

“Building Bridges in Health Care”

Remarks by Senator Richard T. Moore
Senate Chairman, Committee on Health Care Financing at

“Bridging the Gap - Health Reform: The Glass Half Full?”
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When Sir Isaac Newton observed that “We build too many walls and not enough bridges.” He might have been thinking about the field of health care.

Some of the most contentious health policy debates that we hear at the State House concern health professions arguing to protect or expand the scope of practice. For example:

- Optometrists want to expand their ability to diagnose and treat Glaucoma rather than diagnosing the disease and having to refer their patient to an ophthalmologist for treatment. The ophthalmologists argue that this risks patient safety despite the fact that 49 other states and allow optometrists, duly certified and registered, to issue written prescriptions, to treat glaucoma and a handful of other eye conditions with oral therapeutic agents with no known deterioration of care.
- Podiatrists want to be able to treat diabetics when foot problems expand around the curve of the heel, but orthopedic physicians content that this is beyond the capability of a podiatrist and would be unsafe even though podiatrist receives sufficient training, but cannot use that training in our state. Nevertheless 43 other states include ankle in their scope of practice for podiatrists.

- Physicians contend that Nurse Practitioners and Certified Nurse Midwives should not be considered to be primary care providers. Massachusetts is one of only six states that require direction and supervision of midwives rather than a collaborative model of care.
- Registered Nurses, too often, discount the services of Licensed Practical Nurses and Nurse Assistants in delivering care to patients
- Dentists worry that Dental Assistants and Dental Hygienists might be allowed to perform services without the oversight of a dentist. Yet 22 other states, including all those which border Massachusetts allow dental hygienists to provide preventive care in public health settings without the supervision of a dentist.
- Physicians have opposed limited service clinics – sometimes called “Minute Clinics” in pharmacies, supermarkets, shopping malls, and other popular locations that would be run by nurse practitioners or physician assistants placing care in places and at times that are convenient to patients.

In each of these debates, both sides present arguments, data, political contributions, and other means of attempting to influence the outcome. Both sides claim to be only interested in protecting the patient, yet the current system of care is often more costly, not necessarily more safe, and sometimes the patient goes without care because of the shortage of the “more advanced” providers available to deliver the care.

Let’s look at this issue of shortages for a moment. The medical profession readily admits that there is a shortage of primary care physicians as well as a shortage of nurses. Primary care physicians have many of the same costs as

their specialist colleagues, but significantly less income driving many medical students and residents to by-pass the primary care field in favor of more lucrative specialty practices. In addition, reports from government sources and leading foundations indicate that we face a projected shortage of 400,000 nurses (or 20% of the number needed) a decade from now. A major part of the reason is that we are rejecting too many qualified nursing student applicants because we don't have enough nursing faculty. Again, the costs of becoming a nurse educator are greater than the cost of becoming a clinical nurse, while the compensation for a Ph.D. in nursing is about half of the pay of an RN in a hospital.

The Massachusetts nursing faculty vacancy rate of 8% in 2006 will continue to limit enrollment in associate, baccalaureate and graduate degree programs at a time when nursing schools need to increase enrollments to meet future workforce demands.

Massachusetts in 2005 needed 70,621 nurses, but had a shortfall of 4,820 nurses or 7%. This shortage is expected to grow to 12% in 2010 in what health care experts contend is an "unacceptably dangerous shortage."

This shortage of health care professionals also has a significant impact on the quality of care that is delivered and the cost of that care. Resolving the shortage of health care professionals, then, is not only essential to the ability of Massachusetts to deliver on the promise of health care reform by providing real access to care, but is also critical to ensuring that health care for all is of the highest quality and safety, and that it can be delivered at a cost that society can afford.

Massachusetts residents are gaining access to health insurance, but they will now be seeking care in a state with a "critical shortage" of primary-care physicians, according to a study by the Massachusetts Medical Society released recently, which found that 49% of internists aren't accepting new patients. Boston's top three teaching hospitals say that 95% of their 270 doctors in general practice have halted enrollment.

For those residents who can get an appointment with their primary-care doctor, the average wait is more than seven weeks, according to the medical society, a 57% leap from last year's survey. As it happens, primary-care doctors, including internists, family physicians, and pediatricians, are in short supply across the country.

The Senate President's health care reform bill addresses this shortage in several important ways:

- There will be loan forgiveness for physicians and nurse practitioners who agree to focus on primary care delivery, and for nursing faculty who will help to create more clinical nurses.
- There will be tuition assistance for medical students, advance practice nursing students, who agree to focus on primary care delivery, and for nursing faculty who will help to create more clinical nurses.
- There will be first time home buyer assistance for new primary care physicians.
- There will be a Nursing and Allied Health Trust Fund to assist with improving the supply of nursing faculty, the purchase of technology to

aid nurse education, and the enhancement of clinical settings for learning.

Another important feature of the Senate President's health care reform bill is to increase the Commonwealth's investment in health information technology and the setting of goals when hospitals, health centers, and physician office practices. There is increasing availability of academic research that documents the success of technologies such as electronic or e-prescribing, computerized physician order entry systems, and electronic health records in improving the quality of care while helping to contain costs and measure outcomes. We plan on investing \$25 million a year for the next decade, combined with federal, foundation, and private investment to build an electronic health information exchange throughout Massachusetts.

The Senate President's legislation also focuses on improving the transparency of our health care system by shedding light on the factors that drive health insurance premiums and charges and on the factors that drive the cost of care by health providers. By identifying the factors that are driving the cost of access to high quality care, we can concentrate our efforts on health system redesign to reduce those costs and improve care at the same time.

Finally, there's one more reform that I hope can be achieved in this session of the Massachusetts legislature.

As anyone in the nursing profession knows so well – whether you are a nursing student, a nursing professor, nurse practitioner, registered nurse, licensed practical nurse, nurse assistant, or nurse executive – the issue of

nurse staffing has deeply divided the profession – a profession in which every member at all level's care deeply about patient safety and good clinical outcomes for patients.

I believe that it's time to move beyond the tired old arguments for the MNA's (Massachusetts Nurses Association) rigid one-size-fits-all mandatory nurse to patient ratio that is focused on job protection for nurses, and the tired old arguments for the MHA's (Massachusetts Hospital Association) publication of nurse staffing plans that is focused on reducing hospital expenses, and move to a plan for safe, high quality nursing care focused on the patients. We need to tear down the walls that are dividing the nursing profession and build bridges to improving patient care highlighting health care quality improvement and health care cost containment!

What we need to agree upon is to begin measuring registered nursing hours per patient day and compare that to the quality of health care outcomes of the patients.

Rather than saying every patient deserves an equal ratio of nurses, we need to say every patient deserves a level of nursing care and time consistent with their level of illness. Rather than saying we'll publish our staffing levels and that should assure the public that we've got enough nurses, nurse assistants and support staff, we need to look at how much RN nursing time – the most skilled level of nursing – is being devoted to a patient in direct bedside care, in leading the patient care team, and in working to educate patients and their families about patient needs both during the hospital stay and after discharge. It's not a question of how many nurses are on duty on each shift and in each area of hospital service, but more a question of how much

nursing time is devoted to the needs of the patient in order to improve the likelihood of a favorable health outcome for the patient. If everyone could come together around such a solution – changing how we organize patient care in and out of hospital settings – our health care system will produce better quality with fewer errors and infections, and we can do it at what we will see as an affordable level.

Although I started out my remarks praising the value of bridges over walls in health care, there are, of course, some situations where walls may clearly be needed – in order to protect the patients and the need for trust between patient and provider. As Robert Frost wrote in his wonderful poem, *The Mending Wall*, “Good fences make good neighbors.”

This is the case with our proposal to prohibit gifts from pharmaceutical companies and medical device manufacturers to those with prescribing authority – physicians, nurse practitioners, and others. There is a growing body of research on this topic.

An article published in the January 2006 *Journal of the American Medical Association* – entitled, “Health Industry Practices that Create Conflicts of Interest” – declared that earlier voluntary efforts to prevent ethical transgressions in the relationships between physicians and the drug and medical device industries, continue to erode medical professionalism as well as the integrity of the industry. By offering physicians even subtle inducements – small gifts, modest meals and drug samples – the pharmaceutical industry is still successfully getting physicians to prescribe the newest and often most expensive drugs when cheaper therapeutic

equivalents are available, and to petition their inclusion on hospital formularies, according to the article, which included as co-authors representatives of the Association of American Medical Colleges (AAMC) and the American Board of Internal Medicine (ABIM).

This recent critique is premised on a surprising research finding: that permitting only small gifts, requiring full disclosures and making earnest efforts to avoid bias – hallmarks of the voluntary guideline approach – do not prevent non-rational prescribing behavior by physicians after exposure to promotional presentations by drug reps. The *JAMA* article argued that the urge to reciprocate, even when given a gift of nominal value, operates at an unconscious level which physicians cannot effectively prevent, and recommended more external restrictions on physician contact with drug reps – specifically at academic medical centers because of their leadership role in the medical profession, their ability to organize and implement new policies rapidly, and the importance of habit-formation during physician training.

Some academic medical centers and health systems, such as UMASS Memorial Health System and the University of Massachusetts Medical School here in Worcester, citing concerns about drug rep marketing behaviors, agree with the premises of the *JAMA* article and have begun to implement further institutional restrictions on drug rep interactions with physicians, in some cases banning all gifts and drug samples.

In the next few months, and in the years that follow, there will be continued analysis by public policy makers that will need to reforms in our health care delivery system. They will require nurses and other health care professionals to remain aware of the changes proposed to expand excess,

improve quality and contain costs in health care, if you want to be part of the solution rather than part of the problem. Conferences such as this Becker Nursing Symposium are among the important methods to help you remain connected to changes in your profession and in the laws, regulations and policies that directly impact you, your profession, and your patients. I want to commend each of you for taking time to become both a better nurse and a better citizen by your participation.