Expanded Scope of Practice:  
A Response to Demand for Primary Care?

FORUM SESSION ANNOUNCEMENT

Friday, November 4, 2011
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION
Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

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nhpfmeet@gwu.edu

A DISCUSSION FEATURING:

David Goodman, MD, MS
Professor
Dartmouth Medical School

Linda Cronenwett, PhD, RN
Beerstecher Blackwell Term Professor
Dean Emerita
School of Nursing
University of North Carolina at Chapel Hill

Ned Calonge, MD, MPH
President and Chief Executive Officer
The Colorado Trust

Barbara Safriet, JD, LLM
Visiting Professor
Lewis & Clark Law School

FORUM SESSION ANNOUNCEMENT

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC
Exhortations to transform the way health care is delivered in the United States strike common notes that have come to sound familiar: Improve quality. Reduce costs. Increase the supply of primary care providers. Proposals for how these imperatives should be accomplished are less harmonious. With respect to primary care, some say we need to produce more physicians and find ways to get them to choose and stay in careers in primary care rather than more lucrative specialty practice. Some suggest the educational process for physicians could be shortened without compromising it, getting providers into the field sooner. Others argue that the issue is the supply of primary care services, not all of which need to be performed by a physician.

A major array of new care models—the patient-centered medical home, the Medicaid health home described in the Patient Protection and Affordable Care Act, the community-based service network—incorporate a health care team in their architecture. The details are less defined. Must a physician issue all orders, sign off on all tasks, supervise in person? Other categories of clinicians, including nurses, physician assistants, and pharmacists, believe that care could be delivered more effectively and efficiently if they were permitted to carry out in practice all that they have been trained to do (the term most often used is “practice to the top of the license”). Barriers to their doing so are raised by state licensing and scope of practice laws, credentialing processes, and a reimbursement system anchored on physicians. Resistance on the part of many physicians and physician organizations also plays a part.

GROWTH OF THE PRIMARY CARE WORKFORCE

Although various providers, including specialty physicians, may provide primary care services, the bulk of such services are provided by physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAs). The latter two, new professions since the 1960s, have grown considerably in numbers, and NPs have been joined by other advanced practice nurses (APNs), including clinical nurse specialists and nurse midwives. Recent survey data from the National Council of State Boards of Nursing shows approximately 197,000 APNs in practice, two thirds of whom are NPs. Census data from the American Academy of Physician Assistants put the number of practicing PAs at about 83,500. (This compares with about 732,000 practicing physicians in the United States in 2009.) Most APNs and a majority of PAs hold master’s degrees.
Both APNs and PAs now practice in a wide variety of settings. PAs are more likely to be found in a specialty practice. NPs may practice in collaboration with other clinicians or (in some locales) independently.

**SCOPES OF PRACTICE**

By the early 20th century, each state had adopted legislation defining the practice of medicine and limiting those permitted to practice to duly licensed physicians. Once licensed, a physician may legally perform a broad range of activities to diagnose, treat, or advise on an equally broad range of conditions, irrespective of specialized training. The same breadth of activities does not apply to other clinicians, whose permitted scope of practice is essentially carved out of the larger picture and frequently limited to what is ordered by a physician.

States vary in their licensing and credentialing requirements. For example, about half the states require NPs to document their collaboration with a physician in diagnosis and treatment; others allow independent practice. Similar variation is found in specific authorization to order tests, refer to other clinicians, and prescribe drugs. Physician assistants, who by definition work with physicians, also face a patchwork of practice regulations. And even where supervision of NPs and PAs is explicitly required, its definition is not standard. States differ as to whether and how much of the time the physician must be on site, how many NPs a single physician is permitted to oversee, and the extent to which his or her delegation of tasks to a PA is limited by regulation. Some states have passed practice acts for NPs that allow those practicing in rural and frontier areas, or in a setting such as a community clinic serving the poor and uninsured, greater latitude.1

Several nursing organizations came together in 2008 to develop a model practice act to standardize the regulation of APNs, covering education, accreditation, certification, and licensure.5 The Institute of Medicine, in its 2010 report *The Future of Nursing: Leading Change, Advancing Health*, called on state and federal governments to work together to establish standard practice acts.6

**Why Is Scope of Practice Controversial?**

Expansion proponents ground their case in the assertion that licensed professionals are capable of doing what they were trained to do, at a level of quality equal to that of physicians and at lower costs. Numerous studies may be cited showing comparable quality,
in some cases accompanied by better patient experience scores. Cost effectiveness has a couple of elements. First, NPs and PAs can be educated and trained more quickly and thus more inexpensively than physicians. Second, they are paid less.

Reimbursement, as ever, is not a simple proposition. An NP or a PA is often employed by a medical practice, hospital, or clinic; the employer clearly benefits from the reduced salary outlay as compared to a physician. However, Medicare and other payers may pay for NP or PA services at the physician rate if these services are deemed “incident to”—basically, occurring along with—physician services to a patient. In this case, the payer does not reap the benefit of the lower compensation of the primary care service provider. Payers may choose not to reimburse the cost of independent services provided by an APN, even where state law does not require practicing in collaboration with a physician. Thus a key goal of practice expansion proponents is a greater acceptance of independent billing.

Some critics of practice expansion proposals worry that a savings potential will last only until non-physician clinicians achieve their ambitions for independent primary care practice and payment. At some point, one could expect the profession then to say, “We are doing the same thing. We should be paid the same.”

And therein lies the rub for some physician groups, who are unwilling to concede parity. They maintain that physicians’ longer, more intensive training means that NPs cannot diagnose as accurately or deliver services of equal quality and safety. Some expansion proponents would respond, “We are not arguing that nurses are a substitute for physicians, but rather that we should consider how primary care services can be more effectively provided to more people, with the use of the full primary care workforce.” They would assert that NPs and PAs recognize when referral to a physician is appropriate.

At the same time, one group within nursing leadership is working to make a doctorate-level degree de rigeur for NPs, lengthening the education period and raising questions (as noted by the New York Times) about what happens when the nurse wants to be called “doctor.” The question of where to draw the lines between clinicians—or how long-standing lines can be woven together in team practice—is likely to be with us for some time.
SESSION

This Forum session will look at where practice expansion efforts stand, locations in which they have been successful, and challenges remaining. A range of stakeholder interests will be considered, including physicians, nurses, and state and federal policymakers.

SPEAKERS

David Goodman, MD, MS, professor at Dartmouth Medical School and prominent health services researcher, will talk about the current status of state medical practice acts, efforts to change them, and some pros and cons. He will describe a range of physician views of such efforts. Linda Cronenwett, PhD, RN, Beerstecher Blackwell Term Professor and former dean of the School of Nursing, University of North Carolina at Chapel Hill, will represent the range of views of the nursing profession, describe the gap between what NPs and other nurses are trained to do and what they are permitted to do, and discuss contemplated changes in nursing education. Ned Calonge, MD, MPH, president and chief executive officer of the Colorado Trust and past president of the Colorado Medical Board, will discuss his state’s experience with scope of practice expansion. Barbara Safriet, JD, LLM, of the faculty of Lewis & Clark Law School, will consider the legal ramifications of scope of practice changes and opportunities for federal policy to influence state-based developments.

KEY QUESTIONS

• What is the history of state practice acts? What forces contribute to the current pressure to change them?

• What has enabled some states to make changes? Where expansion has occurred, how has care delivery changed?

• How does clinical education reinforce or undermine the legitimacy of practice acts in the 21st century? To what extent is education changing to be more consistent with expected future scopes of practice?

• How might Medicare and Medicaid payment policies change to support expanded scope of practice? Are there barriers to private payers considering similar policies?

• What is the likely impact of the Patient Protection and Affordable Care Act on scope of practice?
ENDNOTES


3. Author’s calculation from data available at http://factfinder.census.gov/servlet/SAFFPopulation (population) and http://www.oecd.org/document/16/0,3343, en_2649_34631_2085200_1_1_1_1,00.html (practicing physicians per thousand population).


