Past Event: 2024 NCSBN Scientific Symposium - Scope of Practice: Influence of Nurse Practitioner Practice Restrictions on Chronic Disease Health Disparities Video Transcript

Event
2024 NCSBN Scientific Symposium

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Presenter
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- [Dr. Brooks Carthon] So, if it's okay, I'm going to stay here on the floor with you all. Hopefully, we can have a dialogue. I'm going to share results of a research study, but I really hope to be able to share conversation with you about how the findings resonate with you in your various roles on regulation, policy, and education.

So, thank you for that, probably, too long introduction. But let me just say in one sentence what my program of research is about. And it really is core to who I am as a nurse and a nurse practitioner and as

So, we're very grateful for that. And so for the purpose and the aims of this particular study, we focus particularly on disparities between Black and White Medicare beneficiaries who are diagnosed with coronary artery disease. And so why did we pick CAD? Well, CAD is the most prevalent heart disease in the U.S., affecting over 18 million people in the United States.

And heart disease is the leading cause of death in the U.S. And while we have clear ways to attend to and treat CAD through lifestyle and medication and diet and exercise, we know that it's important, in order to do those things, to screen appropriately through annual cholesterol testing. Despite having clear ways to address coronary artery disease, there are clear disparities between older Black and White patients.

And so while the prevalence of CAD between Black and White patients is very similar, the mortality rates between them are not. And so what we have here is that over the last few decades, mortality has decreased among all older adults diagnosed with CAD. But the disparities in mortality, as you note here from this slide, continue to be worse for older Black patients, compared to their contemporaries.

And so what are the challenges, what are the problems, what are the factors that underlie disparities? And so what we know about health disparities or health inequities is that they're multifactorial and they're complex, and that the factors leading to health disparities operate at the patient, the provider, and healthcare settings themselves.

Right? And so from the patient perspective, older Black patients may have more comorbidities. So, they may have higher prevalence of hypertension, obesity, diabetes. So, they could have more severe coronary artery disease. They may have lower economic resources, and so may not be able to access some of the lifestyle modifications that we recommend.

They may live in under-resourced communities. And there also may be their own preferences. Right? And so there could be preferences, there could be comorbidities, there could be provider-level factors. And so there could be differences in prescribing patterns, there may be implicit bias, there may be medical mistrust.

And we also know from other research that older Black patients are more likely to be concentrated in healthcare settings that are known for lower quality in general. And so when we think about these factors in total, it helps us to think about the ways in which these are all factors that we should be thinking about when we think about solution setting. Right? And so for the purposes of our study, we were very interested in provider and setting-level factors.

We knew from other research that examined physician characteristics and practices that physician characteristics and practice size had been associated with CAD disparities. But none of that research had looked at nurse practitioners. And we know that that's really important because nurse practitioners are a growing part of our workforce. They're increasingly providing large proportions of primary care.

And we already know from numerous studies and systematic reviews that nurse practitioner care quality is equivalent to physician colleagues, satisfaction is high. But we also recognize that there can be constraints and barriers to the care they deliver. And that those constraints and barriers, I view those constraints and barriers as system-level factors that may be driving health inequities.

So, you think of it as scope of practice. I think of scope of practice as a factor that may impede access to necessary care for minoritized populations in underserved areas. When you say...or when we think about

unsupportive practice environments similarly, we think about the organizational climate that empowers nurse practitioners to provide necessary care.

And so when organizational climates constrain nurse practitioners or where regulatory environments constrain or restrict nurse practitioners, these factors can have significant consequences for populations that already have all of the other factors that we just talked about.

Right? And so one of the things that was curious to us and really that underpinned our study was really understanding more specifically how these factors, particularly for the study I'll talk about today, how unsupportive practice environments are really key to thinking about how we might improve the care outcomes for older Black patients diagnosed with CAD.

So, what do I mean when I talk about the nurse practitioner practice environment? And so as I mentioned, this is a study that I was a co-PI with Dr. Lusine Poghosyan. And she helped to conceive of a measure that helped to measure the organizational climate of nurse practitioners.

And the good thing about this measure is that it was built around nurse practitioners who participated in focus groups and surveys, who then were able to say, "These are the things that impede, impact, or facilitate my ability to provide care." So, I didn't mention at the top of the hour that I'm a nurse practitioner and worked for many, many years in community care settings.

And so when I read about these factors, core of which is my independent practice and my autonomy and my ability to bring my expertise to my practice is pivotal. So, that's really important. In addition to my ability to practice within my scope, but also within my skills and my knowledge and my expertise, is the relationships with the people around me.

So, whether it be my physician colleagues, whether it be the administrators or leaders in my practice or in my office setting, but also the level of professional visibility and reputation and respect that the role of the nurse practitioner has. And so when you think about the practice environment, I want you to think about a practice environment that's supportive.

So, I want to teleport you to a really good practice environment. And so for me as a nurse practitioner, a really supportive practice environment looks like one where I have adequate support. So, I come in, maybe I have a tech, maybe I have an MA who's helping to take vitals and help organize a problem list. That could also be a nurse who does that, as well.

Maybe I have a scribe who helps to chart for me. Like, this is utopia, but this is a good practice environment. When I'm scheduled with patients, I don't have five crammed into an hour. In fact, my scheduler works with me and she can see, "Well, you have Mr. Jones and Ms. Thompson in this hour, and they're going to take a lot of time. So, instead of giving you another heavy patient, I'm going to slide in someone who's probably a quick med management call."

So, that means that it's not just kind of, like, churn and burn. We're really thinking about the needs of the patients and we're working together so I have adequate resources, my schedule is helpful. When I'm finished seeing my patients at the end of my visit, I have someone that I can hand off to. Maybe it's a nurse who's able to say, "Okay, I'm going to make sure that some of these post-visit, whether it be prescriptions, whether it be lab work, that I help connect people to make sure that they know where to go next."

So, that sounds amazing and that sounds great. But I can tell you in most clinical settings, all of those things aren't there. And so unfortunately, a lot of times as NPs, we are running around like chickens with our heads cut off just trying to do all the things we need to do. And unfortunately, for people who have more needs, what falls by the wayside is patient-centered care. What falls by the wayside is attending to your cultural needs and preferences.

And so it's just kind of routine. So, you get the same care as you, and you, and you, and you. You just get what I get. Because this is all I have left, because where I'm working is not allowing me to practice to the top of my skill, my expertise, and my capacity. So, some of the work that we've seen so far is that what I experienced as a nurse practitioner, and colleagues, around me is true.

And so we know that in better practice environments, patient-centered care is increased. We know that prescribing medications for asthma is increased. And we also know from a nurse level that burnout is decreased and job outcomes are decreased. Well, decreased in environments...job outcomes such as burnout are decreased in better work environments. And so when we thought about what we wanted to

- [Audience Member] Good morning. Excellent presentation and lots of good food for thought. Question about the LDL. So, you... I'm a nurse practitioner, as well. So, when you were looking at the LDL and the billing, were you looking at it as being something that was ordered on its own, or as a bundle?

Because I think about, you know, you can order a lipid panel, you can order a CMP. It can be...there's a lot of different ways to go about getting that LDL. So, could you speak to how you were talking about the billing with LDL? Thank you.

- I think... And I'd have to kind of go back to check, but I think it was LDL purely. I don't think we looked at whether it was a part of a lipid panel, but don't quote me. And I didn't mention that this paper is in the Journal of Nursing Regulation, the October version, the October issue.

But that's a good question, and one that I probably, if I had to guess, I think it was just the LDL, but I don't want to say 100% for certain. But that's a good point, that maybe they were getting other types of cholesterol screens that we didn't pick up because we didn't look at the full. But part of me feels like, because...

So, one of the things that we do is when we evaluate kind of CAD patients, we kind of look to see, like, what are all the diagnoses that one might use for CAD. And so, you know, you kind of go to precedent for that. And I'm wondering, for the LDL, if we said, "All of these ways, like all of these billing codes, to get this particular, did we do that, as well, for the LDL?"

I know we did it to find our cases of CAD, we used a wide net to make sure we had everyone. But for the LDL, I'm curious if we used just strict LDL or if we said, "Okay, did they have LDL? Did they have a lipid panel? Did they"... So, I don't want to say 1

- There had to... So, the NP gave their feedback about the environment. Right? So, they had to be working in that practice. And their NPI number corresponded they worked in that practice. But did they...could we attribute like, you know, "They saw this patient"? You know, we know that at some point in time that there was care delivered in a practice where NPs were.

But that's a big limitation, is that we can't always connect. I mean, some can. Like if you can... You know, you can find some NPIs where the NP themselves provided care. And to the degree we could, we did. But for 111,000 patients, we can't directly say that the NP provided all of that direct care.

So, that's a limitation.

- Yeah. I think so. Because, you know, when you look at...when you start to kind of break down NP...and I don't want to say "versus," but NP care, MD care, you know, I love my MD colleagues, but we have different...we come to the same places, but we have a different mindset of how we get there. I think that's a good way of saying it.

Right? And so that could be something to further study, to look at and kind of tease out just the NP role. And it would actually be a nice contrast to what you've already presented here and really kind of fine-tune it a little bit. But it's really good food for thought, thank you so much.

- Absolutely. Thank you. Thank you. Everyone, thank you. I don't want to, like, cut into the time of the next person. So, thank you, all.