Access to Care Coalition

Response to White Paper III On Independent Practice of Advanced Practice Nurses

The proponents of S-1522/A-2286 are distributing a White Paper with the intent to sway policymakers in Trenton to allow Advanced Practice Nurses (APNs) to provide care to patients without any involvement or affiliation with a collaborating physician and without the consumer protections offered by a joint protocol, prescribing practices and patient chart review.

The Legislation:

S-1522/A-2286 would allow an APN, a nurse with a masters or doctorate degree in nursing, to practice on their own in all specialties from primary care to anesthesia (CRNAs) without any involvement, relationship, collaboration, engagement, direct communication or availability of a collaborating physician.

Fiction (What They Say)	Fact
APNs and CRNAs claim they have been working independently since the pandemic began under Governor Murphy's Executive Order 112, which intended to provide relief for overburdened physicians at the height of the COVID-19 pandemic related to oversight of APNs, and they have proven they can work without collaborative and joint protocol agreements with a physician.	There is **NOT** one health system in NJ that changed the way their physicians oversee APNs during COVID in the hospital setting or community-based physicians' practices. This did not happen in critical care, anesthesia, emergency or any other specialty, including primary care/hospitals since EO 112 has been in effect.
APNs claim they should be allowed to practice independently to address potential physician workforce shortages and improve access to care in NJ.	APNs are an essential part of a health care team, but there is no substitution for a highly trained physician in all specialties. APN training can be sufficient and complementary when practicing in a physician-led team, but independently, APN training simply does not offer the depth of medical knowledge necessary to provide a full scope of medical services to patients, whether in primary care, cardiology, anesthesia, or any other specialty.
APNS claim to provide higher quality and lower-cost care to patients and can help reduce health care costs in our state.	Studies have shown that APNs working independently may end up **increasing** costs to the health care system due to inappropriate prescribing, unnecessary referrals to specialists, and unnecessary orders for diagnostic imaging studies, such as x-rays. This is because APN training doesn't have the depth to allow for differential diagnosis without this extra help. APNs do not know, what they do not know. A **study in Mississippi** looking at 10 years of practice data at a clinic where APNs and physicians were given their own distinct patients found that independent APNs failed to meet the goal of providing patients with an equivalent value-based experience as physicians, resulting in worse medical outcomes, and significantly higher costs, over-testing, and even lower patient satisfaction.

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APNs claim allowing independent practice without any physician involvement will reduce provider shortages in underserved areas.	**Studies** show that in states where APNs have independent practice authority, they overwhelmingly set their practices in higher-income areas that already offer abundant medical care options, and do little to resolve provider shortages in underserved communities.
APNs claim to be practicing on their own already in NJ, seeing their own patients without any engagement or ever seeing their collaborating physician.	**This is an exception rather than the rule, and an extremely rare exception at that.** The vast majority of APNs and CRNAs are practicing at the same medical office or hospital setting with their collaborating physician. A distortion of the current law has enabled a small number of APN outliers to open a practice of their own with a remote collaborating physician. This was not the intent of the law and should be regulated.
APNs claim they need this bill because it's too difficult to find a collaborating physician if APNs want to open their own practices.	This is likely true because it is hard to find a physician to take on the responsibility and risk of being the collaborating physician of record and simultaneously agree to be removed from the day-to-day practice and care of patients. Most physicians want to play an active role in leading the care team and not collaborate under these terms as a no-show physician.
APNs claim the joint protocol requirement has become an increasingly expensive contract that creates red tape, limits patients' access to APN care, and adds real costs to the health care system. APNs claim they pay an average of $1,000/month for these contracts with fees up to $50,000/year for collaborative and joint protocol contracts.	These alleged fees are a misnomer. In NJ, APNs are almost exclusively working in the same practice or employment as their collaborating physician. **NO** fees are charged to the APN in this type of arrangement. The survey cited on fees is a national survey reported in the Journal of Nursing Regulation, which had responses from 8,701 APNs from 29 states that do not have independent practice. The study concluded that the overwhelming majority of APNs paid **ZERO** dollars to establish or maintain a collaborative agreement with a physician. The single outlier fee of $50,000 in the survey was not in NJ. APNs making this claim should be asked to present their collaborative/joint protocol agreements that outline any fees.
APNs claim their collaborating physicians are only required to review **ONE** patient chart seen by the APN annually and joint protocols are only about prescribing medications.	This is blatantly untrue. Physicians and APNs who work together in private practice or in hospitals have daily, weekly, and quarterly chart reviews, depending on the practice. Emergency physicians, anesthesiologists, and other hospital-based specialties review charts at the end of every shift for APNs. The law **(N.J.S.A. 45:11-49)** states clearly that the joint protocol agreement - not patient records - must be reviewed at least annually, and the joint protocol also outlines agreements of the practice, including chart review and other practice requirements - not just prescribing medications.