PATIENTS **AT RISK**

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The Rise of the Nurse Practitioner and Physician Assistant in Healthcare

NIRAN AL-AGBA, M.D.
REBEKAH BERNARD, M.D.

Universal Publishers
Irvine • Boca Raton

Patients at Risk:
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Universal Publishers, Inc.
Irvine • Boca Raton
USA • 2020
www.Universal-Publishers.com

ISBN: 978-1-62734-316-9 (pbk.)
ISBN: 978-1-62734-317-6 (ebk.)

Typeset by Medlar Publishing Solutions Pvt Ltd, India
Cover design by Ivan Popov

Library of Congress Cataloging-in-Publication Data

Names: Al-Agba, Niran, 1974- author. | Bernard, Rebekah, 1974- author.
Title: Patients at risk : the rise of the nurse practitioner and physician assistant in healthcare / Niran Al-Agba, M.D., Rebekah Bernard, M.D.
Description: Irvine : Universal-Publishers, Inc., [2020] | Includes bibliographical references.
Identifiers: LCCN 2020034646 (print) | LCCN 2020034647 (ebook) | ISBN 9781627343169 (paperback) | ISBN 9781627343176 (ebook)
Subjects: LCSH: Patients--Safety measures. | Medical errors--Prevention. | Physician and patient.
Classification: LCC R729.8 .A43 2020 (print) | LCC R729.8 (ebook) | DDC 610.28/9--dc23
LC record available at https://lccn.loc.gov/2020034646
LC ebook record available at https://lccn.loc.gov/2020034647

DEDICATION

This book is dedicated to the memory of Alexus Jamel Ochoa-Dockins and the countless others who have been harmed by a healthcare system corrupted by greed. May the telling of her story give a voice to those who have been silenced and lead to changes in healthcare policy that will ensure that all patients receive equitable, high quality medical care.

(Photo contributed by family)

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INTRODUCTION

On a sunny Tuesday in March 2015, the steps of Capitol Hill were draped in white as nurse practitioners from across the United States descended on the nation's capital. Their long white coats flapping, and stethoscopes draped around their necks, the lobbyists marched with determined steps.

The organizer of the event, the American Association of Nurse Practitioners, called it a record day. Nurse practitioners had scheduled more than 250 visits with legislators.[1] Their message to lawmakers was clear: Nurse practitioners are just as good—or better—than physicians.[2] Further, if it were legal for nurse practitioners to practice autonomously, the country would save money while also increasing access to healthcare in physician shortage areas —a promise with tremendous appeal to those in public office.[3]

The nurse practitioners had a compelling argument. The cost of the 15,000 hours of training required of physicians before being permitted to practice medicine is much higher than the minimum 500 hours required of nurse practitioners.[4] At the same time, lobbyists showed lawmakers studies that appeared to indicate that nurse practitioners were just as safe and effective as physicians, despite this difference in training and experience. So, why pay for the high cost of medical school and residency for physicians when nurses can be trained in less time and for less money?

Lawmakers listened attentively to these arguments. Representatives with large rural constituencies were particularly intrigued by the idea that nurse practitioners could increase access to healthcare in underserved areas. After all, economists were once again predicting a physician shortage, and nurse practitioners promised to fill that void.

By 2019, legislators in 23 states and Washington DC were convinced. Despite opposition from physician and patient advocacy groups,

lawmakers in these states granted nurse practitioners the right to provide medical care to patients without physician supervision. Corporations and private equity markets were delighted. Instead of paying top dollar for fully trained physicians, these organizations now had the green light to hire less expensive nurse practitioners. Retail pharmacies across the nation rushed to install nurse practitioners into mini-clinics on every corner. Hospitals began to staff emergency departments and intensive care units with "doctors" of nursing. University medical centers even began to utilize nurse practitioners to teach medical students and resident physicians. Noting the success of nurse practitioners, other groups began to follow suit, with physician assistants, pharmacists, and psychologists lobbying for expanded practice rights.

With an increased demand for nurse practitioners, private, for-profit training programs rapidly emerged. These programs competed fiercely for student tuition dollars, boasting 100% acceptance rates to potential students,[5] offering flexible options for nurses to work and attend school at the same time,[6] and promising accelerated study tracks to become a nurse practitioner in just 2 years.[7] Some programs even promoted 'direct entry' programs that allowed non-nurses to become nurse practitioners—no previous nursing experience required.[8] Students flocked to attend such programs, many of which offered 100% online training.[9] Not to be left behind, physician assistant programs began to jump on the bandwagon with Yale University graduating its first online class of physician assistants in May 2020.[10]

Experienced nurse practitioners who completed their training at traditional brick-and-mortar nursing institutions complained that these programs were nothing more than 'diploma mills' offering inadequate clinical experience. However, the American Association of Nurse Practitioners did nothing to slow down the production of new graduates. Increasingly, nurse practitioners were starting their first day of work with little to no nursing experience—and corporations were ready to hire them to care for patients independently, no questions asked, due to the lower payroll costs compared to trained physicians.

Unfortunately, most Americans have remained dangerously unaware of this revolution in healthcare. Being treated by a non-physician is not on the radar of the average patient, most of whom assume that anyone in a white coat is a physician. If patients do wonder about being treated by a non-physician, they are reassured that their nurse practitioner or physician assistant is 'just as good' as a doctor, an idea reinforced by multi-million-dollar direct-to-patient advertising campaigns. But is care

by nurse practitioners and physician assistants really as good as that of physicians?

Imagine this scenario: There is a looming shortage of pilots in the nation, and experts expect that there will not be enough available pilots to fly the nearly 2 million Americans who want to board a domestic flight every day. It takes about two years and 1,500 flight hours for a pilot to be certified to fly commercially by the Federal Aviation Administration (FAA).[11] Imagine that instead of training additional pilots from scratch, the FAA decided to put flight attendants in the cockpit. The attendants would take an online course on aviation with flight simulations, and then spend 500 hours in the cockpit shadowing a certified pilot before they were permitted to fly independently. Statistically speaking, there is an extremely low chance of a plane crash, and if there are no complications or mishaps, the flight attendants should do just as well as the fully trained pilots. But if your flight were being flown by a pilot with little experience, would getting onboard really be as safe?

A similar scenario is playing out in hospitals and clinics across our nation. Patients are being treated by practitioners with just a fraction of the training of physicians, and few are questioning whether this care is safe or effective. Americans should be every bit as concerned about their safety when they enter medical care as when they board an airplane. After all, more people receive medical care than fly in this country, with the Centers for Disease Control estimating that almost 85% of American adults—about 213 million people—have had contact with a healthcare professional in the past year.[12]

Like pilots, physicians have strict regulations that govern their education and training, and the requirements are standardized across the entire country. For non-physicians, however, this is not the case. Due to a lack of standardization, some non-physicians train for a relatively short time without access to experienced mentors in the clinical settings in which they will practice. Treatment by these practitioners may place patients at harm.

Consider the case of Brad Guilbeaux, a 45-year old father of two from Texas.[13] Just a few days after the March 2015 lobbying event described above, Brad initiated care with nurse practitioner Kevin G. Morgan. Although he was generally healthy, Brad was seeking an improvement in his overall sense of wellness and vitality. Nurse practitioner Morgan ordered blood tests, which showed normal thyroid and testosterone levels. Even though these labs were normal, the nurse practitioner wanted to make his patient feel better, so he prescribed Brad high doses

of supplemental testosterone and thyroid medication. This treatment must have indeed given the patient an improved sense of well-being, as Brad returned to the nurse practitioner for continued prescriptions for the next year and a half. Unfortunately, Brad was unaware of the risks of taking these medications. More alarmingly, nurse practitioner Morgan was also unaware of the risks in prescribing them. As a family nurse practitioner who trained through an online program, Morgan did not have the training or experience to treat endocrine problems like thyroid disease or low testosterone. He seemed to be unaware of the increased risk of heart attacks in patients on these medications and was not being properly supervised by a physician. This lack of training and supervision was to prove fatal. On February 23, 2017, Brad Guilbeaux died of cardiac arrest caused by hormone therapy.

Even after being implicated in his death, it took nearly a year for the Texas Board of Nursing to take any action against Morgan, who continued to treat patients until his license was finally suspended on December 1, 2017. The Board also charged him with a second patient death and with harming 10 other patients by writing prescriptions for unnecessary medications.[14] Patients like Brad Guilbeaux, who are seeking an improvement in their health, are put at risk when they receive treatment from unqualified clinicians. Unfortunately, the risk is growing as non-physicians increasingly gain the right to provide medical care to patients with no supervision.

The rise of independently practicing non-physician practitioners has everything to do with money, politics, and control—and nothing to do with better patient care. The growth of these professions is the result of a systematic and coordinated effort by special interest groups to convince politicians, policymakers, and patients that non-physicians can do everything that doctors can do. Corporations have been quick to capitalize on the expansion of these practice rights. Across the country, physicians are being replaced by non-physician practitioners to save companies money. In the emergency department, for example, the chance of being treated by a non-physician instead of a medical doctor has skyrocketed over the last twenty years.[15] Most retail clinics, drugstore chains, and urgent care clinics are staffed entirely with non-physicians.[16] Large healthcare systems and even many university teaching hospitals have replaced staff physicians with non-physician practitioners.[17]

For no reason other than cost savings, physicians are being fired from their corporate jobs and replaced by nurse practitioners or physician assistants.[18] In states that still require non-physician supervision, doctors

are being forced to supervise a high number of nurse practitioners and physician assistants to keep their jobs.[19] These doctors dare not speak out; physicians who express concerns about non-physician practitioners face punishment. Steven Maron, MD, a pediatrician with 31 years of experience, was fired from United Community Health Center in southern Arizona after writing a newspaper article explaining the difference in training between a physician and a nurse practitioner. As Maron pointed out in his op-ed, while there are excellent and experienced nurse practitioners and physician assistants, their education and training are not the same as that of a physician. He suggested that to make an informed decision about medical care, the public should know who is treating them and the critical differences in the training of clinicians.[20] Although Maron had worked for the community health center serving socioeconomically depressed children for 10 years without any disciplinary actions, he was terminated just days after the op-ed appeared in the *Green Valley News*. "I was told that my article stood in opposition to the principles of the organization, specifically the principle of mutual respect."[21]

Maron's firing likely stemmed not from a lack of respect, but from a vested interest in keeping patients in the dark about the difference in training between clinicians. After all, if patients begin to demand a doctor, organizations like United Community Health Center, which currently employs twice as many non-physician practitioners as physicians,[22] would be forced to restructure their entire staffing model.

THE RISE OF NON-PHYSICIAN PRACTITIONERS

Physicians created both the nurse practitioner and physician assistant professions. The roles were designed for the two to work side-by-side to provide complementary care, with physicians providing careful supervision and mentoring, and treating the most complex patients. This model works. Studies show that when physicians and non-physician practitioners work together, patients receive high-quality and cost-effective care.[23] However, this scientifically proven model began to shift in the 1970s, as nurse practitioners sought an expanded role in healthcare.

Nurse practitioners began to organize in the 1980s to advocate for increased practice rights. In 1993, they formed a coalition specifically to lobby Congress for "provider" status—a designation allowing nurse practitioners to be directly reimbursed for services, bypassing physician supervision.[24] This lobbying organization trained nurse practitioners in

political activism, including how to most effectively communicate with legislators.[25] Nurse practitioners were taught how to share personal stories of patient care focusing on the needs of underserved patients. They also showed legislators studies that seemed to indicate that care by nurse practitioners was equivalent to physicians and more cost-effective.[26]

After hearing this direct testimony, many legislators were convinced. In 1997, 18 senators and 58 representatives co-sponsored the Primary Care Health Practitioner Incentive Act. The bill, which was signed into law by President Bill Clinton as the Balanced Budget Act of 1997, granted provider status and direct Medicare reimbursement to nurse practitioners.[27] The American College of Nurse Practitioners attributed their success to lobbying efforts from its members, stating that "the key to success came from the calls, the faxes, emails that applied the pressure on Congress to get the job done."[28]

The Affordable Care Act of 2010 further expanded the role of nurse practitioners by funding new community-based nurse-managed health centers. The law increased the production of nurse practitioners by authorizing millions of dollars to increase training program enrollment.[29] This expansion of funding resulted in a rapid proliferation of nurse practitioner training programs.

Historically, nurse practitioners trained at brick and mortar institutions, often associated with esteemed universities. These schools accepted only the top candidates, usually seasoned nurses with extensive clinical experience, and provided intense training. While such programs still exist, less rigorous training programs have become increasingly common. These schools, accused by critics of being nothing more than "diploma mills," boast high acceptance rates, 100% online curricula, and accelerated tracks with minimal clinical experience requirements.

For example, the nurse practitioner who was held responsible for the death of Brad Guilbeaux (as well as the death of another patient and harm to ten others) graduated from McNeese State University's Family Nurse Practitioner Program, which is only offered online.[30,31] He had just two years of experience as a nurse practitioner when he began to treat Brad Guilbeaux and was not being properly supervised by a physician despite the requirements of Texas law.[32]

Not to be outdone by nurse practitioners, physician assistants have also sought legislation to allow unsupervised practice and to be directly reimbursed for their services.[33] In 2019, physician assistants won a landmark legislative victory, and they are now permitted to practice independently for the first time in the state of North Dakota.[34]

Other professions are following suit:

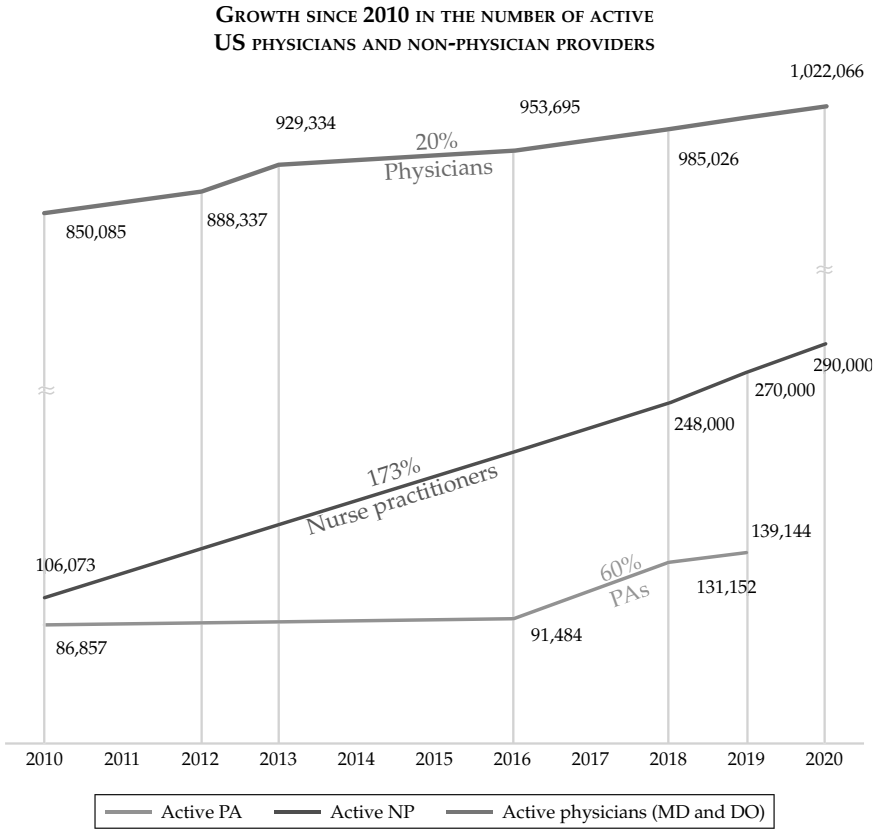
- Optometrists are aggressively lobbying to expand their scope of practice to include surgical procedures. Currently, only ophthalmologists—who train for four additional years—have these privileges.[35]
- Psychologists are seeking the right to prescribe psychotropic medications—previously the domain of psychiatrists, who train for an additional four to five years after medical school.
- Pharmacists are advocating for the right to not only dispense medications, but also to make medical diagnoses, order lab tests, and prescribe medications without physician involvement.[36]
- Naturopaths, alternative practitioners who do not follow standard scientific practice, successfully lobbied to be considered primary care physicians in several states and even receive payment from insurance and Medicaid in Washington, Oregon, and Vermont.[37]
- In several states, chiropractors have won the right to perform minor surgery, do pelvic examinations, and practice obstetrics.[38]

As non-physician groups continue to push for an elevated role in healthcare, more Americans will receive treatment from non-physician practitioners without ever being informed. Patients rarely think to ask about the qualifications or experience of their healthcare practitioners. We simply assume that the person providing us with treatment in a healthcare setting is qualified, especially when we are under medical duress. But with the replacement of physicians by non-physician practitioners, it is no longer safe to assume that all care is the same. More alarmingly, patients are increasingly learning that they no longer have a choice regarding who will provide their medical care.

In 2019, there were a little over 1 million physicians actively licensed in the United States[39] and 421,000 non-physician practitioners: 290,000 nurse practitioners[40] and 131,000 physician assistants.[41] While physicians currently outnumber non-physician practitioners in the United States, the rate at which non-physicians graduate and enter the healthcare field is significantly outpacing that of physicians. For example, over a ten-year period, the number of physician assistants increased by 53.8%[42] and nurse practitioners doubled,[43] while physicians grew by only 12%.[44] An examination of the growth of these professions between 2010 and 2020 shows even more dramatic growth in nonphysician practitioners compared to physicians (see graph below). If these trends persist, it is not

unreasonable to expect that the number of non-physician practitioners will eventually surpass the number of physicians.

In other words, if you aren't already being treated by a non-physician practitioner, then odds are, you soon will be.



WHERE IS THE DATA?

Non-physician advocacy groups point to studies that claim that nurse practitioners and physician assistants can provide care for patients safely and effectively. Indeed, some studies have shown that non-physicians can and do provide quality care when working in teams with physicians, following clear medical protocols. *However, there are absolutely no credible scientific studies that support the safety and efficacy of non-physicians practicing without physician supervision. None.*

This is a bold statement, but it is unequivocally true. While medical literature headlines and abstracts may imply that the non-physician practitioners being studied were providing care 'independently,' the fine print reveals otherwise. A detailed reading of each article makes it clear that in every single study, physicians were available for consultation and supervision when non-physician practitioners ran into trouble. Proponents of independent non-physician practice are making a dangerous assumption: that if a non-physician can practice safely with physician supervision, as studies seem to indicate, then they should be able to practice equally as safely without physician involvement.

Patients need to know the truth. *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare* will provide you with the essential background you need to understand the dangers you may face in an increasingly corporate healthcare system. More importantly, it will provide you with tools to protect yourself and your family from harm:

- Learn to identify who is providing your care.
- Gain the confidence to ask for your practitioner's credentials if they are unclear.
- Learn the differences in training and education of each type of medical practitioner.
- Know to ask if a non-physician is practicing under physician supervision.
- Be empowered to walk away from a medical practitioner if you are uncomfortable with the quality of care.
- Find out where to look for physician-led medical care.

Most importantly, this book will cause you to speak out and demand changes to our healthcare system that prioritize patient care.

CHAPTER 1

DIFFERENCES THAT CAN KILL

Alexus Ochoa-Dockins was a healthy and vibrant 19-year-old girl from Oklahoma. A straight-A student and top-notch athlete, only an unfortunate injury to her knee—a torn anterior cruciate ligament—precluded her participation in Division 1 basketball during her first year of college. In September 2015, Alexus had just begun her sophomore year at Redland College in El Reno, Oklahoma. On Thursday, September 24, she began feeling unwell, but like most healthy teenagers, Alexus ignored her symptoms and went about her regular activities.

According to court records, Alexus and her boyfriend Cortez Wright drove home for the weekend to visit family and returned to El Reno on the afternoon of Sunday, September 27, 2015. Upon arrival at her college dormitory, Alexus began to experience chest pain. She told her boyfriend that she couldn't breathe. Then, Alexus fainted.

Alarmed, her boyfriend called 9-1-1. An ambulance owned by the local hospital—Mercy El-Reno—responded to the call. The emergency paramedic who arrived on the scene immediately suspected that Alexus was suffering from a pulmonary embolism and called ahead to the emergency room to give her assessment. (A pulmonary embolism is a life-threatening medical condition, caused when a blood clot in the lungs interrupts the flow of oxygen to the rest of the body.) Without proper medication to dissolve the blood clot, patients are at high risk of death.

When Alexus arrived by ambulance at the Mercy El-Reno emergency room on September 27, nurse practitioner Antoinette Thompson met her to provide care. Thompson was an experienced health professional. She had worked for 15 years as a firefighter and paramedic before returning to school to become a nurse. She also worked for several years as an emergency room nurse before returning to school in 2012 to become a nurse practitioner. Thompson graduated from the University of South Alabama in 2014 with a master's degree in nursing, where her curriculum

was completed entirely online, other than the two weeks of classes she attended on-campus. In addition to her online training, Thompson was required to complete 500 hours of clinical experience. She earned these hours working at a county health department providing medical care to healthy, stable pregnant women.

On December 30, 2014, Thompson passed her nurse practitioner certification exam and applied for a job with the Mercy Health system. Although she had no nurse practitioner experience in an emergency room or urgent care setting, Thompson was hired a month later to work in the emergency room of Mercy-El Reno Hospital. On the day that Alexus was rushed to the emergency room, Thompson had been a nurse practitioner for only eight months. Alexus Ochoa's life now rested in her hands.[45]

HISTORY OF NURSING

The first nurse practitioner program opened in 1965, and by 2019, more than 290,000 nurse practitioners were licensed to practice in the United States.[46] This number has grown exponentially in recent decades, with the total number of nurse practitioners doubling between 2005 and 2019. Meanwhile, new physician graduates have remained relatively flat. How and why has the nurse practitioner model grown so rapidly?

The origin of professional nursing is generally attributed to Florence Nightingale, a British social reformer. In 1854, Nightingale, along with a team of 38 women, succeeded in significantly reducing mortality in a Crimean War hospital barrack by establishing standards for basic sanitation, the provision of medical necessities, and close attention to the psychological needs of the soldiers. Upon her return from the war, Nightingale started a School for Nursing in London and wrote the book "Notes on Nursing: What It Is and What It Is Not" (1859).

In the United States, a female physician—Susan Dimock, MD—established the first professional nursing school. Dimock studied medicine in Switzerland after her application was rejected from Harvard University, which refused to accept women at the time. After graduating from the University of Zurich with high honors, Dimock returned to the New England Hospital for Women and Children in Boston, where she developed a training program for nurses in 1872, including lectures on the study of anatomy. Linda Richards, a graduate of Dimock's nursing program, became America's first professional nurse and went on to establish nursing schools across the country.

The number of nursing professionals rapidly increased in the early 1900s as the number of hospitals in the U.S. grew from 149 in 1873 to 4,400 in 1910. With an increased demand for hospital nurses, nursing schools began to fall under hospital authority. This change shifted nursing training from the Nightingale-Dimock model of using books and lectures to a greater emphasis on clinical experience—a development considered by some nurses to be a clever disguise for cheap labor.

Nurses were also in demand outside the hospital. The growth of inner cities and crowded living arrangements led to greater numbers of patients being afflicted with tuberculosis and other communicable diseases. Community nurses were critical in the care of these patients. The importance of public health nursing was further bolstered by the 1918 flu pandemic.

During World War II, nurse volunteers served soldiers in the field and civilians at home. The war provided nurses with experience in leadership, which they utilized upon returning home to organize and lobby for better pay and working conditions. By the 1950s, most nursing schools moved out of hospitals and into universities. Anticipating the need for more nurses, the Federal Nurse Training Act of 1964 increased funding for nurse training.

THE DEVELOPMENT OF THE NURSE PRACTITIONER MODEL

The designation of *nurse practitioner* was first described in 1964, when pediatrician Henry Silver and nursing professor Loretta Ford created a pediatric nurse practitioner program at the University of Colorado. The program opened its doors in 1965, with the goal of graduating advanced nurses who would work alongside physicians to provide well-childcare. Nurses were trained to perform well-child exams, administer immunizations, and provide education on disease prevention and health promotion.[47] The new designation caught on, growing to 65 nurse practitioner programs in 1973. Rather than focusing simply on wellness, nurse practitioner programs began to train nurses on diagnosing and treating disease states.

This created a challenge: the scope of practice for a nurse practitioner now fell outside of the American Nurses Association's 1955 definition of nursing, which emphasized that nurses did not diagnose or prescribe. To resolve this problem, the U.S. Department of Health, Education and Welfare (today's Department of Health and Human Services) established

a *Committee to Study Extended Role for Nurses* in the 1970s. The group concluded that extending nursing scope of practice was "essential to providing equal access to healthcare for all Americans," and called for a national certification for nurse practitioners, as well as increased federal funding to train nurse practitioners.[48] Private philanthropy played a large role in the development of the nurse practitioner model, with the Commonwealth Fund, Robert Wood Johnson Foundation, and the Carnegie Corporation of New York all donating large sums of money towards the effort.[49]

Idaho became the first state to recognize the nurse practitioner role in 1971. In an effort to increase healthcare in underserved areas, the Rural Health Clinic Act of 1977 authorized funding for nurse practitioners working in rural health centers. The law further required that 50% of all services provided by federally funded rural health clinics be provided by nurse practitioners or physician assistants. In 1989, the Omnibus Budget Reconciliation Act added reimbursement for rural nurse practitioners working under physician supervision outside of these clinic settings.[50]

While the goal of the first nurse practitioner program was for physicians and nurse practitioners to work together collaboratively, the tide began to shift as nurse practitioners sought more autonomy and independence. Up until this point, nurse practitioners were paid through their association with a physician or hospital, except in certain rural areas. In the 1990s, nurse practitioner leaders began a concerted campaign to make direct reimbursement a "top legislative priority."[51] They did this by bringing together 125 nursing leaders in 1993 for a leadership summit, which led to the formation of the National Nurse Practitioner Coalition. This Coalition combined eleven different organizations to form a powerful lobbying group that would later become the American College of Nurse Practitioners (ACNP).[52]

Members of the ACNP received training on political activism, attending lectures on how to effectively spread their message to legislators. The College released calls-to-action with specific instructions on how to communicate with policymakers—and their hard work paid off. As policymaker support for nurse practitioner legislation grew, nursing organizations "thanked their congressional advocates with awards and recognition at local, state, and national meetings, and worked within their membership to express gratitude at the district level."[53]

Even nurse practitioner students were encouraged to participate in the political process. "Political advocacy is built into nurse practitioner programs," said Dara Grieger, MD, a former nurse practitioner-

turned-physician, who attended political events during her nurse training program. "If there was an important vote pending and they needed our support, class would be canceled for the day. You needed to be there to make an impression on the legislature." In 1994, on the day of the final vote granting nurse practitioners prescribing privileges in Tennessee, Grieger recalls, "our entire class was taken by faculty to the state capital to sit in the chamber."[54]

To take their agenda to the next level, the ACNP hired a full-time lobbying firm in 1996, which would prove to be a highly strategic decision. The very next year, President Bill Clinton signed the Balanced Budget Act, recognizing nurse practitioners as "providers" by Medicare and Medicaid, and authorizing direct payment for their services in any setting.

THE ROBERT WOOD JOHNSON FOUNDATION

The increase in nurse practitioner autonomy has been influenced by major funding from advocacy groups, most importantly, the Robert Wood Johnson Foundation (RWJF). Robert Wood Johnson was the founder of the company Johnson & Johnson, one of the world's largest manufacturers of health products. Today, the RWJF is considered the United States' largest health-focused philanthropy, with $11.4 billion in assets reported in 2017.[55] The Foundation has shown a particular interest in nursing, contributing $674 million since 1972 to promote the work of nurses across the country.[56]

The RWJF has been instrumental in advocating for an expanded role for nurse practitioners. Since 1997, the organization has spent $41.2 million to fund Executive Nurse Health Policy Fellowships intended to "prepare a select cadre of outstanding nurse executives for leadership roles in clinical service, education, and public health."[57] The RWJF chose Shirley Chater, PhD, RN, FAAN, a nurse with political experience, as the fellowship's founding chair. Chater previously served as commissioner of the U.S. Social Security Administration under President Bill Clinton.[58] According to the Foundation, the fellowship offers "exclusive, hands-on policy experience with the most influential congressional and executive offices in the nation's capital."[59] Nurse fellows "spend a year in Washington, D.C., working on health-related legislative and regulatory issues with members of Congress and the executive branch. They … also engage in seminars and discussions on health policy and participate in leadership development programs.[60]

Through this program, more than a dozen RWJ nurse fellows participated in congressional committees responsible for crafting healthcare legislation and formed powerful relationships with legislators.[61] Of the 300 nurse fellows produced by the RWJF, more than 30 were later appointed to health committees and task forces. Six were appointed to high-level positions in local, state, and federal government programs, including the Commission of Veterans Affairs and the National Institutes of Health. Twenty-seven RWJ fellows and alumni participated in the Institute of Medicine's influential 2010 Future of Nursing initiative.[62]

These opportunities led to politically important connections for nurses. In 1989, Congress named Nurse Carol Ann Lockhart, PhD, RN to its 13-member Physician Payment Review Commission, a group tasked with providing advice on reforming payments to physicians.[63] Based on the Commission's recommendations, the Omnibus Budget Reconciliation Act of 1989 granted reimbursement to rural nurse practitioners, established Medicaid payments for primary care nurse practitioners, and mandated a study of Medicare payments for non-physician practitioners.[64]

Another politically influential nurse, Sheila P. Burke, RN, MPA, became the chief of staff for Senate Majority Leader Robert Dole. In 2000, Burke was appointed as a member of the Medicare Payment Advisory Commission, which would ultimately recommend that nurse practitioners receive direct payment for services.[65] The plan to place nurses into positions of leadership was so successful that in 2014, nurse practitioner groups announced it as a national strategy: to put 10,000 nurses on boards by the year 2020.[66]

FUTURE OF NURSING REPORT

In 2009, the RWJF gave $4.2 million to the Institute of Medicine (now the National Academy of Medicine) to develop policy recommendations for nursing. The Institute's *Future of Nursing* committee released their report in 2010, providing "national recommendations for action on the future of nursing."[67]

The Institute of Medicine calls itself "objective, independent, and evidence-based." However, in addition to being heavily funded by the RWJF, 11 of the 18 Future of Nursing committee members had close relationships with the RWJF as board members or recipients of grants and scholarships. Several of the committee members had close ties with

the American Association of Retired Persons (AARP), which receives funding from the Robert Wood Johnson Foundation.[68]

The Institute of Medicine's *Future of Nursing* committee was chaired by college-president-turned-politician Donna Shalala and members included a Chief Nursing Officer, several academic nursing professors, a nurse-midwife, the Vice Chairman of Johnson & Johnson, the CEO of the AARP, several healthcare administrators, think-tank advisors, a chief information officer, a business professor, and just three physicians. Of the physicians that participated on the committee, one worked in academia, another was the chairman and CEO of insurance giant Aetna, and the third was Vice-President of pharmacy giant CVS-Caremark.[69]

This committee, heavily weighted with nurses and industry, recommended significant changes in nursing education and payment structure. In particular, the group called for an increase in nurse practitioners with a doctorate (Doctor of Nursing) and demanded that insurance companies pay nurse practitioners directly. Ultimately, the report proclaimed that "nurses should be full partners with physicians and other healthcare professionals in redesigning healthcare in the United States."[70]

In addition to funding the *Future of Nursing* Report, the RWJF worked to implement the report's recommendations. The organization chose the AARP to lead its *Campaign for Action*, granting the organization $1.35 million in 2010.[71] The AARP received another $4.5 million per year in 2013, 2014, and 2015, and $8 million in 2019.[72] According to their website, "the *Campaign* works with policymakers, healthcare professionals, educators, and business leaders to respond to the country's increasing demand for safe, high-quality, and effective healthcare."[73] Efforts have included funding Action Coalitions in 34 states and helping to place nurses in leadership positions and board seats.

This technique worked. Government agencies and academic centers hastened to comply with the Institute of Medicine's recommendations, with a surge in the development of doctorate-degree programs and new 'residency' training programs for nurses.[74] Thousands of nurses received leadership training and were placed on boards.[75] Dashboard indicators on the *Campaign for Action* show that since these efforts began, ten states have granted nurse practitioners independent practice, and fifteen states have made incremental to substantial progress towards independent practice.[76]

Why is the Robert Wood Johnson Foundation so invested in expanding the role of nurse practitioners in the U.S? Some critics suspect that the Foundation has much to gain by funding the profession, pointing to