National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

Federal and State Governments Should Advance Policies to Promote the Use of Alternative Sources of Lower Cost Primary and Preventive Care

Issue: Primary and preventive care are foundational necessities for sustained and improved health, and quality of life. But, the availability of practicing primary care physicians is dwindling, a phenomenon which is only expected to increase. A recent report prepared for the Association of American Medical Colleges (AAMC), projects shortfalls in primary care of between 14,900 and 35,600 physicians by 2025.[i] What is more, a 2015 Kaiser Family Foundation survey found that more than 58 million Americans reside in areas with primary-care physician shortages.[ii]

But while the supply of doctors is shrinking, the demand for and access to care has never been greater, with an ever increasing focus on primary prevention, coupled with an expanded insured population. Employers could face reduced access to primary care for plan participants, declining satisfaction among employees, and increased costs associated with a rise in specialist care and more emergency room visits. Even worse, there is a concern that employees with complex or chronic medical conditions could fall through the cracks without proper care coordination strategies, which are often orchestrated at the primary care level.

To meet these challenges and sustain the medical system, pioneering solutions must be embraced to 1) improve the patient experience of care, including convenience, quality and satisfaction; 2) improve the health of populations; and 3) reduce the per capita cost of health care.[1]

One approach is to expand the utility of advanced practice nurse practitioners (APRNs),[2] physician assistants (PAs), and other non-physician clinicians, where appropriate. These alternative sources of primary care, able to practice to the top of their licenses, would expand the requisite workforce and should be fully integrated into the health care delivery system, such as at provider-based offices, patient-centered medical homes and accountable care organizations (ACOs) that emphasize team-based care, as well as all other suitable locations offering primary and preventative care services such as retail clinics, community health centers, and even telehealth platforms. Through this approach, the projected shortage of primary care practitioners could be somewhat alleviated. Moreover, there are a wealth of studies comparing the quality of care provided by physicians and various non-clinician physicians and have found no difference in clinical outcomes or patient satisfaction. In fact, surveys find that most people who have seen health professionals other than physicians are satisfied with the experience, and would choose a non-physician clinician if that meant receiving more timely care when needed.[iii]

[1] The three numbered components make up the "Triple Aim," a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. The Triple Aim has been widely adopted as a US national strategy for tackling health care issues, especially by regulators responsible for the implementation of the Affordable Care Act (ACA).

[2] APRN is an umbrella term for registered nurses (RNs) who have met advanced educational and clinical practice requirements – including nurse practitioners, certified nurse-midwives, clinical nurse specialists, and certified registered nurse anesthetists.

Challenges to a fully integrated delivery system for primary and preventive care services exist within the current legislative and regulatory environment. Scope of practice regulations vary from state-to-state, creating many different practice environments. The level of autonomy, prescribing authority, physician supervision and other concerns must be addressed as employers and other payers continue to favor a team-based model of care, in which the traditional and inefficient fee-for-service reimbursement model is phased out, and new and innovative approaches to paying for what works take root. Additionally, disparate payment policies that reimburse non-physician clinicians practitioners only a portion of what is paid to physicians for the same services potentially undervalues primary care services.[iv]

Position: The National Business Group on Health, representing approximately 425 large employers (including 72 of the Fortune 100) who provide coverage for 55 million Americans supports public policies that would promote more effective integration of non-physician clinicians. To that end, we support modifications to state and federal policies that regulate all health care practitioners' practice to facilitate collaboration, foster innovative practice, and enhance the accessibility of high-quality primary and preventive care.

SCOPE OF PRACTICE AUTHORITY

APRNs

- Fewer than half of states (22) grant APRNs full practice authority;
- 17 states require APRNs to have a formal, written collaborative agreement with a physician in order to provide care, and these states restrict APRN practice in at least one domain (e.g., treatment, prescribing); and,
- In the remaining 12 states (CA, FL, GA, MA, MI, MO, NC, OK, SC, TN, TX and VA), APRN practice is even more restricted, and these states require physician supervision or delegation for APRNs to provide care. Click here for a map of scope of practice laws for APRNs.*

Physicians Assistants

- 34 states plus Washington, D.C. allow for PAs and the supervising physician to establish a written agreement outlining PA scope of practice;
- 6 states require PA scope of practice to be approved by the State Medical Board; and
- 10 states legislatively define the PA's scope of practice.
- 23 states plus Washington, D.C. allow for physician co-signature requirements of patient records to be determined at the practice level, while 27 states pre-establish conditions for the supervising physician to monitor PA patient records.
- 38 states plus Washington, D.C. allow the supervising physician to establish the prescriptive authority of the PA, while the other 12 states restrict PA prescriptive authority for specific medications (generally controlled substances).

** APRN is an umbrella term for registered nurses (RNs) who have met advanced educational and clinical practice requirements – including nurse practitioners, certified nurse-midwives, clinical nurse specialists, and certified registered nurse anesthetists.*

Specifically, we support:

- Allowing non-physician clinicians to practice to the full scope of their professional licenses, to maximize the utility of APRNs, PAs and other non-physician clinicians;
- Expanding the authority of APRNs and PAs to diagnose, treat, prescribe and manage a wide range of medical conditions, as appropriate;
- Supporting primary care practices' efforts to reduce global costs while increasing patient outcomes and satisfaction by implementing alternative payment models that incentivize alternative sources of high-value primary and preventive care;

- Neutralizing disparate reimbursement models that disincentivize qualified non-physician clinicians from taking on a more proactive role in primary and preventive care delivery by increasing reimbursement rates for same services;
- Prioritizing health outcomes by undertaking research/data collection to compare and monitor process and patient outcomes when coordination is performed by integrated primary care teams;
- Removing unnecessary regulatory burdens which impede expanded access to primary and preventative care and allowing greater flexibility to interprofessional primary and preventive care teams to rapidly and efficiently adapt to changes in workforce needs, technological advances, payment systems and standards of care;
- Encouraging broader uptake of nurse-managed health centers, which would expand primary and preventive care services to vulnerable and underserved populations;
- Address professional tensions to enhance coordination between professionals within and across sites of care, which may include creating effective interprofessional primary care team models; and
- Finally, promoting a consistent standard of care for patients by encouraging state licensure authorities to adopt existing consensus-based approaches to scope-of-practice. Specifically:

For APRNs

- Enhance borderless APRN licensing standards by putting in place education, accreditation, licensure and certification requirements for all four categories of APRNs in the U.S.
- Promote scope of practice regulations consistent with those endorsed by the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules
- Support recommendations made by the Institute of Medicine (IOM) for advancing the practice of APRNs, which provide that:[v]
    - Nurses should practice to the full extent of their education and training.
    - Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
    - Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
    - Effective workforce planning and policy making require better data collection and information infrastructure.

For Pas

- Support the six key elements of the model PA practice act, as developed by the American Academy of PAs (AAPA), which recommend:[vi]
    - "Licensure" as the regulatory term
    - Full prescriptive authority
    - Scope of practice determined at the practice level
    - Adaptable collaboration requirements
    - Chart co-signature requirements determined at the practice
    - No restriction on the number of PAs with whom a physician may collaborate

References

[i] Tim Dall et al., "The Complexities of Physician Supply and Demand: Projections from 2014 to 2025" (IHS, Inc., April 5, 2016), https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf.

[ii] Amanda Van Vleet and Julia Paradise, "Tapping Nurse Practitioners to Meet Rising Demand for Primary Care," January 20, 2015, http://kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/.

[iii] Michael J. Dill et al., "Survey Shows Consumers Open To A Greater Role For Physician Assistants And Nurse Practitioners," *Health Affairs* 32, no. 6 (June 1, 2013): 1135–42, doi:10.1377/hlthaff.2012.1150.

[iv] Mary D. Naylor and Ellen T. Kurtzman, "The Role Of Nurse Practitioners In Reinventing Primary Care," *Health Affairs* 29, no. 5 (May 1, 2010): 893–99, doi:10.1377/hlthaff.2010.0440.

[v] Institute of Medicine (IOM), *The Future of Nursing: Leading Change, Advancing Health* (Washington, D.C.: National Academies Press, 2011), http://www.nap.edu/catalog/12956.

[vi] American Academy of Physician's Assistants, "AAPA MODEL STATE LEGISLATION FOR PAs," May 2016, https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=548.