

Maximizing Access to Health Care in New Jersey: The Case for APNs, Part II

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Current State of APN Practice in New Jersey

Her cell phone rings at 6:15am just as she is loading the heavy brief case into her car to head off to the clinic. Expecting to hear the familiar voice of her friend and colleague, Dr. John Smith, a woman's voice softly delivers the shocking news: John had suddenly collapsed last evening and died a few hours later of a massive heart attack. Mary, an Advanced Practice Nurse and Dr. Smith's right hand clinician, is fully prepared to take over the responsibilities of the appointment-crammed day until she realizes that her joint protocol agreement with John, her collaborating physician, prevents her by law, from writing or renewing a single prescription without his signature on that document. Too, her insurance carrier will not reimburse her for care without a co-existing and active contract with Dr. Smith. Not only does she lose her dear friend, not only are her joint protocol and her livelihood gone, but 1500 patients are suddenly without care.

In 2014, implementation of the Patient Protection and Affordable Care Act (ACA) is expected to confer health care insurance on more than 440,000 New Jersey (NJ) residents including an estimated 234,000 new Medicaid recipients.¹ This massive influx of the newly insured begs the question: who will provide their care?

Anticipating the passage of the ACA in 2009, Torre, Joel and Aughenbaugh described NJ Advanced Practice Nurses (APNs) as the logical choice to help fill the need for more health care providers in the state, but showed how existing statutory, regulatory and reimbursement barriers would impede their availability to consumers.² The Institute of Medicine Report: "The Future of Nursing: Leading Change, Advancing Health," published in March, 2010, makes this case on a nation-wide basis, arguing that nurses must be allowed to practice to the "...full extent of their education and training" and that they should be full leadership partners with physicians and other health care professionals in "...redesigning the delivery of health care in the United States."³

This White Paper* examines the current state of APN practice in New Jersey: the increasing demand for health care providers, APNs' need for full practice authority** in order to increase the supply of providers, the progress that has been made toward achieving that goal, and the impediments that persist requiring statutory and regulatory changes for policy makers. It references the most recent research demonstrating that APNs provide high quality, effective, safe care comparable to that of their physician colleagues.

* This paper is an update to Torre and colleagues first White Paper of 2009, entitled "Maximizing Access to Health Care in NJ: The Case for APNs."⁴

****Full Practice Authority** is defined by the American Association of Nurse Practitioners (AANP) as "the collection of state practice and licensure laws that allow Advanced Practice Nurses to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments [and] prescribe medications under the exclusive licensure authority of the of the state board of nursing. Full practice authority (FPA) is occasionally referred to as autonomous practice or independence" (AANP Policy Statement, 2013, retrieved from aanp.org, 1/2/14).

Consistent with health care reform, the demand for health care will increase in NJ as it will in the rest of the United States over the next decade with a surge of new individuals covered by both the private insurance market and by Medicaid. Furthermore, incentives have been built into the ACA for seeking preventive care. As the total population increases, most notably, the elderly, there will be an increase in the need for chronic disease management.^{5,6} Experts universally acknowledge that physicians alone cannot meet these patient-care needs, and APNs are increasingly recognized as a solution to address the provider gap.⁷⁻¹²

The number of Advanced Practice Nurses in New Jersey certified by the NJ Board of Nursing, including nurse practitioners, clinical nurse specialists and nurse anesthetists** continues to climb, increasing from 5, 479 in 2011 to 6, 080, in 2013, a rate of about 5.5 percent/year.¹³ In contrast, the number of physicians in NJ continues to decline and the NJ Physician Workforce Taskforce predicts a shortfall of 2, 800 by 2025.¹⁴ Among the areas in which demand for services is most likely to increase with the rise in those covered by health care insurance is primary care and psychiatric care. In the former regard in particular, APNs are well positioned to provide significant workforce capital: eighty nine percent of nurse practitioners are educated in primary care and approximately seventy-five percent currently practice in family/adult/women's health, pediatrics or in gerontology.¹⁵ A significant need for more psychiatric providers in NJ is demonstrated by long waits for appointments, and psychiatric APNs are helping to meet that need.

***In NJ, the title APN encompasses nurse practitioners (NPs), Clinical Nurse Specialists (CNSs) and APNs-anesthesia (formerly CRNAs); APNs are licensed and regulated by the NJ Board of Nursing. Nurse Midwives in NJ are licensed and regulated by the NJ Board of Medical Examiners. Approximately 2/3 of NJ APNs are NPs; the largest number of CNSs practice in psychiatry; APNs-anesthesia number about 600. Because NPs are APNs in NJ, because the most exacting outcomes studies on APN care have been done on NPs and because this article focuses on the use of NPs in primary care, the titles APN and NP are used interchangeably throughout the article.*

Joint Protocol: A Barrier to Patient Care

A number of barriers involving statutes, regulations and insurance reimbursement limit APNs from being both directly consumer-accessible and from practicing to the full extent of their education and clinical training. The most significant of these barriers in NJ is the statutory requirement (N.J.S.A. 45:11-49.2) mandating that APNs prescribe drugs only according to a written joint protocol developed in agreement with and signed by a collaborating physician. (Note that Federal barriers also impede APN practice, in particular those related to Medicare reimbursement).

The Joint Protocol requirement was inserted into the language of the first NJ APN bill in 1991. This policy action was similar to compromises made to APN bills all over the United State which were necessary to allow APN practice to move forward, but placed them in a legally dependent position relative to Medicine; these laws have subsequently required amendments in order for APNs to achieve *full practice authority*. This authority has now been achieved by 18 states and the District of Columbia. Currently at least 10 states including New Jersey, New York, Pennsylvania and Connecticut have introduced bills in their respective legislatures to do so.¹⁶

After a 2008 vote of the New Jersey State Nurses Association membership to remove the Joint Protocol from APN statutes, the association developed and initiated the introduction of the Consumer Access to Health Care Act: S2354 (Vitale/Madden)/A3512 (Munoz/Jasey/Benson/Coughlin)¹⁷ in 2012. The bills were re-introduced in the 2014 legislative session as A906/S870.¹⁸ These bills seek to eliminate the joint protocol. A906/S870 would also confer what is called global signature authority on APNs- lifting current statutory and regulatory restriction- so an APN's signature would be equally acceptable anywhere, in law, that a

physician's signature is currently required on a form, document, affidavit or attestation. The bills would retain the requirement for a joint protocol only for prescribing between an APN and a collaborating provider (an experienced APN or a physician) for those APNs with less than two years or 2400 hours of experience. They would continue to require that APNs have completed NJ Board of Nursing educational requirements of a master or doctorate in an advance practice specialty, have achieved national certification in that specialty and have met the biennial continuing nursing education (CNE) requirement (proposed to be increased to forty CNE every two years upon the bills' passage). It must be emphasized that all other aspects of APN practice in New Jersey are already fully autonomous, including physical assessment, diagnosis and management of episodic and chronic illnesses, ordering of laboratory and diagnostic tests, ordering and performing needed treatments and procedures and referring to other providers. ***These bills do not expand APNs' scope of practice since they have been prescribing for over twenty years; it simply changes the parameters under which that prescribing must occur by removing the Joint Protocol.***

Organized Medicine's Opposition to the Consumer Access to Health Care Act

The current legislation has met with resistance. The American Medical Association (AMA) sent a February, 2013 letter of opposition to NJ Senate President Sweeney claiming that APNs should practice only in physician-led, team-based care settings because, they assert, physicians are the most qualified providers of care and teams are the most cost-effective means of care delivery.¹⁹ The letter is a direct outgrowth of the call to action articulated by the AMA in its 2009, publication, "Scope of Practice Data Series: Nurse Practitioners": any and all attempts by health care providers of "... limited licensure to seek ...unwarranted scope of practice expansion should be challenged because [they] may endanger the health and safety of patients."²⁰ Similar opposition has arisen from the American Academy of Family Physicians²¹ and The Physicians Foundation which published, "Accept No Substitute: A Report on Scope of Practice," describing the strategic necessity of maintaining physicians at the helm of health care and intervening to stop scope of practice changes which would permit an "...influx of mid-level providers..." who will result in "greater fragmentation, higher costs and inferior outcomes."²²

The opposition by organized medical groups to any and all APN autonomous practice emerges from their historical position: since medicine encompasses every element of health care (as defined by broad state medical practice acts); other health care professions are deemed not competent to perform elements of that care, independent of medicine. Safriet contends that this attitude constitutes a "...profound misapprehension of the dynamic nature of knowledge and skill acquisition and it stands in stark contrast to a more realistic version of shared versus exclusive prerogatives."²³ In 2007, the National Council of State Boards of Nursing in association with five other professional regulating bodies, *including the Federation of State Medical Boards* published a monograph which concluded: that:

1. Changes in scope of practice are inherent in our current health care system Health care and its delivery are necessarily evolving. Health care practice acts need to evolve as health care demands and capabilities change.
2. Overlap among professions is necessary. No one profession actually owns a skill or activity in and of itself. Just because a skill or activity is within one's professional skill set does not mean another profession cannot and should not include it in its own scope of practice.²⁴

Quality of APN Care

Beyond claims of medical scope of practice infringement, organized medicine's opposition to APN's practicing absent physician direction, supervision or mandated collaboration is typically framed around assertions that APNs do not provide the same quality of care as physicians and are not as safe. These assertions are not borne out by repeated research over two decades detailed in both the 2009 White Paper and the 2010 IOM Reports. Indeed, as the IOM authors point out, "...no data suggests that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of physicians in less restrictive states has changed or deteriorated."²⁵ In fact, a comprehensive, 2013 study which examined research between 1990-2009 evaluating the comparative health care quality, safety and effectiveness of care delivered by either physicians or nurse practitioners, found that outcomes for NPs were comparable to physicians in ten of eleven instances (satisfaction with care, health status, functional status, number of emergency department visits and hospitalizations, blood glucose, blood pressure, and mortality) and better, in the 11th instance, serum lipid levels.²⁶

Liability

If medical malpractice suits and settlements are used as a near proxy for safety, physicians in New Jersey are at far less litigation risk working with an APN than with physician colleagues. Between September, 1990 and November, 2012, only 1 percent (71 out of 6, 080) APNs in NJ were reported to the National Practitioner Data Bank for malpractice suit settlements or payout, compared to nearly 34 percent of New Jersey physicians [12, 434 out of 35,152] (National Practitioner Data Bank [NPDB], 2012).²⁶ *

*Data regarding numbers of actively licensed NJ physicians were obtained from: Young, A., et al. "A Census of Actively Licensed Physicians in the United States," Federation of State Medical Boards, 2013. Raw numbers of APNs and Physicians reported to the National Practitioner Data Base between September, 1990 and November, 2012 were obtained from the NPDB 2012 Report cited; numbers of actively licensed NJ APNs were obtained directly from the NJ Board of Nursing in 2012.

Moreover, in 2012, an analysis of closed claims over a five year period, of CNA-insured NPs by the Nursing Service Organization, found that NPs were more likely to be sued when working in physician offices than in any other setting, including private NP solo practice and NP group practices. The presence of a collaborating or supervising physician "...had little impact on the extent of the liability."²⁷

Because the New Jersey Board of Medicine's Corporate Practice Rules (N.J.A.C. 13:35-6.5 i) preclude physicians from being employees of professionals of "lesser licensure," most APNs in NJ are employees of physicians. This places physicians at greater liability risk than if an APN were an independent practitioner (working as a limited liability partner), under the theory of respondeat superior (an employer may be held liable for the negligence of an employee). If the APN is an independent contractor and not an employee of the physician, there is no legal basis on which to impute liability automatically to the physician.²⁸ Removing the requirement for the joint protocol from NJ APN statutes and regulations "...will make it clear that the responsibility for the totality of APN care resides solely with that provider and that should reduce real or perceived physician anxiety about increasing liability risk when sharing care with their APN colleagues."²⁹

Education

The AMA's letter to Senator Sweeney opposing the Consumer Access to Health Care Act essentially claims that APNs cannot substitute for physicians because their education and training encompass fewer years and hours. Further, he argues that eliminating the Joint Protocol means that team practices will no longer be operative, isolating APNs' patients in silos without recourse to physicians.³⁰ The AMA letter reflects what John Rowe, M.D., co-author of the IOM Report, describes as a physicians' fear of loss of their "captain of the ship" status; he says that, "...Of course [physicians] know more, but it is well established that they do not know more about providing the core elements of basic primary care."³¹ When APNs are utilized to their full capacity, physicians will be free to manage more complex cases and make waiting time for care shorter for patients. Moreover, it must be emphasized, that APNs are not simply practicing as physician substitutes but as professionals in their own right who bring a holistic, patient within-the-family-and-community perspective to bear on the process of evaluation and care. Finally, time alone, is not the best measure of the integration of knowledge and skill; as an American Association of Nurse Practitioner's policy statement (2010) points out, educational effectiveness should be determined by patient outcomes.³²

Team Based Care

In a changing health care environment, teams and their leadership need to remain fluid and responsive to those changes, a strategy encouraged by individual physicians.³³ Collaboration is a mutual professional responsibility that cannot be assured by mandate but which APNs undertake continually related to every element of their practice, not just prescribing. Eliminating the Joint Protocol from NJ APN statutes will not remove this professional responsibility any more than it will prevent APNs from reaching out to their physician and other health care colleagues for counsel and referral for care, as do physicians themselves. The AMA letter to NJ Senate President Sweeney chooses to ignore that sometimes the most cost-effective, patient-centered teams are not led by physicians but by nurses. Team management and coordination of care have long been core essentials of nursing practice.

Economic Competition

Underlying the opposition of organized medicine to changing the parameters by which APNs practice is their concern about economic competition but this has been shown to be unfounded. Pittman and Williams³⁴ report that the salaries of physicians and surgeons have risen to the same extent in states with full APN scope of practice laws as in those with more restrictive laws. The Federal Trade Commission has issued a series of letters to at least five states over the past four years, most recently to Connecticut, recommending the elimination of scope of practice barriers which the Commission views as potentially anticompetitive and limiting to patient choice.³⁵

Effects of Statutory and Regulatory Barriers on APN Practice in New Jersey

Because APNs are required to be tethered to a mandated collaborative physician to fulfill the Joint Protocol (JP) statute and regulation for prescribing, their practice may be made cumbersome, difficult, or unworkable in the ways delineated in: TABLE 1. Other outdated regulatory language in NJ that restricts completion of tasks, legally within the scope of practice of APNs to physicians, means that duplicative and unnecessarily costly care is required. See TABLE 2. Currently, hundreds of similar regulatory barriers must be addressed one at a time, often with the additional hurdle of making statutory change first. Global signature authority would immediately relieve many of these regulatory impediments.

Reimbursement Barriers to APN Practice

NJ HMO Law (Health Care Quality Act: P.L. 1997, c.192) permits **but does not mandate** health care insurers to credential, empanel and directly reimburse APNs as primary and specialty care providers. This provision is a barrier that results in decreased patient access. With this in mind, Massachusetts instituted legislative change in 2008 which requires that insurers define nurse practitioners as Primary Care Providers, reimburse them as such, and list them along with physicians in provider directories.³⁶ Mandated physician involvement in APN prescribing has also been shown to reduce the likelihood that Managed Care Organizations (MCOs) will credential and empanel APNs independently.³⁷ NJ Health Care Insurers have increasingly reimbursed APNs at a rate between 70-85 percent of what they pay a physician for the same service. Still, a number of health care insurers in the state continue to require that in order to become and remain credentialed and empanelled, the APN must be linked to a mandated collaborating physician, who is also credentialed and empanelled by the company. If the physician then dies, retires, moves from the state or loses a license to practice, the APNs' patients are rendered provider-less, and the practice effectively stops until the APN succeeds in securing another appropriately credentialed and empanelled physician able and willing to act as the mandated collaborator. *These kinds of restrictions limit APNs' practice choices and opportunities, making it less likely they will select rural or urban underserved areas where physicians are less likely to be located.*³⁸

NJ APNs are directly reimbursed by both Medicare, and NJ Medicaid, at 85 percent of the physician's rate. These lower reimbursement rates from insurers make it more difficult for APNs to develop and sustain independent practices. Physicians employing APNs in NJ frequently demand that Medicare patients be billed only incident-to the physician (that is, under the physician's number with the physician seeing all new patients or old patients with new complaints), so that 100 percent payment can be captured. Medicare allows this billing practice, under the strict parameters noted, and only if the physician is present in the office suite. This billing practice has the effect of making APNs "ghost" providers and results in negatively skewed data on the number and types of Medicare patients actually served by APNs. Increasingly, health care policy experts are calling for equity in reimbursement for APNs and physicians for providing the same services as a means of fully realizing APNs potential to bolster the health care workforce.³⁹⁻⁴²

In 2013, the Oregon House of Representatives passed a bill with bipartisan support that would pay NPs and Physician Assistants (PAs) at the same rate that they would pay physicians for the same services. The bill passed despite opposition from the Oregon Medical Society and represents a legislative effort to help keep NPs and PAs practicing in underserved areas of the state.⁴³ In a 2013 discussion, MedPAC, the group that sets Medicare reimbursement rates, "...questioned policies that discount payments to NPs for the same Medicare services provided by physicians and that create uneven rules for certification and documentation of care."⁴⁴

Summary:

Effectuating the public policy changes necessary to make NJ APNs fully accessible providers will require the recognition that: There is a growing demand for health care providers, both nationwide and in NJ. The pool of available physicians, particularly primary care physicians, is shrinking. The pool of available APNs is growing and projected to double by 2025. Nearly 90 percent of APNs are educated in primary care and 75 percent of them practice in a primary care specialty area. Educational effectiveness is more accurately measured by clinical outcomes than by the length of educational programs and studies show APNs provide high

quality, cost-effective care with outcomes comparable to that of physician colleagues. Working cooperatively, APNs and physicians cover the full spectrum of patient care needs.. APNs are educated for and skilled at team management and care coordination and team leadership should be shared among APNs and physician colleagues; teams are most effective when all members are free to work to their full educational and clinical capacity. Professions determine their own scopes of practice and areas of practice necessarily overlap and evolve. No studies have shown APNs to be less safe than physicians or that safety is increased by physician oversight. Removing statutory and regulatory barriers imposed on APNs' practice will make care timelier, more efficient, and eliminate duplicative physician services that add unnecessary costs. When insurers directly credential, empanel and pay APNs free of a link to a mandated collaborating physician, both their employability and their availability as primary providers will increase.

National organizations calling for the removal of barriers to APN practice include the Institute of Medicine, The Josiah Macy Foundation, AARP, The American Hospital Association and The National Governors Association.⁴⁵⁻⁴⁹ Currently a divide exists, in NJ as well as in many other states, between what APNs can do by virtue of educational and clinical preparation, and what they are allowed to do by virtue of statutory and regulatory limitations. Granting NJ APNs full practice authority will bridge this divide and will benefit state residents by:

- Improving patient access to primary care
- Relieving primary workforce shortages
- Reducing patient waiting times for appointments.
- Increasing health care efficiency, timeliness, seamlessness and safety
- Reducing health care costs
- Preventing precipitous loss of service
- Permitting a patient to exercise provider choice

Conclusion

Now is the time for NJ to remove the statutory, regulatory and reimbursement constraints, aptly described as "...historical artifacts of medical preemption,"⁵⁰ that prevent an APN from being a fully accessible choice of provider for the residents of the state. As the demand for health care increases, there will be a surplus of patients for all willing practitioners. It is essential that those providers licensed to and capable of fulfilling the need for services be freely available to meet them.

TABLE I: STATUTORY BARRIERS OF THE JOINT PROTOCOL

- a. APNs may be unable to secure a relationship with a physician willing to act as a mandated collaborator and to sign the Joint Protocol agreement.
- b. Physicians' fees for acting as a collaborator.
- c. If the mandated collaborating physician moves, retires, dies, loses their license or refuses to renew the joint protocol, practice stops until the collaborating physician is replaced.
- d. Laboratory, diagnostic test and consultative care results are often sent to a mandated collaborating physician not the APN who ordered them, delaying timely patient care.
- e. Medication containers may list both prescribing APN and the collaborating physician causing confusing for patients or other providers.
- f. Health insurance companies often refuse to credential, empanel or directly reimburse an APN unless the mandated collaborating physician (CP) is credentialed and empanelled by the insurer. If the CP terminates such a contract, any of the APNs' patients insured with that company can no longer see the APN; causing disruption and discontinuity in the patient's care.

TABLE II: EFFECTS OF REGULATORY BARRIERS ON APN CARE

- a. A psychiatric APN with a destabilized schizophrenic patient cannot sign in-patient commitment papers.

- b. An APN caring for the homebound elderly cannot sign for continuation of emergency electrical power with a public gas and electric company.
- c. APNs caring for terminally ill patients can diagnose their conditions and manage all aspects of their care but cannot declare the cause of death or make the required entry into the state data base.

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Published as:

Torre, C. and Drake, S: "Maximizing Access to Health Care in New Jersey: The Case for APNS,"
New Jersey Nurse, March/April, 2014, 10-12.