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## Authors and Disclosures

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## From Medscape Nurses > Nursing Perspectives The Nurse Practitioner Will See You Now

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### The Nurse Practitioner Will See You Now

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Will patients soon hear these words more often? As the shortage of primary care physicians in the United States becomes increasingly dire, some people believe that that qualified healthcare professionals should be uniformly permitted to function at their greatest potential as healthcare providers.<sup>[1]</sup>

Much has been said lately about "unleashing the potential" of nurse practitioners (NPs).<sup>[2,3]</sup> Nursing leaders decry the invisibility of NPs in the primary care landscape. Often working quietly in rural or underserved settings, NPs are not permitted to lead patient-centered medical homes, their names are not found on preferred provider lists, and they cannot secure funding for much-needed primary care programs. In many states, NPs are restricted in their abilities to practice under their own licenses or write prescriptions.

Why has such a huge rift developed between the educational preparation of NPs and their ability to practice after they graduate? And can anything be done about it?

In a recent address at a seminar sponsored by *Health Affairs*, Joanne M. Pohl, PhD, ANP-BC, Professor at the University of Michigan School of Nursing, and NP at the University of Michigan School of Nursing's Nurse Managed Health Centers, spoke about the need for unfettered practice by our nation's 150,000 NPs.<sup>[2]</sup>

The basic facts are:

- The healthcare reform bill is expected to increase access to primary care services for 32 million more Americans;
- We currently (and for the foreseeable future) have a shortage of primary care providers;
- Two thirds of practicing NPs work in primary care and 20% work in rural areas, the most difficult settings to staff; and

- Each year, 8000 new NPs graduate, and 7000 of these new graduates are prepared as primary care NPs.<sup>[2]</sup>

In contrast, new graduate physicians are avoiding primary care in droves. In a recent survey, only 7% of fourth-year medical students planned careers in adult primary care.<sup>[4]</sup> Medical students are reluctant to specialize in primary care because of the prospect of higher workloads and lower incomes.<sup>[4]</sup> The primary care workforce is clearly in jeopardy.

So, why aren't stakeholders welcoming NPs into the primary care workforce with open arms? Dr. Pohl explained the main barriers that currently block NPs from practicing to their full potential.

**State scope of practice regulations.** An uneven patchwork of varying state regulations now characterizes NP licensure and scope of practice in the United States. State laws define NP roles and oversight requirements; they govern practice and prescriptive authority.<sup>[5]</sup>

Laws in some states restrict NPs from practicing as their education has prepared them to do. However, the scope and autonomy of advanced practice nursing, and specifically NPs, varies from state to state, resulting in widely differentiated abilities to provide primary care, prescribe medications and order tests, be reimbursed, and be primary care providers of record. The recent advanced practice registered nurse (APRN) consensus guidelines, which delineate the essential elements of APRN practice and regulation (licensure, accreditation, certification, and education), hold promise for greater uniformity in nationwide NP scope of practice regulation.<sup>[6]</sup> However, adoption of these guidelines is still at the discretion of individual states, and no one can predict whether, when, and how the states will use these guidelines.

If states are to achieve conformity in NP regulation, perhaps it ought to begin with the question of who oversees and regulates NPs within the states. In 28 states and the District of Columbia, NPs are regulated solely by the boards of nursing. In the remaining 22 states, boards of medicine or pharmacy are authority over NPs along with the board of nursing.<sup>[3]</sup>

Nurse practitioners want the regulatory barriers to practice the way they were trained to practice lifted. They are ready, along with all primary care providers, to be held accountable for quality and efficiency of care measured by patient outcomes.<sup>[1]</sup>

**Payer policies.** The discrepancies between what NPs and physicians are reimbursed for equivalent services are well known. A shred of hope for pay parity with physicians is seen in the healthcare reform legislation, which specifies that for Medicare Part B patients, nurse midwives (who are essentially providers of primary care) will receive reimbursement equal to that of physicians. However, other nurse-managed health centers will not survive without a similar capacity to participate fully in the system of reimbursement from third-party payers.<sup>[1]</sup>

These inconsistent scopes of practice and varying payer laws and policies make it difficult to educate primary care providers to function as effective teams. The discordance between education and practice is an impediment to true collaboration.

### **Medical Homes and NPs**

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The model most widely promoted for primary care in the United States right now is the patient-centered medical home, a system of care that embodies the full spectrum of primary care, from the preventive to the curative.<sup>[3]</sup> It is patient-centered, accessible, comprehensive, integrated, and interdisciplinary. The

patient/provider relationship is clearly defined, as are the roles and responsibilities of provider team members.

With respect to NPs, one problem with the medical home model is that the National Committee for Quality Assurance (which certifies primary care settings as medical homes) recognizes only physicians as leaders of medical homes.<sup>[7]</sup> Thus, NPs are formally excluded from leading such care models, although in practice they have been doing so for years in nurse-managed health centers.

The Patient Protection and Affordable Care Act (popularly known as "the health reform bill"), signed into law in March 2010, takes an important step toward increasing primary care access to vulnerable populations by funding nurse-managed health centers. However, unless policy changes are made, these centers will not be designated medical homes.

Schram<sup>[8]</sup> suggests that NPs should participate in medical home demonstration projects and publish their outcomes to increase the body of evidence to support the ability of NPs to lead medical homes. Getting payers to recognize NPs as primary care providers is another necessary step if NPs are to gain the right to coordinate care in the primary care setting.

### **The Nurse-Managed Health Center**

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The Patient Protection and Affordable Care Act also designates grants for nurse-managed health centers. Currently, nurse-managed health centers are uncommon, but the hope is that NPs will establish more of these safety net programs, particularly for underserved populations.

Megan Eagle, MSN, FNP-BC, is 1 of 7 NPs and nurse midwives working at the University of Michigan School of Nursing Nurse-Managed Health Centers, based in Ann Arbor, Michigan. Eagle explained the principle of the nurse-managed health center, helmed by an NP.

"We decide what programs we will offer, what our priorities will be. For example, we decided that to provide really comprehensive care, we needed to have a social worker on staff, and we have done so. We decide how many patients we will see, how long our appointments will be, and what other resources we need. In a conventional primary care setting, the NPs wouldn't necessarily be making these kinds of decisions." The health center also bill insurances, and the NPs are listed as primary care providers on numerous insurance and health plans.

"It's a common misconception that 'nurse-managed' means we are completely autonomous, that we don't ask for advice from our physician colleagues when we need their input. This is far from the truth. We have a collaborating physician who is available 24 hours a day by telephone for consultation, and we also consult with other NPs and physicians. In addition to discussing cases and offering advice, our collaborating physician performs the requirements of Michigan law, such as writing prescriptions for certain medications."

What are the advantages of a nurse-managed health center as a medical home? Ms. Eagle explains that "it's a role that NPs play very well: We provide patient counseling and advocacy and practice mutual decision-making. We are doing the coordination piece, the case management that is needed for chronic problems. We communicate with the specialists, we make sure patients understand their test results -- it's a skill that comes from our nursing background."

Most of the health center's new patients come from word-of-mouth referrals. Patients are very satisfied and

come back even after they've moved out of the area, and they refer their friends and family members to the health center. They feel listened to. The patients are diverse and from all walks of life -- a homeless patient and a university administrator might be in the waiting room.

The downsides to the nurse-managed health center, from Eagle's perspective, are minimal and are related to the practice restrictions mandated by law or reimbursement policy. "The one thing that annoys me, every single day, is not being able to order home care or durable medical equipment. When a patient of mine is discharged from the hospital and needs a nebulizer, he needs it now. I even have to call someone to get an order for a walker. It makes no sense and is not based on any evidence; care would just be better and more cost efficient if we didn't have that extra step." Eagle also misses working with a larger multidisciplinary team. In her current setting, Eagle is usually the only NP in the clinic on a given day, a shortcoming that is not necessarily related to the health center being nurse-managed but instead stems from the physical size of the 2-examination room clinic.

### **Nurse Practitioners: The Evidence for High-Value Care**

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Pohl<sup>[5]</sup> emphasized that NPs are well positioned to be part of the solution to issues of access to primary care. Forty years of evidence confirms that NPs provide high-quality, cost-efficient care and therefore can contribute significantly to narrowing the primary care gap. According to Pohl, there is no place for limitations on practice or other regulations that are not based on evidence.

Naylor and Kurtzman<sup>[9]</sup> conducted a structured literature search to identify and synthesize available evidence on the value of NPs in delivering primary care. They found evidence of the equivalence of care provided by NPs and physicians, beginning with the first randomized trial conducted in 1974. This and numerous subsequent studies confirm that care provided by NPs is as effective as, and no different from, that of physicians in terms of health status, treatment practices, and prescribing behavior. Moreover, NPs achieved consistently better results than their physician colleagues on measures of patient follow-up, consultation time, satisfaction, and the provision of screening, assessment, and counseling.<sup>[9]</sup>

The intent of allowing NPs to practice at their full potential is often misconstrued as an objective to replace physicians with nurses. This, maintains Pohl, is not the case. The reason for permitting NPs practice to their full potential and preparation is to be able to fully use NPs to provide primary care, the need for which is great enough for both physician and NP providers. The regulatory disparities that result in NPs being able to practice as they are prepared to practice in one US state but being supervised by a physician in another state are not evidence-based. Such regulations are more about a discipline protecting its turf, says Pohl, than about protecting patients, which is what regulations ought to be doing.

Where do we go from here? Pohl's recommendations are to:

- Use each primary care provider to the full extent of his or her education and scope of practice;
- Expect collaboration, but hold each primary care provider accountable for care delivered under his or her own license;
- Expect all primary care providers to be accountable for outcomes of care; and
- Create a vision for ideal primary care teams and educate learners from each discipline about these effective practices.

If these recommendations come to fruition, patients will be able to receive appropriate and cost-effective care from skilled and fully functional health teams.<sup>[5]</sup>

## Suggested Reading

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