ACHI
Arkansas Center for Health Improvement

ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

Physician Extender Roles in a Patient-Centered Future • May 2013

Does Arkansas have enough primary care providers for our citizens in all parts of the state now? Will we have enough to meet future demand? What role are advanced practice nurses (APNs) and physician assistants (PAs) fulfilling in various parts of the state? What is their future role in a patient-centered health care system?

Study results show that although there is an overall primary care physician shortage, much of it is mitigated by physician extenders—advanced practice nurses and physician assistants—who provide direct patient care often under the supervision of, or in collaboration with, a physician. The result is an overall estimated shortfall of about four percent in the statewide supply of primary care clinicians. However, maldistribution of primary care clinicians remains a significant problem. This brief provides information regarding the working relationships between physicians and physician extenders—APNs and PAs—and the statutory and regulatory environment for APN and PA practice. It is intended to inform policy decisions about the health workforce of Arkansas, with a particular focus on the role of APNs and PAs.

INTRODUCTION

Arkansas's health system is undergoing substantial change. Health care providers are more often using health information technology to store and update medical records, communicate with patients, and, in some cases, provide services from remote locations. Payment methods are shifting from fee-for-service models to those that incentivize care coordination and promote efficient and effective care that results in improved outcomes. Delivery systems are integrating and patient-centered medical home (PCMH) models are becoming more prevalent across the state.

All health care system participants, including patients, share in the burden of widespread reform, but providers are facing an unprecedented wave of change at a time when rural areas of Arkansas lack a health care workforce that is able to meet demand. Our recently published study, *Arkansas Health Care Workforce: A Guide for Policy Action*, indicates that while the statewide primary care clinician supply approaches demand—largely bolstered by an excess supply in urban areas—there are rural areas in the state that face significant primary care access issues.

The maldistribution of our primary care workforce is a clear challenge, but what is not so clear is how to address this challenge in a comprehensive and integrated manner that will lead to solutions. Traditional options have focused on expanding the scopes of practice for certain clinicians or eliminating physician supervision or collaborative arrangements with the ultimate goal of "independent" practice. Optimizing the PCMH model, however, will require teams that work together to coordinate patient care and improve outcomes, as opposed to more detached practice.

Copyright © May 2013 by the Arkansas Center for Health Improvement. All rights reserved.

"The problems of making health care work are large. The complexities are overwhelming governments, economies, and societies around the world. We have every indication, however, that where people in medicine combine their talents and efforts to design organized service to patients and local communities, extraordinary change can result."

–Atul Gawande, MD

APN AND PA BACKGROUND

In response to a nationwide shortage of primary care providers in urban and rural areas, the original program for nurse practitioners started in 1965 as a master's degree program for pediatric nurses. The National Organization of Nurse Practitioner Faculties developed guidelines for nurse practitioner programs in 1995 and by the late 1990s almost all educational programs for nurse practitioners were in higher education settings with a master's degree awarded upon completion of the program.[1]

There are currently three accredited nurse practitioner programs in Arkansas offered at the University of Arkansas for Medical Sciences, Arkansas State University, and the University of Central Arkansas, and the programs are typically 1.5–2 years long.[2] There are four types of APNs: clinical nurse specialists, nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists.[3]

The physician assistant profession began at Duke University when Navy hospital corpsmen were trained to offset the shortage of physicians.[4] It was not until 1970 that the American Medical Association passed a resolution to develop educational guidelines and certification procedures for PAs.[5] PA programs are approximately 27 months long and include classroom instruction, consisting of "hard" science classes such as biochemistry and pathology, and clinical rotations in internal medicine, primary care medicine, surgery, etc.

STATUTORY AND REGULATORY ENVIRONMENT

At the core of medical professional regulation is the concept of **scope of practice**, which has been defined as the "rules, the regulations, the boundaries within which a fully qualified practitioner, with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field."[6]

Some states define professional scopes of practice by statutes—often called **practice acts**—enacted by the state legislature, while others delegate this authority to licensure boards.[7] Practice acts in Arkansas generally define the scope of practice for a number of medical professions, including physicians and nurse practitioners. Physician scope of practice is generally defined very broadly and was developed long before the advent of the APN or PA professions and scopes of practice. Consequently, it is not surprising that APN and PA scopes of practice overlap with physicians.

Nurse practitioner scope of practice in Arkansas dates back to 1979. Legislation in that year authorized the Arkansas Board of Nursing to license registered nurse practitioners (RNPs). RNPs may deliver health care services beyond those considered to be activities recognized by the nursing profession only in "collaboration with and under the direction of a licensed physician or under the direction of protocols developed by a licensed physician."[8]

Act 409 of 1995 created APN licensure and scope of practice and has been largely unchanged since then. For those licensed as APNs, the legislation served to eliminate the RNP requirement for collaboration with and supervision by physicians such that APNs could practice autonomously. Included in the legislation was a provision affording APNs prescriptive authority, but that authority was limited to APNs who had a "collaborative practice agreement" (CPA) with a licensed physician.

The legislation granted the Arkansas Board of Nursing the ability to grant certificates of prescriptive authority. For an APN to be qualified to apply for prescriptive authority, however, a CPA must be in effect and filed with the Board of Nursing.[9] The CPA must include, without limitation "the availability of the collaborating physician for consultation or referral or both; methods of management of the collaborative practice, which shall include protocols for prescriptive authority; coverage of the health care needs of a patient in the emergency absence of the advanced practice nurse or physician; and quality assurance."[10]

Physician assistant scope of practice was defined with the advent of the profession in Arkansas in 1999. Explicitly excluding only the practice of optometry, Act 851 of 1999 indicates that PAs may "perform those duties and responsibilities, including the prescribing, ordering, and administering drugs and medical devices that are delegated by their supervising physicians."[11] The PA scope of practice has not undergone statutory change since 1999.

STATE APPROACHES TO SCOPE OF PRACTICE

Although a variety of nuances exist, there are generally three approaches (Figure 1) used by states to regulate the relationship between physicians and APNs or PAs as it relates to diagnosis and treatment:[12]

- **Requirement for written documentation of physician involvement**—Twenty states[a] require written documentation of physician supervision or collaboration for an APN to diagnose and treat patients. "Supervision" or "collaboration" in each state varies, and may not require a physician to be on-site or have face-to-face interaction with the APN.
- **Physician involvement required, but written documentation is not required**—Four states[b] require physician supervision or collaboration to practice as an APN, but these states do not require written documentation of the relationship.[c]
- **No requirement for physician involvement**—The remaining states[d] and the District of Columbia require no physician supervision or collaboration for an APN to diagnose and treat patients.

[a] Alabama, California, Delaware, Florida, Georgia, Illinois, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, South Carolina, South Dakota, Texas, Virginia, and Wisconsin.

[b] Connecticut, Indiana, Minnesota, Pennsylvania.

[c] Practice authorities may include authority to diagnose, order tests, and refer.

[d] Alaska, Arizona, Arkansas, Colorado, Hawaii, Idaho, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Washington, West Virginia, and Wyoming.

State regulation of APN prescriptive authority (Figure 2) can be divided into two categories:

- **Requirement for written documentation of physician involvement—**Thirty-two states[e] require physician supervision or collaboration and written documentation of the relationship for APNs to prescribe medications.
- **No requirement for physician involvement—**Eighteen states[f] and the District of Columbia have no requirement for physician supervision or collaboration for an APN to prescribe medications. Although categorized as requiring no physician involvement, some of these states nonetheless require articulated plans or attestations for physician collaboration or consultation for certain classes of drugs.

Figure 1: Approaches to Regulation between Physicians and APNs/PAs

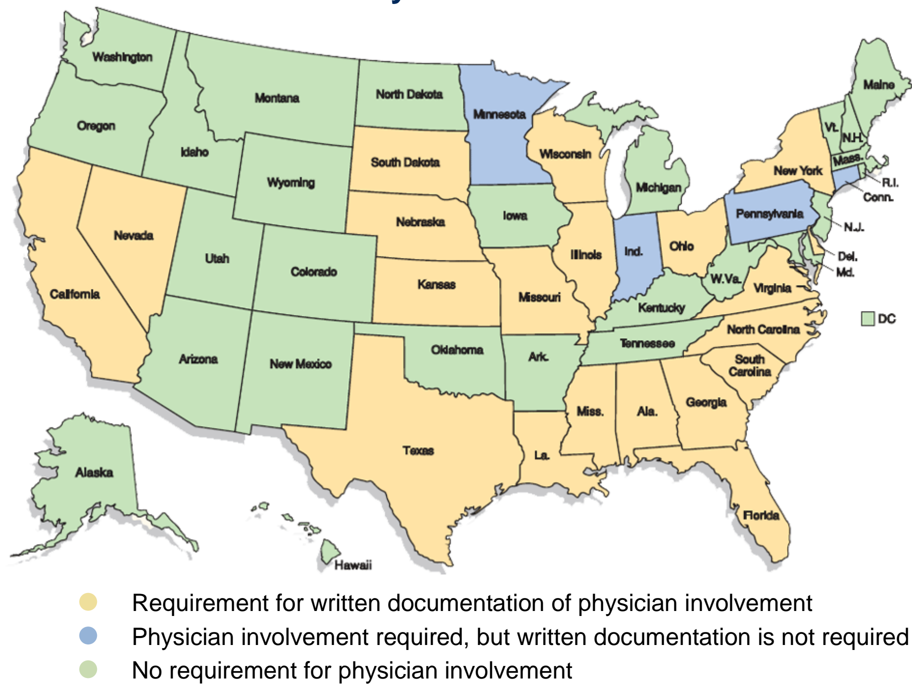
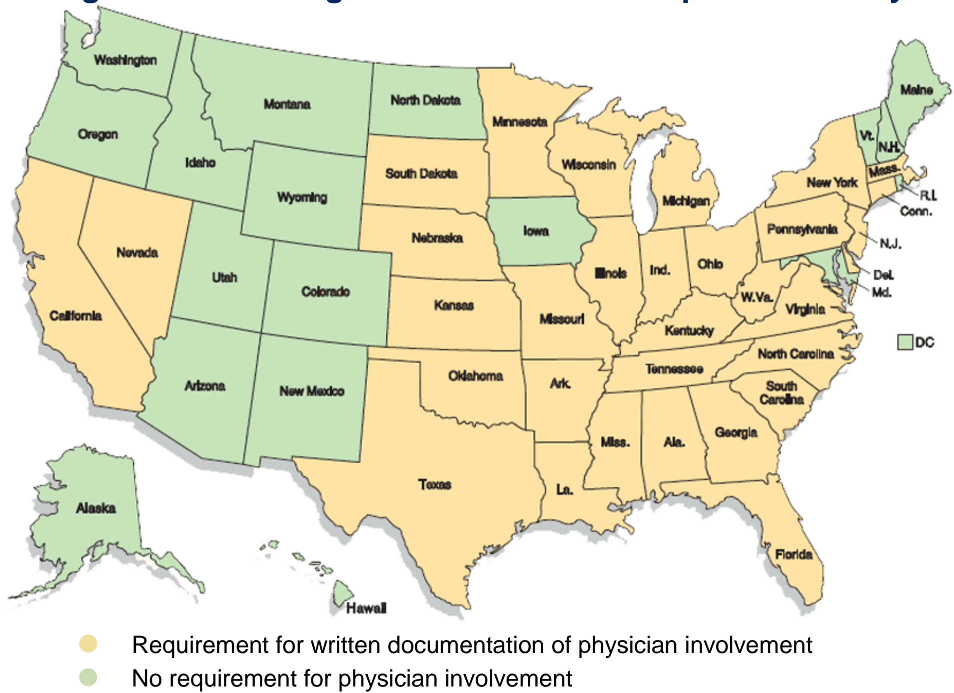


Figure 2: State Regulation of APN Prescriptive Authority



[e] Alabama, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

[f] Alaska, Arizona, Colorado, Hawaii, Idaho, Iowa, Maine, Maryland, Montana, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Utah, Vermont, Washington, and Wyoming.

Even within these broad categories, there is a great deal of variety. For instance, *Michigan* has a statutorily defined scope of practice within which APNs may diagnose and treat independently, and anything beyond the statutory scope of practice must be provided under physician supervision. *California* uses the standardized procedure (SP) as the legal mechanism for nurse practitioners to perform functions that would otherwise be considered the practice of medicine. SPs are developed collaboratively by the departments of the health care system in which they will be used. Some states, such as *Maine* and *Missouri*, distinguish between "medical" and "nursing" diagnoses.

PATIENT-CENTERED MEDICAL HOMES: APN AND PA ROLES

With expanded coverage that is available through the Patient Protection and Affordable Care Act (PPACA), market demands will trigger health system integration, new financing arrangements, and more effective delivery models. The U.S. Department of Health and Human Services' Center for Medicare and Medicaid Innovation (CMMI) has engaged states and health care providers in a number of demonstration initiatives to test new models that have the potential to meet this demand. Arkansas is participating in the CMMI Comprehensive Primary Care Initiative (CPCI), for example, which is a partnership between Medicare and state public and private insurers to provide funding to physician practices for care coordination, with the ultimate goal of transforming those practices into viable patient-centered medical homes.

Although PPACA includes funding for nurse-managed health clinics and nursing education at all levels—from entry-level preparation through the development of advanced practice nurses—the role of APNs and PAs in the reform process under PPACA is ill-defined. Below are examples of how states have approached defining PCMH roles, the former being more open-ended and the latter being more specific.

New Mexico[13]

The New Mexico legislature passed legislation in 2011 creating a PCMH program under the state's Medicaid, State Children's Health Insurance Program and State Coverage Initiative Program Medical Home waiver by allowing home care services to be provided as a component of the medical home model. The legislation defines medical homes as "integrated care management model that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate." It allows for assignment of recipients to a primary care provider, clinic, or practice that will serve as a medical home, and includes physicians, PAs, and APNs in its definition of primary care provider.

Kansas[14]

The Kansas legislature passed legislation in 2008 defining a PCMH as "a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

USE OF APNS AND PAS

Physician survey information shows that the framework for team-based care is in place. Many of Arkansas's physicians and physician extenders are working collaboratively to address the needs of Arkansans. In fact, nearly half of physicians from a recent survey responded that they had at least one APN associated with their practice. Of those physicians just under half responded that APNs acted as

primary care physicians with their own patients, and about one-third responded that APNs primarily assisted with the physician's patients. Half of physicians who worked with APNs either reviewed all their charts or just a sampling, and slightly more than a quarter of those physicians said that they do not require consultations by their APNs but are still available for them.

CONCLUSION

At the genesis of physician extender practice in Arkansas was a hope that they would fill a gap in the supply of primary care physicians. According to our report they are filling this gap, but they do little to alleviate the maldistribution issue. Other states have attempted to address supply issues by allowing "independent" practice. However, this remains a contentious debate between various parties. Arkansas is among the states that allow independent diagnosis and treatment by APNs, requiring a collaborative agreement only for prescriptive authority. With a changing practice model for all clinicians—including physicians—from isolated, solo practice to team-based practice, this collaborative model should serve the state well.

The state should continue to build on that collaborative foundation by focusing on PCMH financing arrangements that will promote the use of APNs and PAs in satellite locations. Additionally, the state should continue to enhance the availability and use of health information technology so that physicians can remotely collaborate with physician extender team members for complex patients.

REFERENCES

1. Mezey MD, et al. *Nurse Practitioners: Evolution of Advanced Practice*, *4th ed.* New York, NY: Springer Publishing Co, 2003.
2. National League for Nursing Accrediting Commission. "NLNAC Accredited Nursing Programs 2012." National League for Nursing Accrediting Commission, Inc.. Web 20 Sept. 2012. http://www.nlnac.org/forms/directorySearch.asp.
3. Agency for Healthcare Research and Quality. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. AHRQ Publication No. 08-0043. Rockville, MD: U.S. Department of Health and Human Services , April 2008. Web 12 Sept. 2012. http://www.ahrq.gov/qual/nurseshdbk/.
4. Physician Assistant History Society. "Timeline" in *Illustrated History*. Johns Creek, GA: Physician Assistant History Society. Web 20 Sept. 2012. http://www.pahx.org/timeline.html.
5. Carter R. "Physician Assistant History." *Perspective on Physician Assistant Education*, Spring 2001.
6. Finocchio L J, et al. *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995. Web 20 Sept. 2012.
7. Buppert C. *Nurse Practitioner's Business Practice and Legal Guide, Second Edition*. Burlington, MA: Jones and Bartlett Publishers, 2003.
8. Ark. Code Ann. § 17-87-102
9. Ark. Code Ann. § 17-87-310
10. Ark. Code Ann. § 17-87-310(c)
11. Ark. Code Ann. § 17-105-107
12. Pearson LJ. "The Pearson Report 2012: A National Overview of Nurse Practitioner Legislation and Health Care Issues." The American Journal of Nurse Practitioners. Web 29 Oct. 2012. http://www.pearsonreport.com/tables-maps/category/2012-introduction/
13. 2011 NM House Bill 34
14. K.S.A. 75-7429