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February 5, 2016

John W. Hale, Jr., MD  
President  
Tennessee Medical Association  
2301 21st Avenue South  
Nashville, TN 37212

Dear Dr. Hale,

On behalf of the National Nursing Centers Consortium's (NNCC) Tennessee members, I am writing to express some comments and concerns we have relating to the recently released Tennessee Medical Association (TMA) report entitled, "A Blueprint for Team-Based Healthcare in Tennessee." The NNCC is a national 501(c)(3) nonprofit dedicated to advancing nurse-led models of care through policy, technical assistance and consultation, and innovative programming. As part of this mission, NNCC represents a national network of nurse practitioner-led health centers, which includes approximately 15 centers located in Tennessee. These Tennessee-based nurse-managed health clinics (NMHC) offer a full range of health care, including primary care, health promotion, and disease prevention services, to around 20,000 patients annually. Many of the patients utilizing these clinics are low-income, underinsured, or uninsured, and live in medically underserved areas where there is a shortage of primary care physicians.

We agree that Tennessee's health care system is in need of reforms that promote access to high quality, cost-effective care that is available to all residents. We also agree with the TMA's conclusion that the state's regulations governing the supervision of advanced practice nurses are antiquated and in need of updating, as are Tennessee's payment and reimbursement structures. However, our experience working with NMHCs in states that have implemented a team-based care model like the one outlined in the report has given us reason to believe that the model places additional burdens on both physicians and nurse practitioners, which have the potential to increase costs and restrict access to quality care. For example, page 10 of the report suggests that a physician should review the charts for nurse practitioner or physician assistant patients with complex conditions. In 2012, Virginia passed a similar team-based care law calling for physicians to conduct chart reviews on complex cases seen by nurse practitioners. Our interviews with providers in Virginia yielded two conclusions: 1) that physicians were reluctant to enter into collaborative agreements with nurse practitioners, because the doctors did not understand their responsibilities under the new law, particularly as they relate to complex conditions; and 2) that nurse practitioners felt the chart review requirements under the Virginia law were too broad and time consuming. The principal rationale for this conclusion was again connected to the complex conditions provision. Nurse practitioners in NMHCs serving low-income and rural areas indicated that complex conditions were so prevalent among their patient populations that their collaborating physicians did not have time to complete all of the required chart reviews. One Virginia NMHC leader stated that she had to cancel a rural outreach event that had previously served between 2,500-3,000 people, because of the inability to secure physicians willing to collaborate with nurse practitioners coming in for the event.


Although the Blueprint for Team-based Healthcare document does not define what types of conditions would trigger a chart review, the Health Care Improvement Act of 2015 (HCIA), which was introduced with TMA support, includes a lengthy list of complex conditions, potentially requiring a chart review. This list includes highly prevalent conditions like obesity, heart disease, diabetes, and uncontrolled hypertension. According to the Centers for Disease Control and Prevention, over 30% of adults in Tennessee are obese and that is just one of the listed conditions. Requiring a physician to conduct a chart review for every nurse practitioner or physician assistant patient with a complex condition included in the HCIA would go above and beyond what is currently required under Tennessee law and would place additional constraints on the time available to physicians and nurse practitioners. Additionally, all of these conditions are especially prevalent within the low-income, medically underserved populations typically served by NMHCs. Asking physicians working with Tennessee's NMHCs to review all of the complex charts seen at these sites could lead to a repeat of the access challenges experienced in Virginia.

National research suggests that less physician oversight may be the best way for Tennessee to increase access and decrease health care costs. For example, a 2013 Health Affairs article examining nurse practitioner regulation around the country found that states with the least restrictive nurse practitioner regulations were 2.5 times more likely to have patients seen by nurse practitioners. Moreover, according to a 2014 Federal Trade Commission report, maintaining a collaborative agreement imposes costs on both physicians and nurse practitioners that may harm health care consumers, as well as third-party payors. In view of the growing demand for care in Tennessee and shortage of primary care physicians, the state cannot afford to limit access to physicians or nurse practitioners by asking them to shoulder the additional time constraints that would be imposed by the team-based model's chart review provisions.

Nurse practitioners in NMHCs and other settings fully embrace the concept of team-based care and interprofessional consultation when it improves outcomes and lowers costs, but this type of collaboration will not be accomplished through increased regulation and physician oversight. The decision whether or not to consult is one that is better left to the providers themselves, who best understand the needs of the patient and the appropriate standard of care. Nurse practitioners have relationships in place that they can call on when they need the input of physicians, as well as other providers. Statistics show that nurse practitioners know when and how to use these relationships in order to guarantee high quality care. A 2012 literature review by the National Governor's Association (NGA), which looked at over 30 years of research on the quality and safety of nurse practitioner services, concluded that none of the studies they reviewed raised concerns about the quality of nurse practitioner care. The NGA went on to say, "The research suggests that nurse practitioners can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients." The weight of this evidence suggests that formal legal provisions mandating physician involvement in nurse practitioner practice, like those contained in the TMA's 2015 bill, are not needed in order to guarantee high quality and may result in unnecessary and costly regulatory burdens.

On behalf of NNCC's Tennessee members, I request a meeting with you or your staff to discuss how physician-led team-based care legislation has effected NMHCs in other states and to outline standards for interprofessional team-based care that are suitable to both nurse practitioners and physicians in NMHCs. If you would like more information or to set up a time to meet, please feel free to contact me at 215-731-7140 or [tine@nccc.us](mailto:tine@nccc.us).

Yours,



Tine Hansen-Turton  
NNCC CEO