consider that patients can be lost to follow-up. This could result in even higher cost and morbidity down the line if cervical disease progresses. Common sense and consideration of options that can provide better and more sensible solutions are not always the considerations that are taken into account. While states should maintain their independence for regulating professional groups, perhaps there is some way in which the federal government can assist with helping states and health care systems function in a way that keeps the patient at the center of the care.

In summary, nurse practitioners are highly qualified, competent health care professionals who, when providing care within their scope of practice, provide care equal to that of physicians. Further, the nurse practitioners approach for providing individualized care that focuses on the patient's entire needs and takes the time to determine what those needs are is an important part of the solution for access to care millions of Americans. Balancing the right kind of health care professional with the type of care required and challenging institutions that are more focused on who provides the care versus what care is needed should be examined. As Christensen points out: *"When care is complex, expensive, and inconvenient, many afflictions simply go untreated."*

1. Brown, SA, and Grimes, DE (1995). *A meta Analysis of nurse practitioners and nurse midwives in primary care*. Nursing Research, 44(6), 332-339.
2. Christensen, CM et al. (2000). *Will Disruptive Innovations Cure Health Care?* Harv Bus Rev. 78(5), 102-112, 199.