

Retail Clinics and Nursing Practice: Editorial

The American Medical Association (AMA) previously established policies on retail clinics which addressed standards of care such as the use of electronic health records and adherence to guidelines for proper sanitation and hygiene. The AMA principles called for clinics to use a well-defined limited scope of clinical services and a referral system to ensure continuity of care with doctors in the community. Further, the policies required that patients should be informed of the staff's qualifications, the clinic's treatment limitations and where follow-up treatment was obtainable. The American Academy of Family Physicians (AAFP) produced similar guidelines. Both organizations support using electronic medical records that are compatible with physicians' offices. ([Kaiser Daily Health Policy Report, June 25, 2007](#)). Even though the retail clinic industry incorporated those guidelines into its quality and safety standards ([Convenient Care Association, 2006](#)), the AMA continues to challenge and question the retail clinic model.

The AMA continues to advocate for economic barriers to nurse practitioners' in spite of more than thirty years of evidence that proves safe and efficacious practice. Recently, the AMA and other medical organizations have opposed the growth and proliferation of retail clinics, in part because nurse practitioners are the primary care providers within the retail clinic model. Nurse practitioners see the patients, and, using practice protocols or guidelines, provide a diagnosis; if the nurse practitioner has prescriptive authority, she/he writes the prescription. Medical Directors, along with nursing staff, develop the protocols and review the care. Citing safety, the AMA is concerned about potential conflicts of interest between the nurse-practitioners who prescribe the drugs and the pharmacists who fill them.

In Illinois, the state medical society lobbied for the introduction of the Retail Health Care Facility Permit Act which would allow doctors to supervise no more than two advance practice registered nurses. ([Japsen, B., Chicago Tribune June 26, 2007](#)) This measure is similar to legislation enacted in Maryland that mandates physician supervision ([In-store clinics Should you worry-Medical Economics, September 16, 2005](#)). Texas regulations mandate an even stricter supervision; requiring that a physician be at a clinic 20 percent of the time to review patient charts and offer guidance. ([Dallas Morning News News for Dallas, Texas Business, March 19, 2007](#)).

No matter the arena, nurse practitioners are more than capable of providing competent service. Physicians benefit from nurse practitioners' services when they work collaboratively in medical offices and the physician can bill for the nurse practitioner's services. Retail clinics were borne using existing state licensure laws and the long-term track record of nurse practitioner safety to create a new clinical model which relied on the expertise and low-cost of nurse practitioners.

The health care delivery model has changed and is becoming less dependent on physicians with the advent of retail clinics in chain stores across America staffed by nurse practitioners and physician assistants. In response to this new workforce asset and the slow, but constant evolution in practice spurred by the public's desire for access to cost efficient care, physicians have targeted the new business and health care delivery model created by retail clinics.

At the recent AMA House of Delegates, the organization passed a resolution to increase federal regulation of clinics which calls for state and federal probes into a possible conflict of interest between the clinics and the pharmacies that own or host them. The new policy also opposes the waiving of state and federal regulations for retail clinics that do not comply with standards for medical practice facilities, as well as opposes the practice of insurers reducing or lowering co-pays to encourage the use of the clinics.

Few nursing organizations have addressed this assault on scopes of practice. The American College of Nurse Practitioners (ACNP) has collaborated with the Convenient Care Association (CCA) to publish a statement in response to the AMA resolution ([ACNP 2007](#)); however, responses by the nursing industry reflect lack of coordination and discussion. The retail clinic industry's attitude and corporate response reflects a lack of respect of the legislative foundation developed by the nursing industry upon which their business model is premised; and the nursing profession's ambivalence shows lack of awareness or knowledge of the growth of the industry. The continued hands-off approach of nursing and the retail clinics provides the medical association with new opportunities to reduce the existing nurse practitioner scope of practice. Thus, we make the following recommendations:

- Development of a relationship between nursing organizations and the retail clinic industry. While the nursing community applauds the inroads made the American College of Nurse Practitioners, we believe other nursing organizations and associations need to expand and formalize their relationship; and coordinate their work within this industry.
- Strategize options to counteract the AMA state and federal regulatory recommendations. The AMA premised the resolution on the government's response to self-referral through the anti-kickback laws, thus a response should be modeled which addresses corporate self-interest; and more importantly emphasizes the lack of mandates upon patients to use in-store pharmacies.
- Educate the industry on the existing scope and the benefits of protecting the nursing scope of practice. Conversely, the retail industry is willing to cede to the medical industry on scope issues because their medical model does not require nurse practitioners (NP) to utilize the full scope of their practice. In doing so, the industry limits the NP's growth and evolution. NP and nursing organizations need to train the industry about the expanded benefits of protecting the nursing scope of practice.
- Coordinate and enhance research on NP clinical practice. Nursing has compiled data, statistics and compiling research on NP clinical practice, while the retail industry has gathered separate, but related data. Nursing and retail clinic industry need to develop common variables for expanding their respective data bases, to better respond to questions about efficacy, quality and safety in NP clinical practice.

Until nursing and the retail clinic industry recognize and coordinate their mutual interests, medical associations and organizations will continue to whittle at the NP scope of practice.

Windy Carson-Smith, Editor

FDA Announces New Advisory Committee to Address Risk Communication, Call for Nominations

The U.S. Food and Drug Administration (FDA) announced a new advisory committee designed to counsel the agency on how to strengthen the communication of risks and benefits of FDA-regulated products to the public.

The Risk Communication Advisory Committee will:

- Help FDA better understand the communication needs and priorities of the general public;
- Advise FDA on the development of strategic plans to communicate product risks and benefits; and

- Make recommendations to FDA on what current research suggests about crafting risk and benefit messages, as well as how to most effectively communicate specific product information to vulnerable audiences.

“Communicating the risks and benefits associated with FDA-regulated products is essential to help consumers and health care professionals make informed decisions,” said Randall Lutter, Ph.D., FDA’s acting deputy commissioner for policy. “The Risk Communication Advisory Committee will bring together a broad range of experts and views to help improve FDA’s communication of the science-based information about product risks and benefits that the public needs to make informed decisions.”

Establishment of the new Risk Communication Advisory Committee stems from the Institute of Medicine’s (IOM) 2006 report, *The Future of Drug Safety: Promoting and Protecting the Health of the Public*. The report recommended that Congress enact legislation establishing a new advisory committee to address how FDA communicates information about the efficacy, safety and use of drugs and other FDA-regulated medical products. FDA agreed with the value of such a committee and acted promptly to establish it through more speedy administrative procedures. FDA also expanded the scope of the committee to cover communication of risks and benefits of all products regulated by the agency.

The advisory committee will be made up of 15 voting members that include experts and public members who are not affiliated with the FDA. Experts will include authorities knowledgeable in the fields of risk communication, social marketing, health literacy, cultural competency, journalism, bioethics, and other relevant behavioral and social sciences. Public members will include those who can provide the perspective of users of FDA-regulated products, such as consumers, patients, caregivers and health professionals.

Two related Federal Register notices are being published, one announcing the establishment of the new advisory committee and the other requesting nominations for members to serve on the committee.

For information:

<http://www.fda.gov/OHRMS/DOCKETS/98fr/oc07124.pdf> and
<http://www.fda.gov/OHRMS/DOCKETS/98fr/oc07134.pdf>.

Nominations for advisory committee members received on or before 45 days after the Federal Register publication will be given first consideration for membership.

For more information:

An overview of FDA advisory committees
www.fda.gov/oc/advisory/default.htm

FDA’s full response to the IOM report
www.fda.gov/oc/reports/iom013007.html

NOMINATIONS:

The Food and Drug Administration (FDA) is requesting nominations for members to serve on the Risk Communication Advisory Committee in the Office of Planning, Office of the Commissioner. Elsewhere in this issue of the Federal Register, FDA is publishing a document announcing the [establishment](#) of this committee.

FDA has special interest in ensuring that women, minority groups, and individuals with disabilities are adequately represented on advisory committees and, therefore, encourages nominations of qualified candidates from these groups.

DATES:

Nominations received on or before July 20, 2007 will be given first consideration for membership on the Risk Communication Advisory Committee. Nominations received after July 20, 2007 will be considered for nomination to the Risk Communication Advisory Committee should nominees still be needed.

ADDRESSES:

All nominations for membership should be sent to the contact person listed in the FOR FURTHER INFORMATION CONTACT section of this document.

FOR FURTHER INFORMATION CONTACT:

Regarding all nomination questions for membership, the primary contact is Lee Zwanziger, Office of Planning, Office of the Commissioner (HFP-1), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-827-2895, FAX: 301-827-5260, e-mail: rcac@fda.hhs.gov.

Strike Force Formed to Target Fraudulent Billing of Medicare Program by Health Care Companies

WASHINGTON -- Thirty-eight people have been arrested in the first phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program.

The arrests in the Southern District of Florida are the result of the establishment of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing data. Since the first phase of strike force operations began on March 1, 2007 in southern Florida, the strike force has obtained indictments of individuals and organizations that have collectively billed the Medicare program for \$142,061,059. Charges brought against the defendants in these indictments include conspiracy to defraud the Medicare program, criminal false claims, and violations of the anti-kickback statutes.

The strike force is able to identify potential fraud cases for investigation and prosecution quickly through real-time analysis of billing data from Medicare Program Safeguard Contractors (PSCs) and claims data extracted from the Health Care Information System. In phase one operations in Miami, teams have identified two primary schemes that defrauded the Medicare program – infusion therapy and durable medical equipment (DME) suppliers. All of the strike force cases to date target these two areas.

The work of the strike force is just one step in a multi-phase enforcement and regulatory project designed to improve the quality of the industry and reduce the potential for fraud in the durable medical equipment and infusion areas. The Centers for Medicare & Medicaid Services (CMS) is taking steps to increase accountability and decrease the presence of fraudulent providers. The end result will be better service to beneficiaries and savings of billions of dollars that might otherwise go to fraudulent businesses.

To read CMS press releases on this subject, go to:

<http://www.hhs.gov/news/press/2007pres/05/pr20070509c.html>

<http://www.hhs.gov/news/press/2007pres/07/pr20070717a.html>

http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf

State Health Care Reform

Oregon: Health Care Bill Goes to House

This month, the Oregon state senate passed SB 329, which offers a framework for building a health care system that would control costs through bulk purchasing, cost comparisons, research-based practices, electronic records, use of technology, chronic disease management and market incentives. The measure also includes \$2.3 million in state and federal matching funds to hire an executive director and to create the Oregon Health Trust Board to work out details of the plan.

[The Oregonian](#)

Pennsylvania: Governor Signs Health Reform Bills

Pennsylvania Gov. Ed Rendell (D) signed HB 1253, 1254, and 1255 into law on Friday July 20 at the University of Pennsylvania School of Nursing. These laws intend to reduce health-care costs and increase access to treatment by giving nurses and other medical assistants greater latitude. The changes will allow advanced practice nurses -- NPs and CNS -- to take advantage of their experience and expertise. Certified nurse practitioners will be allowed to help patients in ways that only doctors are currently permitted - ordering wheelchairs, for example; or treating chronically ill patients at home. They will also be able to refer patients to specialists such as dietitians and occupational therapists. Certified midwives will be able to prescribe medicines.

Additionally, Governor Rendell recently signed an executive order to permanently establish the Office of Health Equity, which will seek to reduce racial and other health disparities in the state ([AP/Philadelphia Daily News](#), 5/21). The order is part of Rendell's "Prescription for Pennsylvania" proposal, made up of several plans, including ones to expand health insurance access, reduce health care costs and improve care quality (Fahy, [Pittsburgh Post-Gazette](#), 5/21). The order also establishes an advisory committee that will work with the office and the governor on such efforts as identifying the cause of health disparities and finding funding sources to support programs (Rendell [release/executive order](#), 5/21).

Recent Reports

[Quality Concerns Identified through Quality Improvement Organization Medical Record Reviews](http://oig.hhs.gov/oei/reports/oei-01-06-00170.pdf)

The Centers for Medicare and Medicaid Services (CMS) contracts Medicare and to protect over 40 million Medicare beneficiaries. In December 2005, the Senate Committee on Finance requested that the Office of Inspector General (OIG) evaluate the QIO's role in protecting beneficiaries' quality of care.

[Improving Hispanic Elder's Health: Community Partnerships for Evidence-Based Solutions](http://academyhealth.org/ahrq/elders/index.htm)

The Department of Human and Health Services (HHS) released an initiative to improve the health and quality of life of Hispanic elders. The initiative is designed to encourage Hispanic elders and their families to take advantage of new Medicare benefits, including prescription drug coverage, flu shots, diabetes screening and self-management, cardiovascular screening, cancer screening and smoking cessation programs. Communities around the country are invited to apply for pilot projects.

Aiming Higher: Results from a State Scorecard on Health Systems Performance

<http://www.commonwealthfund.org/statescorecard/>

This report released last week by the Commonwealth Fund presents a comprehensive comparison of health systems in all 50 states. The report ranks states based on 32 performance indicators for health care access, quality, equity and healthy living, and how well states do in preventing avoidable hospital admissions and costs.

Elements of State Health Reform: Prevention

http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2063

This Webcast, with a panel of health policy experts from the Kaiser Family Foundation and the National Governors Association Center for Best Practices, explored the utilization of prevention and wellness benefits to increase cost-effectiveness and promote healthy living.

AHRQ's State Snapshots <http://www.ahrq.gov/news/press/pr2007/snapshotspr.htm>

AHRQ's *State Snapshots* Web tool was launched in 2005. It is an application that helps State health leaders, researchers, consumers, and others understand the status of health care quality in individual States, including each State's strengths and weaknesses. The 51 *State Snapshots*—every State plus Washington, D.C.—are based on 129 quality measures, each of which evaluates a different segment of health care performance. While the measures are the products of complex statistical formulas, they are expressed on the Web site as simple, five-color "performance meter" illustrations.

Emergency Preparedness Atlas: U.S. Nursing Home and Hospital Facilities

<http://www.ahrq.gov/news/press/pr2007/nhatlaspr.htm>

The Department of Health & Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) today released *Emergency Preparedness Atlas: U.S. Nursing Home and Hospital Facilities*, which is intended to help local communities identify the health care facilities (hospitals and nursing homes) that could be available and prepared to provide assistance under emergency conditions in their communities.

The *Emergency Preparedness Atlas* includes six case studies in North Carolina, Oregon, Pennsylvania, southern California, Washington, and Utah that each include a series of maps depicting the locations and capacity of nursing homes and hospitals as well as their geographic relationship to a variety of emergency management and bioterrorism preparedness regions, such as HAZMAT response regions, emergency management regions, and Red Cross chapters. The *Atlas* includes maps for all 50 states with the location of hospitals and nursing homes in each state, and it displays the locations relative to the distribution of the elderly population in the case study states.

Advanced for Nurse Practitioners National Salary Survey

Have you ever been curious how your salary compares with others in the same position, in the same state, with the same degree? *ADVANCE for Nurse Practitioners* is currently conducting its biennial salary and workplace survey of nurse practitioners. Take the survey online, and get answers to those burning questions! You'll also be entered in a drawing for \$100.

Take the survey at:

(<http://nurse-practitioners.advanceweb.com/Common/survey/surveyform.aspx?sid=2191>)

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