Nurse Practitioners in West Virginia and Wyoming discuss ways that value-based models of care impact vulnerable populations.

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With more and more physicians choosing specialty care over primary care, Nurse Practitioners have an increasingly important role as providers on the front line, serving more vulnerable populations who experience limitations in accessing healthcare, particularly in rural areas. Joyce Knestrick, PhD, FNP-BC, FAANP, FAAN, past-president of the American Association of Nurse Practitioners, joins Nurse Practitioner Mary Behrens for a discussion about ways that value-based models of care can negatively impact vulnerable populations who are already experiencing healthcare access challenges.

Mary Behrens: Hello and welcome back to the Health Disparities Podcast, a program of the Movement is Life Caucus. Movement is Life is an initiative that aims to reduce health disparities, particularly in the areas of musculoskeletal disease and related conditions, such as heart disease, diabetes, and mental health. We focus on these disparities that we see, particularly in women, black and Latino communities and populations living in rural areas. Thank you for joining us today. Let me just mention that all the views and opinions expressed in the discussion today are the participant's own and do not necessarily reflect those respective organizations or those of Movement is Life. I am Mary Behrens. I'm a nurse practitioner in rural Wyoming, and I have the great honor to serve

on the Movement is Life Caucus Steering Committee, where I constantly remind everyone that advanced nurse practitioners are a vital part of the healthcare provider mix. This podcast continues to build on our previous discussions focused on value-based models of care. Our Movement is Life value monograph provides a really nice overview of how payment systems impact the provision of care, especially to high-risk vulnerable populations, and you can download this from our website at movementislifecaucus.com.

This episode, we'll take a look at the impact of value-based models of care from the nurse practitioner's perspective and to help our listeners get up to speed. Let's talk a little bit about nurse practitioners and it is my pleasure to welcome my good friend and colleague Dr. Joyce Knestrick, a family nurse practitioner from Washington, Pennsylvania, who now cares for low income and underserved populations in rural Appalachia. Among her many distinctions as a leading nurse practitioner and advocate, Dr. Knestrick is the most recent past president of the American Association of Nurse Practitioners. And so welcome Dr. Knestrick to the podcast.

Joyce Knestrick: Thank you very much, Mary. Thank you for that lovely introduction. I'm so happy to be here, to talk about nurse practitioners and our role in providing access to care for nurse practitioners in rural and underserved areas, but more importantly on how we will get paid, to provide those services.

Mary Behrens: According to the American Journal of Medicine article, and this is a 2017 edition. The authors are Dolan, Ryan and Albert only 33% of physicians practice in primary care. So, my question to you is where do nurse practitioners practice and how many are in primary care?

Joyce Knestrick: We know that 89% of nurse practitioners are certified in primary care and about 70%, I think it's roughly around 69 point some percent, actually practice in a primary care setting. And from what we can glean from the data about 30 to 35% of nurse practitioners practice in rural and underserved areas. So, I think we make up a significant workforce that's working with special populations that really need the type of care that nurse practitioners provide.

Mary Behrens: And I also think that they're obviously fulfilling a needed gap right now, due to the fact that, physicians are tending to more go into specialty care. That is important information. So, let's briefly talk about the different payment models that impact nurse practitioners, and that would be fee for service versus bundled payments.

Joyce Knestrick: As in the earlier podcasts, I think explained very well, the fee for service and value-based payments and bundled payments. So, usually, when we talk about bundled payment, we're oftentimes talking about

surgical or hospital settings where a nurse practitioner may be working as part of a team say in an orthopedic practice, which you're most familiar with and the nurse practitioner may be doing the, HNP and some follow-up work and education along with the whole team, in that orthopedic setting perhaps after surgery. And so, all the payment would be bundled into one. I think that's the best way to explain it for people for the audience that bundling would be one charge, which would include everything. So, here the nurse practitioner, would be sort of hidden in that cost because her role, perhaps in doing the HNP or the patient education or taking sutures out or whatever they would be actually doing, that would be all part of that bundle payment. In the fee for service model, is probably one where most people are familiar with, you provide a service, and you get paid a fee. And that is how our government Medicare and Medicaid, have worked for many, many years. And so, that kind of pushed providers into having to see a lot of patients in a day in order to make money, in order to be able to keep their practices afloat. So, it seemed like people were pushed through, maybe they only got a 5- or 10-minute visit, didn't have time to get all their questions answered, etc. I think that the new payment models called value-based payment is really like pay-for-performance. And what we see in a pay-for-performance is starting to look more at the quality of the care that the provider gives and what are the outcomes that the patient receives. And so, this model is more in line with the nurse practitioner model, since we tend to be a more holistic in the care that we give our

patients. So, we're looking at them not only in terms of their disease process, but their health promotion, their health, disease prevention strategies, what's going on with their family and most of the time nurse practitioners are from the community. And so, they understand the needs and wants of the community in terms of, helping the patient with the needs that they have.

Mary Behrens: I think that was a really, nice summary and to show some of the differences that I think that nurse practitioners can make, in making a difference for their patients. Nurse practitioners are often the only ones providing care in rural and underserved areas. And certainly, this is true, where I live in sparse Wyoming. There could be a large, county where there may not even be a physician living there. So, would you describe some of the challenges you face and how payment systems may impact these services?

Joyce Knestrick: So, I think there are multiple issues in terms of payment issues for nurse practitioners. One, we have 23 States in Washington, DC that have what we call full practice authority for nurse practitioners. You're in one of those states. In those states, the nurse practitioner is able to practice fully in her license or his or her license is independent of another provider. In many states, we see some restrictions related to nurse practitioner licensure, either by means of having to have some sort of a collaborative

agreement with a physician usually, in order to prescribe medications or some avenue is restricted. And some states there is even language that the nurse practitioner has to be supervised by a physician. There is no other profession where they are supervised by another profession. That's one of the biggest barriers that we face. And then, oftentimes, in payment, particularly when we see nurse practitioners in states where they're not practicing to the full extent of their licensure or their education. We see a lot of incident to billing, which is where the team or the physician bills underneath their name instead of the nurse practitioner's name. And so, that makes hidden, the role of the nurse practitioner within that healthcare team in the system. Otherwise, we are paid pretty much the same as everyone else. However, if you're not in a community health center or a federally qualified health center, you would get 85% of the physician payment, which is another barrier for nurse practitioners to be successful, at providing practice more independently, if they had their own practice. But, you know, the world is changing and, what we see mostly now is even physicians are hired and employed by larger health systems and nurse practitioners are in that mix as well. So, we see a varying degree depending on where you are in the country. And when you talk about being in Wyoming, I live in Pennsylvania and it wasn't that long ago that my former practice partner who's now passed away, but up until just a few months before she passed, she was seeing patients via telehealth in mid-northern Pennsylvania because they did not have access to a primary

care provider in their area. So, there was a nurse available in a clinic to operate equipment, and she was doing the telehealth visits with those patients and doing their primary care that way, because they had no other choice, no other access. Then that becomes an issue of payment, and regulations across states and with telehealth services, which nurse practitioners, also provide.

So, we have a whole body of payment issues, the same as what was talked about in the other podcasts about the difference in fee for service value-based payment, how you get paid. But I think nurse practitioners do a really good job of caring for the patients, and so, when it comes to value-based payment, and being accountable to the patient, providers, payers, purchasers, all of those that go along with that value-based payment model, I think nurse practitioners are in a good place because it's pretty much how we've always practiced with the best outcome for the patient in mind. We believe the patient is the center of the care.

Mary Behrens: Right. Just as you were speaking, I was thinking just a sidelight that came into my mind that with COVID certainly telehealth, we've seen those services increase and the need for them but, also, some states have passed emergency rulings in terms of nurse practitioners maybe not having to have that collaborative agreement or have a little more, what I call, full practice authority. And I even think one state adopted a new--.

Joyce Knestrick: Yes. We just had Massachusetts that became a full practice authority. And I want to remind folks in the audience that having an independent licensure is what a nurse does now. In Pennsylvania, if I wanted to put my sign up as an RN clinician, I could. That's not true in every state. As a nurse practitioner, I can't, unless I have a physician collaborator. That's like saying, okay, well, if I'm in West Virginia, I could drive a car but when I come over the border in Pennsylvania, I can only drive it if my husband is in the car with me. It just doesn't really make any sense. Now, where you practice in terms of your practice setting, that may dictate different rules because that's in the setting that you choose to practice. So, we do see some changes there, and, of course, every state has different rules and regulations. But what we do know is in the full practice authority states where nurses can establish independent practice, we are more likely to see them going out to provide services in the rural area. And that was in the AEI report that Peter Buerhaus, did the work on, I think in 2018.

I think we do know that would be a positive step for our healthcare system if we could remove barriers. And, sadly with the COVID, we're seeing some states repeal those extra benefits, I guess, or removal of barriers for nurse practitioners, and repealing those back to where they were. So, it's kind of sad to say, well, in an epidemic, you can do everything, but once

that epidemic's over, now you're not qualified to do that by yourself anymore. It really is a disadvantage for the patients and their access to this type of care they need.

In terms of telemedicine or telehealth, I think patients really like that access to care and regardless if you're in a rural area or in a city, having that immediate access to care, generally, via telehealth, I don't think it's going to go away once COVID is over. I think it's going to be assimilated and used differently, within the healthcare system and I think nurse practitioners are well-prepared to use the technology.

Mary Behrens: So, that is a positive that I see that has come out of COVID in the sense that I think we're providing that increased telehealth services. So, let's move on. Nurse practitioners are often faced with complex patients that have not been getting the regular care. Can you help the listeners understand why that might be?

Joyce Knestrick: Well, oftentimes patients, particularly in rural areas, first of all, they have a sense of resilience and hardiness and health is function. So as long as I'm able to get up and function, I'm healthy, that's how it is here in Appalachia. And so, they are more likely to wait until something is really, wrong before they, reach out and seek care. And then, if they do not have that access to care available, or they don't have, health insurance, or if

they're on Medicare and Medicaid, they may not be able to get into services because not everyone takes those types of insurances. And so, that also limits access. And so, nurse practitioners are often, practicing in rural areas, underserved areas in the cities and are more likely to take Medicare and Medicaid, which I think is important in reducing access barriers to patient care in the United States.

Mary Behrens: So, that's really an important issue. I think you touched on this a little bit, but I think we could talk about it a little bit more, but traditionally nurse practitioners have focused on the whole patient and not just a body part. So, has value-based care effected the provision of holistic care and how?

Joyce Knestrick: Oh, well, I think that, in some ways, value-based care has really pushed us to look more at the individual, as a whole, to be more patient-centered, and to look at models that include the patient and as well as providers and payers, and also, it provides for more transparency, and what's going on in terms of the care that the patient received.

So, I think that because nurse practitioners look at the patient more holistically, that we're looking more at, okay, not only is this a patient with diabetes, having poor blood sugar control, but they've had weight gain. We're more likely to take the time to delve in to find out exactly what's

going on. I tell a story of a patient I had, who had an A1C of 14. I was so happy when I got it down to 11, but the payment model doesn't give me credit from getting from 14 to 11, knowing that I'm probably never going to get to 8 or 7 in that A1C. How I got her down to 11 was, I said, "What are you eating?" And she told me, something she's eating, and then, she told me that she eats, at a certain place. I went there and it happened to be a community soup kitchen. And I found that all that they had really in that, place for them to eat, was carbohydrates, macaroni and cheese spaghetti, rice dishes and, that was her only meal really of the day that she ate. She was living on, I think, $30 a month in food stamps, which, doesn't go very far today. And so, you're trying to tell her how to make the best choices from what she has in there, and she's like, just looking at you because, this is what I eat. And also, they had a lot of donated soda there. Where I'm from, we called it pop, but they had a lot of soda, in that area donated and so, she was also drinking a lot of soda and of course that was having a big impact on her diet, as well. So, I think you have to take the time and when you get to know people in the community, and know what's going on, then you could start to really address some of those overall population health disparities. So, from not only talking to them in the kitchen about how they could offer some things a little differently. It doesn't only help her but helps everyone in that community that probably has the same issues or similar issues than she does.

So, I think that our focus has always been, nursing from the very beginning, it's always been about public health population health since Florence Nightingale, Lillian Wald, and other famous nurses that worked on public health issues. And so, we are taught from our undergraduate education, that we look at the patient, the family and the community.

Mary Behrens: So, you've really given a good view of what it's really like in the trenches. So, when a patient in a rural area requires specialty care and must travel to a big medical center, what does the nurse practitioner have to think about before the referral? And then, what happens when the big medical center wants to continue to follow that patient?

Joyce Knestrick: Yes, so, we see that happening a lot, in rural areas. So, for instance, I am the primary care provider of my panel of patients and oftentimes, we have a medical director. I do not have a collaborating physician. In West Virginia, if you don't, prescribe scheduled medications, you don't have to have a collaborating physician. And so, I chose not to do that, but we do have a medical director who is a physician in our clinic. A lot of times what happens, if I have to send the patient out to a clinic or to a specialist, to a large tertiary care hospital for services, oftentimes, I'm kept out of the loop because the information goes to the physician. I think it's gotten better over the years where they have been recognizing nurse practitioners as the provider and I will get a letter to address to me, but

many times, I will get a call from the physician saying, "Oh, is this your patient?"

The other problem that we have, oftentimes, in large teaching hospitals, is that they will make follow-up primary care appointments for the patients in their primary care clinics and then, the patient has further access to care. And then they're kind of confused like am I supposed to see you or am I supposed to see them? And so, I understand that they're trying to make sure there's continuity of care, but if somebody is 50 miles away from that tertiary care, they're not going to go back there for appointments. And so, that really disrupts that trust, I think, with the providers, but also disrupts that continuity of care.

Mary Behrens: Isn't also transportation an issue in the area where you are too because I know in Wyoming, we have big distances to travel?

Joyce Knestrick: Yes, transportation is a huge problem. I also live in a rural area. We have no public transportation or very, limited. I think there is a bus service or a van service that will come around and pick up senior citizens for appointments but, mostly, otherwise, there's very, limited bus services in my town that certainly don't come out to where I live. So, we see, limited bus services or no bus service. We see, patients, most of mine, if they have to choose between a couple gallons of gas to get into an

appointment or buying milk and bread, they're probably going to pick the milk and bread. And so, particularly, I think today around here, the gas prices were about $2.79 a gallon. So, that starts to get kind of steep, for people if they have to drive 30, 40 miles, they're probably just going to miss their appointment.

So, there's not really the services to pick people up in rural areas and then there's also the distance, and then there's also the quality of the cars that they're driving may not be able to make that distance, particularly in bad weather like we're experiencing right now. So, there are multiple things when you're talking, about rural areas, that hinder access to care. So, if we can have nurse practitioners in those little communities that can help, reduce their barriers to access, it's very important, I think for our healthcare system.

Mary Behrens: And, and to make sure that we can really provide good follow-up and they don't have to drive large distances to get that.

Joyce Knestrick: And I think to see the outcomes that we want to see in the value-based care model. I think it's important, to establish those relationships, but also to have the follow-up, and to make those good connections, I always have good connections with the pharmacist. So, I know if they're picking up their medications or they haven't gotten them in a few months,

and I can say, “I heard that you're not, filling your prescriptions, what's going on?” “Oh, this cost too much,” or, “I had to change my insurance.” Then we can make adjustments to try to help them be more adherent, due to the financial cost, which is also a big barrier for many, many people.

Mary Behrens: So, let's just shift a little bit, and I know we could talk about these, individual patient care issues for quite some time, and maybe it actually could be another podcast, but what kinds of national meetings have you been able to participate as a leader in the American Association of Nurse Practitioners to alert regulators and lawmakers, to the issues of care for patients who have healthcare disparities?

Joyce Knestrick: Back in 2016, 2017, I participated in some Hill briefings. And then I testified before Congress in terms of, expanding the ability for nurse practitioners and made that permanent. So, after I testified before Congress, I went to the White House in 2018 to see President Trump sign that legislation. Not only did it make permanent the ability for nurse practitioners to sign medication assisted treatments for opioid disorders, but it also expanded that out to other advanced practice nurses. I was very happy to see, that include our sisters and brothers in other parts of nursing to be able to expand that access, because, when I looked at some of the rural counties around me in Pennsylvania, Ohio, and West Virginia, we would see that, oftentimes, there might be one, physician provider and

maybe one physician assistant and one nurse practitioner in a whole county that was, providing those medications for addiction. And so, I think it was very important that we were able to expand that out to other advanced practice nurses and make it permanent for nurse practitioners. And we've seen nurse practitioners come to the table with the waiver. We also at the American Association of Nurse Practitioners, put together a 24-credit CE program for nurse practitioners that are required in the law, but really, nurse practitioners, PAs, physicians, anybody could take that course on prescribing the medication. So, that was an exciting time.

Most recently, in August, I attended a meeting with then, Seema Verma, the SCMS chair and talked specifically about programs to improve access and decrease barriers to care in rural areas. And so, I think some of that will be continued under the new Biden Administration. So, I'm looking forward to seeing what happens and the changes, perhaps that would improve access to care.

Also, I've been part of the Rural Health Association and some colleagues and I from your part of the country, we presented on preparation of nurse practitioners to practice in rural areas. We were widely received by that, very mixed audience about how to prepare nurse practitioners to practice in that type of setting.

Mary Behrens: So, it's been exciting and the tables that you've been at, to sit at and to really make a difference. You have talked a little bit too about AANP of what they do, but certainly maybe you could discuss a little bit about through, education or legislation to address some of these issues. AANP how they've been involved in this process?

Joyce Knestrick: So, of course, at AANP, we're always watching what's going on. We have a federal office that watches the federal legislation and a state office that watches the state legislation. We're trying to work with states and other agencies that are in the states to improve practice, not only for the benefit of nurse practitioners, but also, keeping that patient in the center of care.

We've been part of moving towards some exploratory models now to remove some of the barriers in home health. There are some projects going on in terms of, I believe it's in Maryland, to expand the ability for nurse practitioners to order home health, to order diabetic shoes, those things at that level that we have been behind on, I guess, and actually ends up costing the patient more time and more money. So, we're constantly watching what's going on at the state level in terms of moving forward, sometimes in baby steps, movement toward the full practice authority in licensure, and also, what nurse practitioners are able to do or not doing in each state. So, AANP continues, that fight in every state. I think it's very important. As I said, for the nurse practitioners, and,

oftentimes, I think it's very important because most of the times nurse practitioners are educated in or near their communities, they do their clinical practicum in their communities, and they tend to stay in that community. So, I think a good example are the two nurse practitioners that run the health wagons on the national front in Wise, Virginia and they say right in on the video, “We could have gone anywhere, but we're from here and we want to stay here and take care of the people here,” and for the people there, I think it's really important to have someone who knows, you, knows your environment, knows your community and knows that they're the center of the care and knows what the health disparities are, and what you're facing in that area.

Mary Behrens: That's important information and I think that the idea that if you can attract people to come to a rural area that we found that that does just necessarily doesn't happen, but if you live in a rural area and you like that environment, then maybe we can educate and raise our own. So very important.

Joyce Knestrick: Yes. I think that's very important in terms of, access to care and just a different value system. And, when we start to look at, social determinants of health, just having an underlying understanding of that, is important.

Mary Behrens: Absolutely. So, if you had a magic wand and could revise payment systems to allow nurse practitioners to provide optimal care, what would that environment look like?

Joyce Knestrick: Well, I think that I would want to make sure that the patient, of course, was the focus of the care and that we were able to provide patients with the necessary services that they need, because I think access to care, would be the first important thing on my list. In terms of nurse practitioners, I think, parity and payment, credit for what we bring in, so that we're not hidden under other billing models, whether it's bundled or incident to billing so that all nurse practitioners will be billing under their own code, their own NPI number. And I think lifting the restrictions in every state to permit, nurse practitioners to practice to the fullest extent of their education. If I had a magic wand, I would make that happen because I don't know, like I said, of any other profession that is bound to another profession to practice. And I think we're making really good strides in those areas because we've been able to show the evidence of the high-quality, cost-effective care that nurse practitioners provide but I also think it's evidenced by the fact that we've had over 1 billion visits to nurse practitioners last year. That's the ones we know of, that's not the ones that are hidden under the incident to billing.

Mary Behrens: And I think you mentioned earlier that you said 23 states had full practice authority. There are states that have some restrictions and then they have more restrictions. Can you name a few states that have some work to do in that area?

Joyce Knestrick: Well, I think if you look at our map, it's primarily, many states in the southern part of the country. So, places like Alabama, Georgia, Texas, many of the southern states, Virginia have supervisory language and still the nurse practitioners are under, not only the nursing board, but also the medical board. And so, I think that in those states, we know that they have a lot of health disparities. They have, a lot of issues like access to care that could be, perhaps, remedied if nurse practitioners were able to practice more autonomously.

Mary Behrens: And I think the states, if you just look around the country, certainly if you look at the Rocky Mountain West or rural areas that states, Alaska, for an example, that there aren't a lot of physicians practicing have had, early full practice authority states.

Joyce Knestrick: We appreciate the work that you've done in States like Wyoming, Montana, Alaska, the early Washington DC, early adopters of full practice authority because we have been able to see that, with the changes in healthcare system. If you think about our history back when, Loretta Ford

and Henry Silver, physicians started the nurse practitioner movement, and there were others. They always get the credit, but there were other places, along with that, that was in 1965. What was happening then, Medicare and Medicaid were starting, and we had a new health system. Then, along comes other changes in the healthcare system. President Obama comes with the ACA model and all of a sudden, we have more people into the healthcare system, not only because of the insurance, but I think just because of the aging population, the Baby Boomers that hit at that time, we started to see an increased need for services. As you said earlier, we see more physicians going into specialty care. But I also want to say that we had, more nurse practitioners also going into some sort of specialty care to work in those specialty teams. We also saw that expansion of Medicaid in many states and what we saw in many states is that even though they had the Medicaid card, now, they still were not able to get the services because no one was expanding their services for the amount of, patients they would see who had Medicaid.

So, all of those elements and changes in healthcare, the aging population have really pushed, a need for a change. And I think that nurse practitioners are a really good answer to some of the problems that we're experiencing in our health care system today.

Mary Behrens: Right and if you look at our, nurse practitioners, we're graduating, large number of students each year and our numbers are growing quite fast. If you look around the country.

Joyce Knestrick: I think we have about 290,000 nurse practitioners in the United States, now, but I do want to remind you that I know we have a lot of people coming out of programs, but we also have a lot of people aging out and looking forward to retirement at the same time. So, the early NPs like you and I are looking at, well, when are we going to retire? And so, I think that while we have more people coming in, I think we'll be seeing just like other professions, seeing some people going out and then we need to replace. I think nursing in general is a wonderful profession. We don't get the accolades. Now, I think COVID has really brought attention to the role of the registered nurse and really helping promote, what we do in nursing. And I think the nurse practitioner is really an innovation in healthcare delivery. Now the payment models have to catch up.

Mary Behrens: Right, so, well said. Thank you, Dr. Knestrick, it's been a pleasure to take a deep dive into this important subject, and we appreciate you, our listeners for joining us today for another discussion about healthcare disparities. You can access the transcript of this podcast on our website, movementislife.com and remember to subscribe to us on any of the

Spotify, Stitcher, Google, or Apple podcasts. Please be safe, be well, and keep working for health equity. So, until next time, goodbye for now.

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