



MAXIMIZING ACCESS TO HEALTH CARE IN NEW JERSEY: THE CASE FOR ADVANCED PRACTICE NURSES: A WHITE PAPER

INTRODUCTION:

The New Jersey State Nurses Association (NJSNA), a constituent member of the American Nurses Association, is committed to assuring that all New Jersey (NJ) citizens have access to high quality, affordable health care. Assuring such access means that all willing primary and specialty care providers who are licensed in the state and available to provide this care, must be used to their full scope of practice in a statutory and regulatory environment that both recognizes and supports full practice and authorizes direct reimbursement for that care. To achieve the goal of maximizing access to health care through increased utilization of Advanced Practice Nurses (APNs), NJSNA seeks to eliminate the Joint Protocol from NJ APN statutes.

Health care in the United States is currently a fragmented mix of employer- based coverage, federal and state governmental programs addressing specialized groups (the military, institutionalized, aged, disabled and the very poor) and costly individual plans available to a limited few. Nearly 50 million Americans are estimated to be fully uninsured, including 1.3 million residents of New Jersey (1, 2). The ranks of the uninsured both in the United States and in New Jersey will undoubtedly swell in 2009 given the current embattled economy where increasing numbers of Americans are losing their jobs along with their health benefits, daily.

With the enactment of S-1557 (Vitale) in July, 2008, New Jersey successfully began the process of health care reform; this first step expanded the Family Care Program, mandates that all New Jersey children have health care coverage either through public programs or private coverage and applies reforms to individual and small employer insurance markets to make them more affordable (3). The statement accompanying the bill describes this as the “initial phase” of comprehensive health care reform that will ultimately result in universal health care coverage for all state residents.

ELEMENTS ESSENTIAL TO UNIVERSAL HEALTH CARE COVERAGE:

The American Nurses Association argues that a successfully restructured health care system in America will be one in which all “people within the United States borders have universal access to a standard package of essential health care services,” a system which:

- Enhances consumer access to services by delivering primary health care in community-based settings
- Fosters consumer responsibility for personal health, self-care, and informed decision-making in selecting health care services; and
- Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings (4).

STRATEGIES TO ACHIEVE BEST CARE MUST INCLUDE APNs:

A number of strategies have been suggested to make health care more patient-centered, including the widely touted medical home model (5). This model, framed around the concept of using of a single physician to direct an individual’s care, glaringly ignores two issues: first, there is a growing primary care physician shortage in the United States which makes the model as currently defined, impracticable and second, advanced practice nurses who have been successfully providing patient-centered primary care for decades and whose ranks are steadily increasing, have been completely left out of this particular model. The shrinking pool of primary care physicians is reflected in the fact that in 2007, only 1, 176 family practice residencies out of a total of the 2, 503 offered, were filled by graduating seniors of U.S. medical schools. In contrast, the number of primary care APN is increasing: more than 3,700 family nurse practitioners, alone, graduated from masters and post-masters level APN programs in that same year (6).

This inconsistency between reality and public policy is an old-fashioned barrier that keeps the knowledge and skill of the APN from the consumer. In a recent policy paper the American College of Physicians (ACP) acknowledges that APNs must be part of the solution to meeting America’s health care needs and agrees that Medical Home models might be usefully constructed to compare outcomes in those directed either by APNs or physicians (7).

The Institute of Medicine Committee on the Future of Primary Care defines Primary Care as the “provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community” (8). This definition succinctly describes the practice of advance practice nurses and not just the practice of those APNs providing primary care but those involved in specialty care as well.

WHAT ARE ADVANCED PRACTICE NURSES?

Advanced Practice Nurses, a term inclusive of, at a minimum, nurse practitioners and clinical nurse specialists and in New Jersey additionally, certified registered nurse anesthetists, are registered nurses with advanced education who provide a full range of health care services across the life span. The populations and age ranges served and the type of care APNs offer, varies with their subspecialty. Some APNs provide general primary care to all age groups (family nurse practitioners); some provide primary care to a particular population (pediatric, adult, geriatric and women's health care nurse practitioners); some provide specialized care to patients with specific conditions (for example, psychiatric advanced practice nurses) and some provide specialized care to distinct populations in in-patient settings (neonatal nurse practitioners, acute care nurse practitioners, palliative care APNs, pediatric or adult clinical nurse specialists and certified registered nurse anesthetists).

APNs work across a full spectrum of health care settings including (but not limited to) acute care hospitals, assisted living residences, nursing homes, community ambulatory care centers, physicians' offices, college health centers, schools, correctional facilities, state psychiatric hospitals visiting nurse services, walk-in clinics, emergency rooms and the workplace.

The first APNs, pediatric nurse practitioners, were educated at the University of Colorado in 1965 in response to a shortage of primary care physicians for the provision of pediatric services, at that time in particular, well child care. The nature and number of advanced practice nursing programs have grown significantly since that time. In 2009, the total number of nurse practitioners in the United States was reported as 147,295 (9). The New Jersey Board of Nursing cites the number of actively licensed APNs in New Jersey as 3,993 (10). This number is fluid; graduates from APN programs are increasing and in this state, graduates are sufficient to exceed the number of APNs lost to attrition or retirement. The total number of APNs in New Jersey will rise significantly in 2009 as nearly 400 certified registered nurse anesthetist (CRNAs) become credentialed as APNs; a process newly available to them through NJ Board of Nursing regulations adopted June 16, 2008.

In most states, including New Jersey, APNs are required to be educationally prepared at the master's level, at a minimum, and to be nationally certified in their specialty area. APNs, authorized to practice in New Jersey by virtue of N.J.S.A. 45-11-49, et seq and Board of Nursing rules: 13:37-7, et seq, are increasingly obtaining doctoral degrees and the American Association of Colleges of Nursing expects that doctorates in nursing practice will become the educational norm for new APNs within the next decade (11).

Primary care APNs are educationally and clinically prepared to make diagnostic decisions about the nature of acute and chronic illness, to order appropriate diagnostic and laboratory tests, to perform clinical procedures, to order or prescribe treatments including drugs and devices and to refer patients to other licensed health care practitioners, as necessary. APNs whose focus is in a particular specialty (for example, psychiatric advanced practice nurses or pediatric clinical nurse specialists working in oncology) can be expected to perform similar functions consistent with their specialized caseload. Certified registered nurse anesthetists (CRNAs), provide anesthesia in hospital and ambulatory care surgical settings throughout the state. All APNs in NJ have prescriptive authority, including authority to prescribe controlled dangerous substances, in accordance with a Joint Protocol cooperatively developed with a collaborating physician.

APN QUALITY OF CARE:

Research comparing the quality of care of APNs and physicians reveals few differences in both patient outcomes and patient perception of that care except that in most studies, patients describe greater satisfaction with the care of APNs and have consistently rated APNs higher than physicians in terms of communicative skills (12, 13, 14). In a classic review of studies comparing nurse practitioner and physician practices, the Office of Technology Assessment concluded that while providing care of comparable quality, nurse practitioners “appear to have better communication, counseling and interviewing skills than physicians have” (15).

A systematic review of 11 randomized clinical trials and 23 observational studies evaluating data on patient satisfaction, health status, cost and/or process of care, determined that nurse practitioner and physician outcomes were comparable but that patient satisfaction was highest among patients of nurse practitioners (16). This review also found that nurse practitioners offered more advice or information to patients, documented findings in greater detail and had better communication skills than their physician colleagues; no differences were determined between nurse practitioners and physicians in the health status of their patients, in the number of prescriptions written, in return visits requested or in referrals to other providers.

A meta-analysis of the Cochrane data base involving 16 studies evaluating primary care provided by nurses and APNs in contrast to that of physicians, found that resource utilization and costs were equivalent for comparable care but that patients were more satisfied with the care of nurses (17).

Recognizing some of the research limitations of prior work, Munding and colleagues conducted a randomized trial directly comparing the outcomes of care provided by primary care nurse practitioners and physicians (18). They found that in an ambulatory care setting where nurse practitioners had the “same authority, responsibilities, productivity and administrative requirements as primary care physicians, patients’ outcomes were comparable.” Lenz reports that in a two year follow-up study to Munding’s original trial, no differences between nurse practitioner and physician patient outcomes could be determined on health

status, physiologic measures, patient satisfaction or the use of specialist, emergency room or inpatient services but that patients assigned to physicians had more primary care visits than those assigned to nurse practitioners (19).

COST EFFECTIVENESS OF APN CARE:

APNs are less costly to educate and less costly to employ than their physician counterparts. Though annual tuition and fees (in addition to living expenses) are comparable for APN and medical students either at public or private institutions (approximately \$35,000 vs. \$60,000/year), APNs master degree students who attend programs full time will complete them in two years compared to a completion time of four years for medical students. Accordingly, the cost of APN preparation totals about 20-25% that of physician preparation (20). APNs are, of course, building upon the four years of basic nursing education already completed in their undergraduate studies. In 2008, Median salaries of nurse practitioners in New Jersey were \$88,920 compared to \$151,950 for family and general practice physicians, \$146,450 for pediatricians and \$180,450 for psychiatrists (21, 22).

Because APNs emphasize disease prevention and health maintenance in the care that they provide, because they are educated to consider all patients in the cultural context of family and community and because their communicative skills mean that patients are more likely to understand the information they receive related to self-care and medication management, recipients of APNs' services are less likely to require costly emergency room and hospital based care. Given the dramatic rise in the number of Americans with chronic diseases like diabetes and asthma which are best addressed with the structured anticipatory guidance APNs are so skilled at providing, increasing the number of APNs employed both in primary care and diseased-focused specialty care can be expected to result in major cost-savings for the United States as a whole.

Roblin and colleagues reported on a study of 26 capitated primary care practices involving two million visits by 206 providers which found that labor costs were lower in practices utilizing more nurse practitioners and physician assistants. (14). That nurse practitioners can improve office revenue was described by a study of a large HMO where it was found that adding a nurse practitioner to the practice could double the typical panel of patients seen by a physician resulting in a projected increase in revenue of \$1.65 million per 100,000 enrollees per year (23).

An analysis of a work-site, nurse practitioner based practice for over 4,000 employees and their dependents determined that compared to claims from earlier years, the nurse practitioner care resulted in significant savings of \$.8 to \$1.5 million with a benefit to cost ratio of up to 15:1 (24). When Paez and Allen compared nurse practitioner and physician management of hypercholesterolemia following revascularization, they found that patients in the nurse practitioner group were more likely to meet their cholesterol goals and to comply with prescribed drug regimens, resulting in decreased costs (25).

Physicians and nurse practitioners working together in a team approach have been shown to reduce patients care costs. A study comparing the cost of physician-only care in long term care with care provided by a physician-nurse practitioner team revealed that costs were 42% lower for the intermediate and skilled care residents and 26% lower for those with long-term stays when the team approach was used. The patients of physician-nurse practitioner teams also had significantly lower rates of transfers to emergency departments, shorter lengths of hospital stays and fewer specialty visits (26). Other studies of in-patient care by nurse practitioner- physician teams confirm that this approach is associated with decreased lengths of stay, decreased costs and higher hospital profit (27, 28). Larkin reported on a number of studies of nurse-managed in-patient care which demonstrated decreased patient stays, decreased ventilator days, improved heart failure outcomes and decreased complications such as skin lesions, urinary tract infections and pneumonia (29).

APNs AND MALPRACTICE:

Though malpractice rates have risen for APNs along with those of every other health care provider in the past decade, the rates remain relatively low compared to those of physicians. Additionally, APNs are far less often sued than their physician colleagues. While this may be, in part because APNs are perceived as having “smaller pockets” than physicians in association with suits or settlements, it is also true that patients sue less often in cases where they perceive a provider to have been genuinely interested in them as individuals, where care has been shown to be competent and where the record of care is well documented (30). Research has shown APNs to be effective communicators and detailed record keepers and these characteristics serve them well with regard to preventing malpractice. Between 1990-2008, 12 out of 3,790 New Jersey APNs were reported to the National Practitioner Data Bank compared to 773 DOs/interns/residents, out of 2, 972- and 9, 654 MDs/interns and residents, out of 33,242 (9).

Some NJ physicians have refused to work as a collaborator with an APN, claiming that this would increase their malpractice risk; given the very low, *real* malpractice history of APNs in the state, such claims are not supported by the facts. All New Jersey APNs carry malpractice insurance; insurance carriers recognize that ordering medications and devices are within the scope of practice of NJ APNs and the increasing rates APNs have paid in NJ since obtaining prescription authority reflect that recognition.

NATIONAL BARRIERS TO APN PRACTICE:

In many states, including New Jersey, APNs face barriers to practice that may impede using them to their full potential as health care providers, both in primary care and in specialty care. (6, 32, 33, 34). Nationally, these barriers can be summarized broadly as:

- Inhibitory state and federal statutory and regulatory language that prevents APNs from practicing to their full scope and/or as fully independent providers
- State Insurance rules which fail to recognize or credential APNs as primary or specialty care providers
- State health insurance plan policies which deny direct reimbursement to APNs

SPECIFIC BARRIERS TO APN PRACTICE IN NEW JERSEY INCLUDE:

1. The Joint Protocol (JP) required for an APN to prescribe drugs and devices
2. Refusals by Health Care Insurance companies to recognize APNs as primary or specialty care provider and to directly reimburse them
3. Reluctance by physicians to work as collaborators with APNs
4. Outdated NJ statutory and regulatory language which uses the word physician alone to define a primary or specialty care provider

Current statutory law in New Jersey (N.J.S.A. **45:11-49.2.**), requires that all APNs who prescribe drugs and devices do so in accordance with a cooperatively developed Joint Protocol with a collaborating physician (35). No other aspect of APN practice requires a Joint Protocol with a physician including physical assessment, diagnosis and management of acute and chronic illness, ordering of laboratory diagnostic tests, ordering and performing of needed treatments and procedures and referring to other providers. APNs are soundly educated in the pathophysiology, diagnostic decision-making and pharmacotherapeutics necessary to safely prescribe medications and devices and there is no clinical reason to maintain the Joint Protocol for prescribing.

Indeed, the Joint Protocol for APN prescribing in the state of New Jersey must be recognized for what it is: an artifact of outdated statutory language added as a compromise to the first successful APN bill in 1991 as a means of securing its passage (36). The compromise, at that time, reflected the lobbying power of organized medicine whose competitive self-interest continues to drive nationwide opposition to the expansion of practice of any health care provider whom it perceives as a threat. The opposition of organized medicine to APN practice is consistently couched as a concern about “quality of care” but as noted above, research does

not justify this concern. At the heart of the opposition is the perceived threat of economic competition.

THE JOINT PROTOCOL A BARRIER TO APN PRACTICE IN NJ:

When the first APN law was passed in the state of New Jersey, organized medicine strove to assure nursing that requiring a Joint Protocol for APN prescribing would provide physicians with the “safety net” they believed was necessary to “allow” APNs this authority and in order to comfortably work with APNs. In actual practice, physicians who work with APNs on a daily basis quickly understand that APNs have the required knowledge to safely and effectively prescribe medications and devices as independent professionals; when the annual necessity arises for reviewing and resigning the Joint Protocol, these physicians are likely to ask: “Isn’t this Joint Protocol unnecessary?”

The Joint Protocol has not had the intended effect of making physicians more “comfortable” with having APNs as colleagues. In fact, physicians in New Jersey intermittently decline to hire, work as consultants with or collaborate with APNs and the Joint Protocol is cited as the impediment in those cases because the physician perceives it to expose them to an increased risk of legal liability and potentially higher malpractice insurance costs. In effect, the Joint Protocol in this state, as in others, acts as a financial disincentive for mutual APN-Physician collaboration (34). Given the low malpractice risk of NJ APNs in contrast to physicians as reflected in the NPDB record noted above, malpractice concerns should neither prevent physicians from working as colleagues or collaborators with APNs nor impel them to charge exorbitantly high fees for entering into a collaborative relationship with an APN. Removing the requirement of the Joint Protocol from NJ APN statutes would go far to eliminate the perceived need for such self-protective behavior on the part of physicians.

Some health care insurers in the state of New Jersey have mistakenly interpreted the Joint Protocol to mean that the APN is a not a legally independent health care professional and have refused to credential and empanel them as providers who can be directly reimbursed. This creates a situation where physicians or institutions in turn, may avoid employing APNs because they are inaccurately perceived not to be reimbursable.

Both Medicare and Medicaid recognize and credential APNs as primary and specialty care providers and both directly reimburse APNs for their care, in New Jersey, at 85% of the physician rate. Despite the fact that New Jersey P.L. 1997, c. 192-the Health Care Quality Act-specifically names nurse practitioners as one of the health care professionals who may be credentialed and reimbursed as a primary care provider in this state, the operative and inhibitory word is “may” and some insurers have declined to do so. However, an increasing number of health care insurers licensed in New Jersey *do* now credential and directly reimburse APNs, including but not limited to: Horizon-Mercy, Oxford, United Healthcare, Qualcare, Amerihealth and Horizon-Blue Cross/Blue Shield.

ACTIONS OF OTHER STATES TOWARD REMOVING BARRIERS TO APN PRACTICE:

In 2008, the University of California at San Francisco Center for Health Profession, writing in anticipation of future health care reform in that state, noted that limitations in the scope of practice laws of individuals states “slow the uniform expansion of nurse practitioner services, prohibit nurse practitioners from providing the care for which they are trained and hamper the use of nurse practitioners in improving access and controlling health care costs” (33).

Recognizing that inhibitory laws unnecessarily limit access to APN care, 12 states- Washington, Oregon, Alaska, Idaho, Montana, Wyoming, Iowa, Arizona, New Mexico, New Hampshire, Maine and Rhode Island- as well as the District of Columbia- have removed language requiring collaborative agreements or joint protocols between APNs and physicians from APN statutes, allowing APNs to practice fully independently (9).

In the current 2009 legislative session, New York State nurse practitioners are actively seeking to pass A-765 (Gottfried): The Patient Access and Advocacy Act, which would remove statutory requirements for collaboration with a physician. At the same time, they are working toward passage of consolidated reimbursement bills which would prohibit health care plans from excluding nurse practitioners from their provider networks and from denying them reimbursement for services rendered (37).

The long time efforts of Massachusetts nurse practitioners to improve consumer choice through increased access to their services resulted in Governor Deval Patrick’s signature on SB2526 in July, 2008 which defines nurse practitioners as primary care providers (PCPs) and mandates that all health care insurers in the state reimburse them as such and list them along with physicians in provider directories (38, 39).

Pennsylvania Governor Ed Rendell authorized increased access to APN care in 2007 by signing a series of bill authorizing nurse practitioners broader scope in ordering treatments, making referrals to other providers and performing assessment; granting prescriptive authority to nurse midwives and conferring title recognition on clinical nurse specialists (40).

REMOVING BARRIERS TO APN CARE IN NEW JERSEY:

In order for New Jersey consumers to have maximum access to New Jersey APNs:

- The Joint Protocol must be removed from APN statutes
- Health care insurers must be required to recognize APNs as primary and specialty care providers

- Health care insurers must be required to credential and directly reimburse APNs as primary and specialty care providers and to list them in provider directories

CONCLUSION:

As health care reform progresses in New Jersey and across the nation and as more individuals are covered by health care insurance, the demand for access to health care professionals will increase. In order to meet this growing demand, it is essential that all primary and specialty care providers licensed to and capable of fulfilling the need for services, be fully accessible. In short, the future will require all hands on deck. Advanced Practice Nurses have been shown to provide high quality, cost-effective care and health care reform demands that they be part of the provider solution. Maximizing access to APN care in New Jersey requires, as a first step, that the Joint Protocol for prescribing be removed from APN statutes; congruent with that removal, all New Jersey health care plans must recognize and directly reimburse APNs as primary and specialty care providers. New Jersey consumers deserve to make choices regarding health care providers and advanced practice nurses need to increasingly be one of those choices.

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