APRN Expanded Scope of Practice

Emergency physicians have historically collaborated with APRN's in the ED and feel the best, most efficient care is provided by a team of health care professionals led by physicians:

- APRN's help provide a valuable service, but do not undergo the same degree and intensity of training as physicians, particularly those physicians residency trained in emergency medicine.
- Even in states that permit APRN's to practice independently, there is always physician supervision and/or collaboration with these providers in the ED.
- In the ED, a physician is always available to provide appropriate guidance and collaboration to ensure patient safety.

APRN's training and certification is vastly different from that of Physicians:

- Training and clinical hours required to become a primary care physician total 21,700 hours compared with 5,350 hours for APRN's
    - APRN's programs of study vary widely from state to state - there is no national standardization; whereas physician training is standardized and consistent regardless of state or school.
- All MD's and DO's, no matter their specialty choice, must sit for and pass nationally standardized exams for licensure (three separate occasions of one and two day testing, hundreds of questions designed to assess the examinee's knowledge of basic science and clinical skill, and supervised clinical interaction.)
    - In contrast, APRN's are only required to pass the original "RN" exam, a six hour 265 question computerized exam taken by all nurses; associate degree RN's, BSN's, MSN's and APRN's.
    - Most states, however, do require APRN's to obtain national certification in a nursing specified area of study, usually with an exam.

There is No Evidence that broad-based APRN scope of practice expansion reduces costs to the health care system:

- There is little if any hard data from states that have already lifted scope of practice restrictions that any cost savings have actually occurred.
- In states that have increased scope of practice for APRN's there is no documentation of what percentage actually have established independent practices.
    - Some estimates place the number of APRN's practicing independently at less than 5 percent (closer to 1-2 %).
- None of the calculations account for professional and medical liability which would inevitably increase with expanded scope of practice and independence.

The perception that APRN's are a "cheaper" alternative than physicians is misguided:

- Many states where APRN's practice independently are now aggressively pushing for the same rates as physicians, negating any proposed savings.
- A Cochran review suggests increased utilization of services and referrals by APRN's, negating any perceived savings by a "less costly" work force.
- Focus on what counts. Physician's net take-home pay amounts to only 8% of overall healthcare spending; most expense in healthcare spending is from:
    - Technology (50% of real health expenditure growth)
    - Administrative expenses (85% of excess administrative overhead attributed to the insurance system)
    - Hospital Costs (31% of all healthcare expenditures)
    - Lifestyle choices (tobacco use, insufficient physical, eating habits, excess alcohol)
    - Chronic disease conditions (patients with 3 or more chronic disease conditions fall into the costliest 1% of patients who account for 20 percent of all healthcare spending)
- The Bulk of medical procedure payments go to hospitals and device manufactures.

APRN EXPANDED SCOPE OF PRACTICE

Expanding APRN Scope of Practice is unlikely to assist the medically underserved populations:

- Studies of the geographic distribution of NPs in the United States show that they are even more concentrated in urban areas than are physicians: 85 percent of NPs work in metropolitan counties and only 5.5 percent of NPs practice in remote rural counties.
- Has not solved the primary care access issues or improved health outcomes for lower costs in those states that have expanded APRN's Scope of Practice.
- What incentives are there to encourage APRN's to practice in rural or underserved areas that currently have a primary care shortage? What incentives are there for APRN's to treat more Floridians who receive Medicaid?

Bridging the Gap: Models of compromise and Middle Ground on APRN Scope of Practice:

- Virginia's Medical Society and the Virginia Council of Nurse Practitioners enacted a "compromise" Scope of Practice legislation in March 2012
    - Law stipulates that APRN's must work as part of a patient-care team led and managed by a physician
    - Law expands from four to six the number of APRN's who can be supervised by a physician
    - Law recognizes telemedicine as a legal form of oversight when nurse practitioners practice in rural locals.
- June 2013, the Texas Legislature with the Texas Medical Association and Texas Nurse Practitioners created a bill that establishes physician-led teams in collaborations with APRN's and PA's
    - Eases physician supervision requirements for NPs and PAs
    - Increases from four to seven the number of APRN's or PA's to whom a doctor may delegate authority
    - Allows physicians to delegate Schedule II controlled-substance prescribing authority in hospital and hospice settings
- The model of the physicians and nurses working together in integrated, coordinated, physician-led health care teams through the patient-centered medical home has proven to reduce costs, improve outcomes and ensure greater efficiency.
    - BCBS of Michigan saved an estimated $155 million over three years from their patient-centered medical home program; accompanied by measurably improved preventive care measures and quality measures.
    - An analysis of North Carolina's patient-centered medical home program from Medicaid recipients estimated that the benefits of this model may have saved the state around $180 million over a 4.75 year period. Patients with chronic conditions benefited the most.
- ***Telemedicine***
    - The VA has demonstrated that telemedicine can improve the health outcome of veterans, including those in rural areas. Its Telehealth program has reduced hospital bed days for veterans by 58% and hospital admissions by 38%.
    - UC Davis found that telemedicine can significantly improve the quality of care for children in remote rural emergency rooms where pediatricians and pediatric specialists are scarce.
    - A study conducted by The Commonwealth Fund found that remote patient monitoring (RPM) can help improve coordination, reduce hospital admissions, generate savings and improve patient satisfaction.
- Baker-Act 52 privileges for suicidal/potentially self-harming patients
    - Currently in Florida, psychologists and police officers can write BA-52's
    - FCEP sees no reason why ARNP's cannot have this privilege, as they are as qualified, or in many cases much more qualified than the above to write Baker Acts
    - The ability of a psychiatric NP to rescind Baker Act would need to be addressed