A State’s View of Scope of Practice

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The Colorado Trust
Objectives

• Discuss the findings and recommendations of Colorado’s Scopes of Care Advisory Committee
• Discuss learnings
  – What were the surprises
  – Where was there consensus
  – Where were the lines of disagreement drawn
• Discuss results
• Discuss advice for consideration of such a project
• Present a few cautionary notes
Regulatory framework prior to 2009

• Certified Registered Nurse Anesthetists have “independent” practice authority under the Nurse Practice Act (NPA) and want the Colorado Governor to “opt-out” of Medicare part A supervisory requirements

• Advanced Practice Nurses must have a “collaborative agreement” with a physician in order to have prescribing authority

• Dental hygienists can’t “diagnose” dental conditions
Factors leading to the study

- Nurse Practice Act is up for “sunset” or required re-authorization (2009 session)
- Nurses announce their proposed deletion of the required collaborative agreement citing unnecessary restraint of trade, and
- Physicians announce their opposition citing quality of care and inadequate education
Scopes of care study

• Legislators had concerns about the scopes battles as well as about Massachusetts reports on an inadequate workforce to meet the demands for primary care associated with the expansion of health care coverage

• The Governor commissioned a systematic evidence review to assess the potential benefits and harms of scope expansion for advanced practice nurses and created an advisory committee

• Study undertaken by the Colorado Health Institute: non-partisan health research non-profit funded by health foundations
Advisory Committee

- Anesthesiologist and CRNA
- OB/GYN and CNM
- Family Medicine doctor and FM nurse practitioner
- Pediatrician and Pediatric nurse practitioner
- Physician assistant, Registered Nurse
- Dentist and dental hygienist
- R and D senators and representatives
- Relevant stage agency representatives
- Governor’s policy office representative
- Chief Medical Officer as chair
Systematic Evidence Review

• Develop key questions
• Use electronic literature search
• Pull related research articles
• Review study and rate quality
• Extract study findings
• Synthesize findings
Key questions

• What are the quality, safety, efficacy and cost-effectiveness issues related to utilizing advanced practice nurses (APNs), physician assistants (PAs) and dental hygienists (DHs) as primary care providers, paying particular attention to the provision of primary care provided to underserved populations?

• What is the quality, safety and efficacy evidence for utilizing independent practice certified registered nurse anesthetists (CRNAs) in anesthesia settings?

• Are there models of care, care settings or aspects of care settings including relationships between different providers that have been shown to improve access to quality primary health care when employing APNs, PAs and DHs?
Findings

• APNs working as members of interdisciplinary health care teams deliver quality health care comparable to physicians in a variety of settings while receiving high patient satisfaction ratings

• CNMs and CRNAs provide quality specialty care without the direct supervision of a physician, often operating under specific practice protocols developed in consultation with a licensed physician

• Consultation and referral to other appropriate providers consistent with training and scope of practice is a necessary component of primary health care to be exercised by all primary care providers
Recommendations

• APN Recommendations
  1. Evaluate the efficacy of changes to APN law and regulations that would allow more flexibility in, or other changes to, the collaborative agreement requirement for prescriptive authority by APNs that would address the identified barriers.
  2. Evaluate and recommend policies that would support and enhance the delivery of health care through interdisciplinary teams including physicians, APNs and other health care professionals.

• CRNA Recommendation – Evaluate the efficacy of implementing changes currently authorized under the federal opt-out provision for Medicare Part A reimbursement to allow Colorado hospitals to bill for CRNA services directly taking into account hospital location and CRNA practice experience.
Nurse Practice Act changes

• Collaborative agreement requirement removed
• Added additional year of physician mentorship after year of physician preceptorship
• Added articulated plan for practice to be signed once by physician mentor and reviewed annually only by APN
  – Consultation and referral plan
  – Decision support plan
  – Ongoing learning plan
• Created ongoing physician/nurse advisory panel (advisory to the licensing boards): NPATCH
Additional helpful items

• Key informant interviews and summary
• GIS mapping of provider availability
• Survey of statutes from other states
• Comparison of education programs
• Comparison of reimbursement policies
• Discussion of liability issues
<table>
<thead>
<tr>
<th>State</th>
<th>Oversight Requirements</th>
<th>Practice Authorities</th>
<th>Prescribing Authorities</th>
<th>National Certification Required</th>
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<tbody>
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<td>AZ</td>
<td>No MD Involvement Req’d</td>
<td>MD Supervision Req’d</td>
<td>Written Practice Protocol Req’d</td>
<td>Explicit Authority to Diagnose</td>
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Sources: University of California, San Francisco, Center for the Health Professions (2007); State regulatory agency contacts http://www.futurehealth.ucsf.edu/pdf_files/Chart%20of%20NP%20Scopes%20Fall%202007.pdf

[1] Not required for state licensing, but practically necessary in order for independent practitioners to receive reimbursement from Medicaid and Medicare.
[2] Wisconsin recognizes two types of nurses that may be compared to Nurse Practitioners in other states -- one (NP) under the broader category of Advanced Practice Nurses, another called Advanced Practice Nurse Prescribers (APNP). The former group is not licensed by the state.
[3] Limited Schedule II authorities, e.g., no amphetamines.
[4] WY rules are being updated to reflect current statutory authorities. NPs may apply for authority to prescribe (Schedule II-V) in areas of expertise after attaining 30 CEUs in pharmacology and 400 hrs as an APN.
[5] Colorado; test ordering authority not cited in UCSF table; included in draft table provided.
[6] Waiting to hear back from Wyoming contact.
Lessons learned

• Areas of consensus
  – Hard to design statute that regulates collaboration or assures professional relationships
  – We should try to support health care delivery by integrated teams

• Areas of no consensus
  – There is no good evidence that the current system is broken
  – Physicians feel they have better training and provide better care
  – Nurses see additional requirements as unnecessary
Changes in relationships

• Since Sunset:
  – Better? (NPATCH, for example)
  – The same? (Retail clinic regulation, for example)
  – Worse?

• What we need:
  – Culture of collaboration centered around the patient
  – Appropriate respect for differences in education, abilities, etc
  – Appropriate respect for areas of similar abilities and care quality
Extra slides

• Colorado rural workforce: supply and demand over time
Workforce pipeline (2006-7)

• MD/DOs: 2 schools, 784 enrollees, 130 graduates
• APNs: 12 schools, 686 enrollees, 212 graduates
• PAs: 2 schools, 148 enrollees, 67 graduates
Demographic profile of rural physicians

- Average age: 50.6 years
  - 34 and younger (4%)
  - 35-44 yrs (29%)
  - 45-54 yrs (32%)
  - 55-64 yrs (25%)
  - 65 and older (10%)
- 29% female
- 88% white
- 18% graduated from medical school in Colorado
- 5% (50) were international graduates

SOURCE: 2009 Colorado Rural Physician Workforce Survey
Intention to leave practice

Approximately 14% of rural physicians plan to leave their practice in next 12 months, of these:

– 1/3 reported retirement as a very important reason
– Other important reasons included: overworked (40%); burden of practice management (31%); relocation out of state (29%) and professional isolation (29%)

SOURCE: 2009 Colorado Rural Physician Workforce Survey
Declining interest in primary care specialties among physicians

A 2007 survey of fourth year medical students at eleven U.S. medical schools found:
• 2% were planning a career in general internal medicine
• 5% were planning a career in family medicine
• 12% were planning a career in general pediatrics

Primary care physician supply and demand: Status quo + universal coverage, 2005-2025

DATA SOURCE: 2005 AMA Physician Master File
Supply/demand model: Primary care PAs 2005-2025

DATA SOURCE: 2005 PA data, Peregrine Management Corporation
Supply/demand model: Primary care APNs 2005-2025

DATA SOURCE: 2005 APN Data, Peregrine Management Corporation

Primary Care Demand
Primary Care Supply

SHORTAGE 660
**Colorado’s rural physicians report...**

<table>
<thead>
<tr>
<th>Payer Source</th>
<th>% reporting</th>
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<td>Practice closed to Medicaid adults</td>
<td>24%</td>
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<tr>
<td>Practice closed to Medicaid children</td>
<td>21%</td>
</tr>
<tr>
<td>Practice closed to CHP+ children and pregnant women</td>
<td>18%</td>
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<tr>
<td>Practice closed to Medicare patients</td>
<td>11%</td>
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*SOURCE: 2009 Rural Physician Survey, Colorado Health Institute*
Lessons from Massachusetts

“Expanding access to health insurance without expanding access to care can turn a positive development into widespread patient and practitioner frustration.”