Florida TaxWatch

BRIEFING

DIAGNOSING THE DEBATE: NURSE PRACTITIONER SCOPE OF PRACTICE

MARCH 2014

THE ISSUE

Florida is facing a shortage of primary care providers, and it may leave some of the 19 million Floridians without the basic care they need. The restrictions placed on Florida's estimated 15,000 advanced registered nurse practitioners (ARNPs) (referred to hereafter as advanced practice registered nurses (APRNs) for consistency with nationally-recognized nomenclature), who are qualified to provide much of that primary care, may be creating even greater barriers to care and depriving the state of valuable, needed resources.

APRNs could provide up to 80 percent of the primary care needs for patients, if Florida did not have legislative mandates preventing them from practicing to the full extent of their training. APRNs have the necessary skills and expertise to provide basic care in Florida. They are highly trained, have a graduate degree and must meet national certification standards, including extensive practical training. APRNs provide care at a lower cost than physician-care. Allowing APRNs to use the full extent of that training and expertise will reduce health care costs for all Floridians and increase their access to quality care.

Forty-nine states are more permissive in certain aspects of APRNs practice than Florida, and a growing number of states permit nurse practitioners to practice independently.[1] Many of these states have adjusted their APRN practice restrictions in response to similar physician shortages like the one occurring in Florida. For example, some states allow APRNs to practice independently of a physician, give them the ability to bill for Medicaid services, and permit them to set up their own primary care practices.

Allowing Florida APRNs to do some of these things would open up care for many Floridians, and could save the state millions of tax dollars. According to an OPPAGA report,[2] Florida could save up to $44 million a year in Medicaid costs alone if APRNs and physician assistants (PAs) could practice with fewer restrictions. If Florida's APRNs and PAs were permitted to practice to the full extent of their training and education, the state could save up to $339 million across the entire health care system.[3]

While APRNs will tell you that they are qualified and ready to provide primary care to patients if only the Legislature would allow them to do so, some physicians are

1 Seventeen to nineteen states allow independent practice depending on terminology and source organization. See American Association of Nurse Practitioners (2014). State practice environment. See also Institute of Medicine (2010). The future of nursing: Focus on scope of practice.

2 Florida Legislature Office of Program Policy Analysis and Government Accountability (OPPAGA) Research Memorandum (2010, December 30). Expanding Scope of Practice for Advanced Registered Nurse Practitioners, Physician Assistants, Optometrists, and Dental Hygienists. Note: The OPPAGA report bases cost-savings figures on certain assumptions that lead to higher saving projections than may be feasible. For example, APRNs and PAs performing all primary care office visits may not actually occur. See original document for more information on methodology.

3 Id.

concerned about what extended nurse practitioner permissions would mean for patient safety, health care quality, controlled substances, and physician practice. What drives these different viewpoints, and how can Florida find a logical, regulated compromise that maximizes patient safety and access, while respecting the invested time and efforts of the respective health care professionals?

THE DEBATE: A BALANCED DISCUSSION

It's Not Easy Being a Physician

Most physicians enter into the study and practice of medicine with an underlying, driving passion: to help other people through medical practice. This entails making a difference in the health of individuals, first doing no harm, then protecting them from other harms, and taking calculated risks on matters large and small based on training, experience, and educated instinct. Years ago, being a physician was a mark of knowledge and earned respect, of carefully spent time giving attention to patients and medical details, of solid pay, and of dedication that put quality and patient safety first without compromise.

Enter managed care. This move toward greater cost-efficiency changed the practice of medicine in unexpected ways, requiring physicians to see more patients in less time, to become administrators and paper-pushers and, eventually, to become technologically-savvy with paper-free medical data entry. For many physicians, this meant a struggle to provide quality care, minimal time with patients, and a host of tedious business processes that deprived them of the ability to practice their passions. During the same period of time, medical liability and insurance costs increased and medical education costs increased, causing some physicians to leave higher-risk practices or stop practicing all together, and some aspiring physicians to choose alternative health professional paths. Add cuts to payments from federal healthcare programs, various new managed care models, increased continuing education requirements, EMTALA,[4] HIPAA,[5] heightened fraud and abuse laws, and the complexity of the Affordable Care Act,[6] and the physician lives in a constant personal and professional struggle to balance multiple competing interests by the patient, the payers, other providers, and the law. Now, in addition to these complexities, physicians may be getting the impression that they are replaceable.

Think a moment about the world of education. Have you noticed that a college degree now has the weight of a high school diploma, and a master's

4 The Emergency Medical Treatment and Active Labor Act (EMTALA). For a historical overview and primer, see, e.g., Lee, T.M. (2004). An EMTALA primer: the impact of changes in the emergency medical landscape on EMTALA compliance and enforcement. Annals of Health Law, 13, 145-178.

5 The Health Insurance Portability and Accountability Act (HIPAA). For a historical overview and primer, see, e.g., Drumke, M. W. (2008). A HIPAA primer. Brief, 37(3), 34-43.

6 The Patient Protection and Affordable Care Act (PPACA). For more information, see generally, Kaiser Family Foundation (2013). Summary of the Affordable Care Act.

level degree now has the weight of a college degree?

In the world of nursing, an increasing number of degrees is being offered. Registered Nurses can solidify credentials and potentially increase salary by getting advanced nursing degrees up to a doctorate, or by certification as an advance practice registered nurse or specialty nurse. As nurses gain educational credentials and experience, new roles and responsibilities are possible. In the case of APRNs, this may include the performance of tasks previously left to physicians.

Additional educational opportunities are also becoming available for other non-physician health care professionals, some now learning skills or gaining experience performing tasks previously done by nurses. However, physicians, whether in specialty or primary care, have not seen a similar expansion in available education credentials or Board certifications. A way to visualize this is by picturing an upward-directed escalator that, instead of having a floor landing at the top, has an empty and unknown drop space. Theoretically, there is a space for everyone on the escalator. However, if viewed as a continuum of traditional health care professionals, as health workers climb escalator steps and take the place of those on the next step up, the physician's view becomes limited, with few places to go but down or over the top into the empty unknown. It is unclear what becomes of the physician's role, particularly in primary care, if nurse practitioners can perform identical functions of the physician. The incentives to study and practice medicine have become less appealing over time. Furthermore, physicians may struggle with not being part of the decision-making process for their patients when important, potentially life-changing and liberty-altering decisions such as involuntary examination or controlled substances are left to other health care professionals.

It's Not Easy Being a Nurse Practitioner

The practice of nursing has come a long way. Like the practice of medicine, the practice of nursing has taken a long time to break old stereotypes, particularly when it comes to gender. Years ago, depending on location and physician preferences, nursing practice entailed anything from coffee-fetching for physicians, to changing bedpans, to education, to something close to the skilled, regulated practice that exists more typically today.

Many nurses enter into the study and practice of nursing with a similar underlying, driving passion: to help other people through nursing practice. Even prior to managed care, nurses had to be flexible with changing conditions, comfortable with managing others and being managed, completing paperwork, and keeping a strict time schedule that allowed for

little waste. The change to managed care also changed the practice of nursing in unexpected ways: it gave nurses (and other health professionals) more time with patients that enabled reduced-cost care. This direct contact with patients, the increased time, was an incentive for more individuals to enter into the study of nursing, some of those individuals having originally contemplated medical school. For the nurses that had practiced a long time, and for those who were very driven, recent years have provided various paths to earn a higher-level nursing degree, to specialize, or to become a top administrator.

For experienced nurse practitioners that have practiced for many years and taken the time to earn degrees and certifications at the highest levels of their profession, there is a reasonable level of frustration experienced in seeing patients suffer from lack of access to health care, from delays in receiving needed life-saving or pain-ameliorating medications, and from delays in acute-need treatments.

This is particularly true when the skilled, educated nurse practitioner knows it is within his or her knowledge base, skill set, and experience level to provide the necessary care but is unable to do so because it is exclusive to physician practice and the physician is unavailable for sign-off. Some nurse practitioners provide patient care in distant physical locations from their supervising physicians. However, nurse practitioners must have written, signed protocol arrangements with the supervising physicians, generally pay the physicians for their supervision, and must have their own practitioner liability insurance. Nurse practitioners sometimes have difficulties billing for services, and must rely on additional physician approvals for issues such as Baker Acting an individual or prescribing controlled substances.

From the nurse practitioner's perspective, the patient also comes first. If the nurse practitioner has the education, skill, and experience to help the patients without physician supervision on important patient care matters for which the physician lacks time, it seems logical that Florida patients should have the benefit of the nurse practitioner workforce. Unnecessary impediments to reasonable, standardized patient care that would be safely regulated in a way that does not take up physician time or leave patients unaided should be removed. Furthermore, the skills and education of the experienced nurse practitioner should be optimally utilized in a way that respects the role of the physician, acknowledges the hard efforts of the nurse practitioner, and balances patient safety with access.

THE BOTTOM LINE: POLICY PERSPECTIVES

There are several line-item policy issues that can be taken up separately or collectively for consideration. The main policy considerations include, but are not limited to:

- Independent practice by APRN outside of a written protocol agreement, including additional core curriculum, certification, clinical experience, and/or registration requirements;
- Ability to order involuntary examination of mental health patient (Baker Act);[7]
- Ability to prescribe medications, including controlled substances;
- Additional core curriculum or continuing education requirements;
- Board of Nursing regulations;
- Ability to perform examinations currently left to physicians by Florida law;
- Billing and reimbursement issues, including questions of parity;
- Costs to APRNs of physician supervision and professional liability insurance;
- Utilizing APRNs to address access to care concerns while maintaining quality and ensuring patient safety.

7 See Section 394.463, Florida Statutes, often referenced as the Baker Act.

TAXWATCH RECOMMENDATION

Florida TaxWatch recommends removing barriers to practice and care for APRNs. Through clarifications and adjustments to practice laws and regulations for APRNs, Florida can save money, increase access to needed primary care, and improve quality of care for Florida's families today while building the foundation for a sustainable system of care tomorrow.

A thoughtfully-considered removal of barriers does not have to be an all-or-nothing change.[8] Rather, for the stepwise items for which there can be easy agreement or reasoned compromise across health care practitioners and across both Florida legislative chambers, let those items move forward. If significant issues cannot find common ground, interim options could still move things forward.

For example, while more controversial issues are further discussed, and unanswered questions seek answers, a temporary period of increased practice permissions in access-challenged areas with reporting requirements could allow for solid data collection on potential impacts to care, good or bad, and may provide the additional comfort-level needed to achieve the ultimate policy goal of increasing quality primary care access toward a cost-effective, long-term, sustainable health system in Florida.

8 See, e.g., Vestal, C. (Council for Ohio Health Care Advocacy). (2014). Nurse practitioners slowly gain autonomy. (discussing successful incremental gains in reducing scope of practice restrictions for nurse practitioners in various states).

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