AMERICAN OSTEOPATHIC ASSOCIATION

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April 30, 2014

Donald S. Clark
Federal Trade Commission
Office of the Secretary
Room H-133 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

Re: Health Care Workshop, Project No. P131207

Dear Secretary Clark:

The American Osteopathic Association (AOA) appreciates the opportunity to provide comments relating to the Federal Trade Commission's (FTC) recent workshop, "Examining Health Care Competition." The AOA has attempted to address several of the questions posed by the FTC (attached) and would also like to comment generally on health care competition and the recent publication, "Policy Perspectives: Competition and Regulation of Advanced Practice Nurses," (Policy Perspectives).

While the AOA recognizes the importance of competition, we firmly believe that this should not be to the detriment of patient care. Every patient deserves the highest quality of care available and the osteopathic medical profession works diligently to expand access to care for all patients, particularly in rural and underserved areas.

The AOA proudly represents its professional family of more than 104,000 osteopathic physicians and osteopathic medical students, promotes public health, encourages scientific research, serves as the primary certifying body for DOs, is the accrediting agency for osteopathic medical schools and has federal authority to accredit hospitals and other health care facilities.

The AOA believes strongly in the physician-led "team" approach to medical care. The physician-led medical model has proven its ability to ensure that health care professionals with complete medical education and training are adequately involved in patient care. The physician, as the team leader coordinating patient care, is the only member of the team that should be categorized as the primary care physician. Policy Perspectives challenges several of our core health care delivery and patient protection principles.

First and foremost, the AOA agrees with the FTC that Advanced Practice Registered Nurses (APRNs) are valuable contributors to the health care delivery system. However, we believe that there is the potential for harmful patient outcomes as a result of expanding the scope of practice for APRNs beyond their education

and training without appropriate supervision. To this end, we believe that physician-led health care teams are the best possible approach to comprehensive medical treatment.

A 2012 study by the University of Washington and the research arm of a non-profit health care provider Group Health showed that physician-led team-based care improved patient outcomes and reduced costs.[1] Adults with depression, combined with either diabetes or heart disease or both were overseen by a team that included nurses supervised by a primary care physician. At the end of the two-year study, patients overseen by a physician-led team were less depressed and had improved levels of blood sugar, cholesterol and blood pressure. Patients who were not seen by a physician-led team failed to realize the same health benefits.

Osteopathic physicians complete four years of osteopathic medical school, which includes two years of didactic study and two years of clinical rotations. Clinical rotations in the third and fourth years are done in community hospitals, major medical centers, and doctors' offices. This is followed by three to seven years of postgraduate medical education, i.e., residencies, where DOs develop advanced knowledge and clinical skills relating to a wide variety of patient conditions. Physicians have both extensive medical education and comprehensive training that prepares them to understand medical treatment of disease, complex case management and surgery.

In addition, AOA board-certified osteopathic physicians have strenuous continuing education requirements and must participate in the AOA's Osteopathic Continuous Certification beginning in 2013. This process ensures that AOA board-certified DOs maintain currency and demonstrate competency in their specialty area. It includes lifelong learning and continuous education, cognitive assessment, and practice performance and assessment.

In comparison, most nurse practitioners have just two to three years of graduate education and less clinical experience than is obtained in the first year of a three-year medical residency. Physicians complete 12,000 to 16,000 hours of supervised post-graduate clinical training, while most nurse practitioner programs only require the completion of 500-720 patient care hours. While all states require physicians to graduate from either a college of medicine or an osteopathic college of medicine, the path for nurses lacks a universal standard.[2] Options for becoming a registered nurse, a required achievement before becoming a nurse practitioner, includes three available routes that can include associate degrees, community colleges and diploma programs administered by hospitals.[3] The variety of different educational routes can lead to differences in the quality and education nursing students are receiving. Comparatively, all osteopathic physicians must graduate from a college of osteopathic medicine that is accredited by the AOA Commission on Osteopathic College Accreditation.[4] Additionally, a recent national patient survey, 91% of respondents

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[1] Katon W, Russo J, Lin EB, et al. Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. Arch Gen Psychiatry. 2012;69(5):506-514. doi:10.1001/archgenpsychiatry.2011.1548.
[2] The Impact of Education on Nursing Practice, American Association of Colleges of Nursing, *available at* http://www.aacn.nche.edu/media-relations/fact-sheets/impact-of-education.
[3] Id.
[4] AOA Commission on Osteopathic College Accreditation, *available at* http://www.osteopathic.org/inside-aoa/accreditation/predoctoral%20accreditation/Pages/default.aspx.

said that a physician's additional years of education and training (compared to an APRN) are vital to optimal patient care, especially in the event of a complication or medical emergency.[5]

The AOA appreciates the FTC's opinion that APRNs, as a group, help alleviate the physician shortage across the United States and particularly in medically underserved areas, however it fails to recognize several factors. First, this ignores the fact that patients in rural and underserved areas deserve the same level of care as those without physician shortages. Ignoring the differences in education, training and competency demonstration requirements between physicians and APRNs is an irresponsible solution to this problem. Second, APRNs as a profession are facing their own shortage, which could even be deemed greater than the physician shortage. Shortages are currently cutting across almost all health care professions, with nursing itself facing a shortfall numbering in the hundreds of thousands by 2020.[6]

Finally, data from the National Center for the Analysis of Healthcare Data demonstrates that the distribution of physicians to several non-physician clinician groups in several areas does not support the FTC's claim. In Arizona, APRNs have long had independent practice. The attached GeoMap compares the distribution of primary care physicians to APRNs and shows that the two groups practice in the same areas across the state. Primary care physicians on the map are actually more often located in rural areas where APRNs are not present.

The osteopathic medical profession provides a disproportionate percentage of care in rural and underserved areas in comparison to other medical professions. Nationwide, while only 8% of physicians are DOs, 40% of all physicians that practice in medically underserved areas are DOs.[7] Further, 21% of all family practice DOs practice in a rural area.[8] Attempting to fill the physician shortage with APRNs is an unworkable solution. With an already increasing shortage of nurses, granting independent practice in order to provide primary care will only gain patients less qualified primary care providers and less nursing treatment.

Instead of trying to solve a physician shortage by endangering patient safety through inappropriate scope of practice expansions, any solution offered should work towards increasing the number of physicians. Several states have begun to make efforts towards training more physicians, such as legislation adopted in Florida last year which will provide additional funding for graduate medical education (GME). The lack of available GME funding is one of the major impediments nationally to training more physicians. Through efforts similar to those of Florida, additional GME slots can be created to train more physicians to provide quality, safe health care. Other efforts that states are pursuing to train and retain more physicians include loan forgiveness programs for a set amount of service in rural and underserved areas, and medical liability reforms to lower the cost of physician practice.

The current physician workforce also can be used more efficiently to treat more patients through physician-led team-based collaboration with non-physician clinicians. Through physician-led teams, patients can gain access to care, while still having their health care safely overseen by a physician. The use of other additional technological innovations, such as telemedicine, can also help current physicians provide more health care coverage. The AOA thanks the FTC for the ability to comment on this important issue. If you have any questions please contact Carol Monaco, Director, Division of Federal Affairs, at cmonaco@osteopathic.org or (202) 414-0145.

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[5] Global Strategy Group conducted a telephone survey on behalf of the Scope of Practice Partnership between August 13-18, 2008. The survey included 850 adults nationwide, and the margin of error is +/- 3.4 percent at the 95 percent confidence level.

[6] *Nursing Shortage*, American Association of Colleges of Nursing, *available at* http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage.

[7] 2013 National Center for the Analysis of Healthcare Data (NCAHD)'s Enhanced
State Licensure

[8] Id.

Sincerely,

Norman E. Vinn, DO, MBA, FACOFP
President, AOA

Enclosures

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Is there evidence that quality of care is improved when professional regulations are narrowly tailored to protect patient safety while facilitating greater deployment of non-physician or non-dentist health care professionals?

The individual states are granted the authority to create professional boards that regulate health professions providing care to its citizens. Each state has a board of medical examiners or board of osteopathic examiners that creates rules and regulations for the practice of medicine in that state. The practice of medicine, for example, is not defined by allowable and unallowable actions, but by the act of diagnosing and treating diseases.[1] Narrowly tailored professional regulations that define the practice of medicine in terms of specific procedures or methods would limit a physician's professional practice based on the physician's education, post-graduate training and examination requirements. This limitation on practice could jeopardize patient safety because physicians have the most complete education and training.

Patient safety is at risk by facilitating greater deployment of non-physician health care professionals. Professional regulations are meant to preserve patient safety by imposing restrictions on unqualified health care practitioners. Patient safety was defined by the Institute of Medicine as "the prevention of harm to patients."[2] Emphasis is placed on the system of care delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) is built on a culture of safety that involves health care professionals, organizations and patients.[3] Non-physician health care professionals do not have equal or substantially identical training and expertise as licensed physician professionals, which is required and maintained by professional regulations.

The AOA opposes efforts by non-physician clinicians to serve as primary care providers because the AOA believes the practice of medicine and the quality of medical care are the responsibility of fully licensed physicians. The education, post-graduate training and examination requirements for physicians are far more extensive than those of, for example, advanced nurse practitioners. Professional regulations function as a framework in which practitioners must work within. By espousing the same rights to non-physician or dentist practitioners, professional regulations become meaningless and patient quality of care diminishes.

What is the relationship between professional regulations and competition? Would changes to professional regulations enhance competition among health care providers? If so, what changes would be desirable?

Individual states have created licensure boards that write rules and regulations governing health care professions. State medical and osteopathic medical boards promulgate rules that apply to physicians (and sometimes physician's assistants) while the Boards of Nursing promulgates rules that apply to only nurses. Competition exists among physicians and among nurses, not between physicians and nurses. Physicians and nurses provide two different types of patient care, regulated by the states to assure patient safety. Promoting competition between the health professions could lead to lower levels of patient safety and health outcomes.

The AOA supports the "team" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. A 2012 study by the University of Washington and the research arm of a nonprofit health-care provider Group

[1] Edward P. Richards, The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations, 8 Annals of Health Law 201, 1999.
[2] Id.
[3] Id.

Health showed that physician-led team-based care improved patient outcomes and reduced costs.[4] Adults with depression, combined with either diabetes or heart disease or both were overseen by a team that included nurses supervised by a primary care physician. At the end of the two-year study, patients overseen by a team were less depressed and had improved levels of blood sugar, cholesterol and blood pressure. Patients who were not seen by a team failed to realize the same health benefits.

Desired changes to professional regulations for the enhancement of competition among health care providers should not be detrimental to the quality of health care. For example, regulations for health care professionals by category should assure patient safety, while promoting competition. However, patients should feel confident that the entirety of their health care being delivered is safe and of the highest quality. Regulating professionals separately, based on their education, training and examination is most appropriate and allows for competition within each health care profession without diminishing the quality of care patients receive.

What is the relationship between professional regulations and access to care, especially vulnerable and underserved patient populations?

There is no relationship between professional regulations and access to care. For example, Arizona has provided Advanced Practice Registered Nurses (APRNs) the ability to practice independently since 2003, one of the longest out of the fifty states.[5] However, APRNs have not expanded to areas concentrated with vulnerable and underserved patients. Comparing the location of physicians and APRNs in the state of Arizona, there is consistent overlap. This provides information that APRNs do not move to rural or underserved areas to practice even with independent practice rights. The professional regulations expanding APRNs scope of practice to reach targeted patient populations has proven to fail in increasing access to care.

Even with limited financial incentives to practice in rural or underserved areas, 21% of all family practice DOs practice in rural areas, 31% of all DOs are in rural areas and 40% of all physicians that practice in an underserved or rural area are DOs.[6]

To what extent do professional regulations vary by state? Does state-by-state variation affect patient health, health care spending, or other important measures?

Each state has its own body of professional regulations. State medical and osteopathic medical boards ensure those entering the profession have met predetermined qualifications that include medical school graduation, postgraduate training and passage of a national medical licensing examination.[7] Only those who meet a state's predetermined qualifications are granted permission to practice medicine in that state. While state medical and osteopathic medical board regulations may vary slightly, other health professional board regulations may vary greatly.

For example, the 2014 Alaska legislature passed SB 162, which would exempt optometrists from the current statutory prohibition that prevents them from prescribing Schedule IA, IIA, or VIA drugs. Under the proposed language, optometrists would be allowed to prescribe pharmaceutical agents from these controlled substance schedules if they contain hydrocodone. The bill does not include any increased education or training as a pre-requisite to prescribing controlled substances with hydrocodone.

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[4] Katon W, Russo J, Lin EB, et al. Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. Arch Gen Psychiatry. 2012;69(5):506-514. doi:10.1001/archgenpsychiatry.2011.1548.

[5] 2002 Ariz. SB 1265

[6] 2013 National Center for the Analysis of Healthcare Data (NCAHD)'s Enhanced State Licensure; OMB's Rural Designation; HRSA's MUA/MUP (12/2013

[7] http://physicians.uslegal.com/state-regulation-of-physicians/

Many other states do not allow their optometrists to prescribe hydrocodone, instead limiting their pharmaceutical use to anesthetic agents and steroids. Because professional regulations vary by state, certain regulations may allow non-physician clinicians to practice in a way that goes beyond the scope of their education and training. To this end, the AOA believes that several states have instituted laws that place patients at risk, which could also lead to negative financial outcomes. Studies have found that in a primary care setting, nurse practitioners tend to utilize more health care resources than physicians, thereby raising costs for the patient.[8]

Historically, only physicians have been permitted to prescribe potentially dangerous controlled substances, due to the risk that poor prescribing practices will harm patients. Osteopathic physicians' extensive medical education and training have prepared them to understand medical treatment of disease, complex case management and safe prescribing practices. The same cannot be said of optometrists. Osteopathic physicians complete four years of medical school, followed by four to seven years of clinical residency programs. By the time osteopathic physicians are permitted to prescribe Schedule II controlled substances, they have completed 12,000 to 16,000 hours of supervised post-graduate clinical training.

In comparison, an optometrist's training generally includes a doctorate-level degree in optometry, 110 combined hours of course work and clinical training in general and ocular pharmacology, one year of supervised experience, and the completion of a two-hour course in preventing medical errors. While all optometry programs in the United States and Canada require clinical training for their students during their final academic year, the standards do not specify a minimal length. Typical clinical experiences vary in length from only 8 to 16 weeks. This education and training is insufficient for the prescription of potentially dangerous Schedule IA, IIA, or VIA controlled substances.

How do current regulations concerning licensure and credentialing affect the ability of health care professionals to relocate or practice in more than one geographic area, particularly across state lines?

When a physician wants to relocate or practice in more than one geographic area, his/her credentials must be reported in accordance with the desired practice area. This physician must apply for licensure with the state and current regulations concerning licensure and credentialing require the practitioner to report his/her information to the state medical or osteopathic medical board in which he/she wishes to practice. This allows individual states to determine the level of training and competency for practitioners in their state, in order to protect the needs of patient safety. The AOA does not believe that the current landscape prevents a physician from relocating his/her practice. Each state appropriately regulates the practice of medicine and relocating across state lines simply requires a new or additional license in that state.

Would greater state-to-state licensure portability improve competition? What issue would increased licensure portability raise?

Greater state-to-state licensure portability could improve competition, if done in a way that would maintain the state control over licensure in order to protect patient safety. More importantly, greater state-to-state portability could enhance patient access to care. However, the scope of practice for each licensure is not inhibited or broadened. For example, a physician who had full prescriptive authority in state A should have equal to or substantially identical prescriptive authority in state B. Alternatively, an APRN should not be granted a broader scope of practice in a different state in comparison to where the APRN was licensed.

Competition would improve with easier portability of licensure. However, not all states have the same prerequisites to practice. For example, continued medical education is necessary in the majority of states. A

[8] A. Hermani, DA Rastegar, et. al. A comparison of resource utilization in nurse practitioners and physicians. Eff. Clin. Pract. 1999 Nov-Dec;2(6):258-65.

physician who was not required to participate in continued medical education in State A would not be "up to date" in State B, assuming he/she does not qualify for any exceptions.

Further, in any consideration of greater portability of licensure, state control over the regulation of health care professionals must be maintained in order to protect safety. Individual states are best situated to determine the licensure regulations that should be in place in order to protect patient safety.

What are the prevalent and emerging forms of health care delivery?

The adoption of telemedicine is growing as physicians seek innovative ways to provide clinical health care to patients who are at a distance, have a disability, or face other barriers that can impede access to quality care. Telemedicine can improve efficiencies, but security and confidentiality must be addressed.[9]

To what extent is telemedicine being used today? What new developments are occurring in telemedicine? What role is telemedicine projected to play in the future?

The practice of medicine via electronic and technological means has been occurring for decades. As technology advances and the breadth of medical practice in this area expands, there is an increasing need to support the delivery of health care through technological resources. Telemedicine provides improved access to medical care and services to patients in rural or distant areas, and allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times, is an additional benefit of delivering health care services through telemedicine.

Eleven state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine. Fifty-seven state medical and osteopathic medical boards plus the District of Columbia Board of Medicine specifically require that physicians engaging in telemedicine be licensed in the state in which the patient is located.[10] Fifteen states currently require private insurance companies to cover telemedicine services to the same extent as face-to-face consultations. Minnesota allows physicians to practice telemedicine if they are registered to practice telemedicine or are registered to practice across state lines. Massachusetts permits coverage for services provided through telemedicine as long as the deductible, copayment, or coinsurance doesn't exceed the deductible, copayment, or coinsurance applicable to an in-person consultation.[11]

In January, Mississippi Governor Phil Bryant, the University of Mississippi Medical Center, and three private technology partners announced a plan to help low-income residents manage their diabetes remotely through the use of telemedicine. The goal is to help them keep the disease in check and avoid unnecessary hospitalizations while remaining as active and productive as possible.[12] "This revolutionary telehealth effort," Bryant said, "will deliver top-notch medical care to patients in one of Mississippi's most medically underserved areas, providing a new lifeline for health and disease management." To make the project possible, Bryant signed a first-of-its-kind law, enacted in March, requiring private insurers, Medicaid, and state employee health plans to reimburse medical providers for services dispensed via computer screens and telecommunications at the same rate they would pay for in-person medical care.

The biggest obstacles for telemedicine advancement are insurance coverage and cross-state-border care. So long as physicians are licensed to conduct their examinations via telemedicine or practice in neighboring states, telemedicine will make huge strides in the near future.

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[9] http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/CON_ID_005122
[10] Telemedicine Overview, Federation of State Medical Boards (accessed Apr. 29, 2014) *available at* http://www.fsmb.org/pdf/grpol_telemedicine_licensure.pdf.
[11] http://www.fsmb.org/pdf/grpol_telemedicine_licensure.pdf
[12] http://www.usatoday.com/story/news/nation/2014/04/18/stateline-diabetes/7864369/

In August 2008, the American Bar Association House of Delegates adopted a proposal that included the recommendation of mutual telemedicine licensure recognition among states. Therefore physicians with unrestricted licenses in at least one state would be able to fill out a single application to practice telemedicine in all jurisdictions, and could do so as long as the physicians complied with the licensure fees, discipline, and other laws in each jurisdiction in which they practice.[13]

The AOA adopted a policy in 2012, supporting the utilization of telemedicine when used appropriately.[14] The AOA's policy recognizes the need for a broad framework to establish telemedicine, while still providing each state with the ability to implement their own policies to meet the health care needs of their citizens. Further, the AOA supports the use of telemedicine so long as the standard of care provided through the use of technology is equivalent to that of care provided when the physician and patient are within close physical proximity.

What are the competitive implications of the increased use of telemedicine on the supply of services, cost, quality, and access to care? Does the increased use of telemedicine raise any patient safety concerns?

Employers and insurers are beginning to offer access to telehealth providers in an effort to cut medical costs and give 24-hour access to physicians.[15] Insurance company WellPoint currently offers telemedicine services to 3.5 million of its health plan subscribers and intends to increase access to more than 35 million subscribers within the next year and a half.[16]

In January 2014, UnitedHealth Group began a pilot program that provided 310,000 Nevada subscribers with telemedicine services. With an estimated shortage of over 90,000 doctors by 2020, the Association of American Medical Colleges says that telemedicine providers can make up for this shortage by allowing more efficient delivery of health care services. However, physicians, non-physician clinicians and users of telemedicine must be aware of the risks associated with the technology, such as patient and staff privacy, inaccurate reporting and symptoms that can only be diagnosed in person. Additionally, physicians may need to address licensure compliance if they deliver telemedicine services outside the state they are licensed. The Federation of State Medical Boards (FSMB) says that only 10 states have created rules and regulations regarding out-of-state providers who provide cross-border telemedicine services to be licensed in that state.[17]

Recently the FSMB adopted the Model Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.[18] The policy is intended to provide guidance and a basic roadmap to state medical and osteopathic boards as they adopt rules and regulations relating to telemedicine, to ensure that patients are protected from harm. The policy provides states with a model telemedicine policy that can be adopted.[19] Similar to the AOA's own policy on telemedicine, the FSMB model maintains that the same standard of care

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[13] Demetriou, A., ABA Health Law Section, Report to the House of Delegates (Aug. 2008), *available at* http://www.abanet.org/health/04_government_sub/media/116B_Tele_Final.pdf.
[14] AOA Policy on Telemedicine H-600-A/12, American Osteopathic Association, *available at* http://www.osteopathic.org/inside-aoa/about/leadership/Documents/policy-compendium.pdf.
[15] Olga Kharif, Telemedicine: Doctor Visits via Video Calls, Bloomberg Business Week Technology, Feb. 27, 2014 (last accessed Apr. 24, 2014) *available at* http://www.businessweek.com/articles/2014-02-27/health-insurers-add-telemedicine-services-to-cut-costs
[16] *Id.*
[17] http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/CON_ID_005122
[18] State Medical Boards Adopt Policy Guidelines for Safe Practice of Telemedicine, Newswise, April 26, 2014, *available at* http://www.newswise.com/articles/state-medical-boards-adopt-policy-guidelines-for-safe-practice-of-telemedicine#.U18Woz3C3hE.email.
[19] Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, Federation of State Medical Boards, *available at* http://www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf.

that has historically protected patients during in-person medical treatment must also apply to the delivery of health care through technology.

A key advantage of telehealth is the ability to support the delivery of more-complex care as well as more-efficient care. The former is likely of particular value to teaching hospitals that may consult on the treatment of patients with complex conditions located in areas with limited access to specialists. The latter may be of particular value to hospitals in more competitive markets that seek technologies to help lower the cost of care delivery, such as teleradiology and eICUs.[20]

What are the competitive implications of recent legislative proposals to expand or facilitate telemedicine across state lines?

The Supreme Court has found that "the states have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of professions."[21] The only limitation on this power is the Commerce Clause, which allows the federal government to regulate interstate trade. Under antitrust laws, health care has been found to be interstate trade and therefore able to be regulated by federal law. States, however, have maintained control over health care licensing within their borders, despite this acknowledgment of federal power because they have the authority to regulate the use of interstate telemedicine due to its impact on the health and welfare of its citizens.

Certain states have a general definition of the practice of medicine that seems to imply inclusion of telemedicine, while others have revised their definition of the practice of medicine to specifically include telemedicine.[22] States with specific laws in place to address telemedicine have taken a variety of approaches to deal with out-of-state physicians practicing within their borders.[23] Texas permits a medical specialist to provide "episodic consultations" using telemedicine if those consultations are requested by a physician in Texas who is in the same medical specialty.[24] Since 1995, other states have passed laws that require full licensure in order to practice telemedicine within their borders.

Another method of regulating out-of-state physicians practicing telemedicine is through the use of limited licensure, which allows physicians to apply to practice in a state without a full license, but limits the practice to a specific scope of services. In Montana, for example, telemedicine may not be practiced without obtaining a specific telemedicine license from the State Board of Medical Examiners.[25] California has yet another approach whereby certain interstate telemedical consultations are permissible, as long as the practitioner does not open an office and does not have ultimate authority over the care of the patient.[26] The physician with ultimate authority over the patient must be licensed to practice medicine in California and obtain the informed consent of the patient for the use of the telemedicine services.[27]

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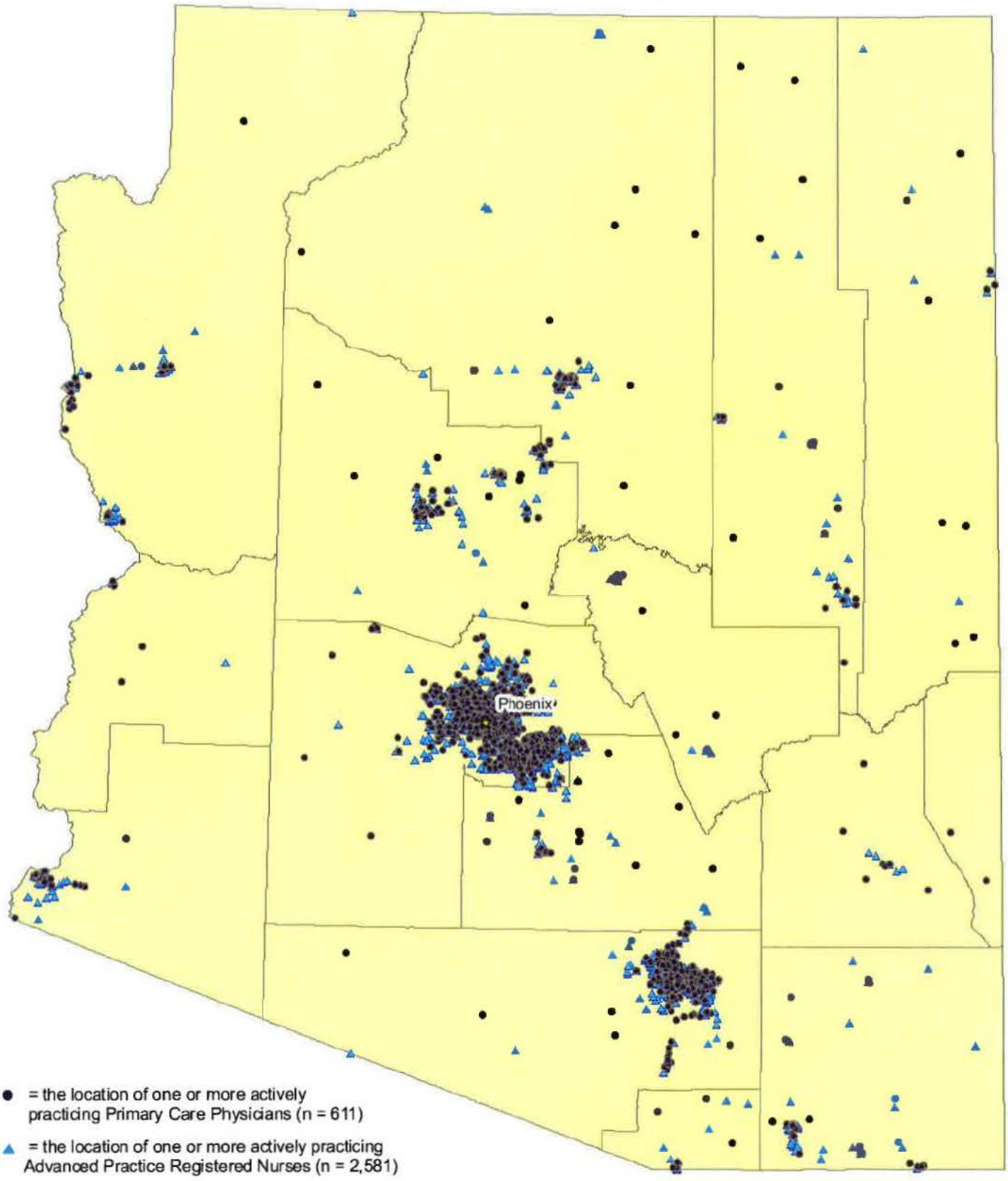
[20] http://www.healthcareitnews.com/news/telehealth-takes-nationwide
[21] *Gade v. Nat'l Solid Wastes Mgmt. Assoc.*, 505 U.S. 88 (1992)
[22] *See* Ind. Code § 25-22.5-1-1.1(a)(4) (2008)
[23] http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Telemedicine.aspx
[24] Tex. Occ. Code §151.056 (2007)
[25] Mont. Code Ann. §37-3-341 (2007)
[26] Cal. Bus. & Prof. Code § 2060 (2008)
[27] *Id.* § 2290.5 (2008)

Arizona Primary Care Physician to Advanced Practice Registered Nurse Distribution Comparison



● = the location of one or more actively practicing Primary Care Physicians (n = 611)

▲ = the location of one or more actively practicing Advanced Practice Registered Nurses (n = 2,581)

Data Source: American Medical Association, American Osteopathic Association (2008) and the Arizona State Board of Nursing (June 2008)

AMA AMERICAN MEDICAL ASSOCIATION

National Center for the Analysis of Healthcare Data (2008)