

I WRITE IN SUPPORT of HB 6391: AN ACT CONCERNING THE PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES.

My name is Joanne DeSanto Iennaco PhD, PMHNP-BC, I am an Advanced Practice Registered Nurse and my area of clinical practice is psychiatric-mental health nursing. I hold a PhD in epidemiology and work as a faculty member at the Yale University School of Nursing, where I do clinical research and teach students preparing to be psychiatric nurse practitioners.

I would like to speak to several concerns that favor removing the *REQUIREMENT* for APRN's to collaborate with a physician. I will address: Restriction of supervision and oversight requirements and quality of care; Restraint of business activities; Financial implications of *REQUIRED* collaboration, including physician pay and shortages.

Collaboration & Consultation vs. Supervision & Oversight:

Since the 1999 Nurse Practice Act revision, supervision and oversight of APRN's have NOT BEEN REQUIRED; the APRN is solely responsible for patients and signs all records. Eliminating the requirement for a *written collaborative agreement* will not change APRN practice:

- APRNs will collaborate and consult with other members of the health care team as they currently do now.
- It will not add any authority based on education, certification, or licensure.
- If a patient problem presents that would be best managed by referral to a physician, physical therapist, or other provider the APRN would continue *as they currently do* to refer patients with needs.

Is there a Quality or Safety Issue? Little or no evidence is provided by physician groups related to why APRN's should continue to be required to collaborate. They identify it is for quality of care and patient safety, *yet provide no evidence*. In fact you will find in the reports and briefings referenced below that the opposite is true. A recent systematic review found equivalent outcomes by APRNs in randomized controlled trial results (Newhouse et al, 2011).

- The National Governors Association in their report, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*, stated: "Most studies showed that NP-provided care *is comparable to physician-provided care* on several process and outcome measures," In addition they state: "Moreover, the studies suggest that *NP's may provide improved access to care.*"

Restraint of business activities and practice:

A current problem with the collaborating physician model is that APRN's are restricted in CT to either: work for a physician to fully implement their allowable scope of practice; or hire a physician to collaborate with them. Some of the results of the requirement include:

- A restriction on APRN's ability to independently practice and do business.
- As an employee in a physician run practice, APRNs recoup very little from fees earned.
- Hiring costly physicians to run their own practice makes it difficult to break even in addition to paying rent, liability insurance, and staff to support patient care.

- Conflicts of Interest: Physician collaborators should not be involved in APRN decisions of where to refer a patient for care – they have a vested financial interest in keeping these patients within their own practices or clinical systems.

One reason physicians and their advocacy groups may be against this is that *they will lose money* if APRNs are *not required* to collaborate with them. This is wrong. For added examples of the financial stranglehold this presents to APRN's see the Connecticut APRN Coalition briefing.

Financial Implications of REQUIRING collaboration

The ability of an APRN to develop her own clinical practice is impeded by this requirement.

- It is often difficult to find a physician to engage in an agreement with.
- This impedes individuals who are skilled and experienced from freely opening their own businesses.
- These arrangements can be too costly for APRN's to bear in clinical practice.

Physicians have a conflict of interest regarding this bill. They currently have financial interest in keeping the law the same, both to directly bill the APRN for collaboration and to collect APRN referral fees in their practices. Physicians employ APRN's as lower cost providers who care for their patients and whose fees go to the practice, enhancing the conflict of interest in the current law.

REGARDING fears of Physician Shortages or Lower Wages:

Claims that removal of this requirement will worsen physician shortages in primary care lack evidence: A colleague shared an email received 3/17/13 from an ACP leader stating:

“While other states have allowed complete independent practice of APRNs, those states are frequently ones which found themselves having greater shortages of available physicians.”

(3/17/2013 email from Robert McLean MD, Governor CT ACP Chapter)

- I suspect the intended interpretation was that NPs often are recruited to practice in areas that have physician shortages – like rural areas, inner city free clinics, etc.
- I am sure he is aware that *NP's are NOT the cause of physician shortages, but actually part of the solution to the problem*
- This is acknowledged by the American College of Physicians (ACP), as well as the Institute of Medicine, and the Association of American Medical Colleges who *identify that physician shortages are caused by* the increasing aging population, and difficulty attracting providers to rural and underserved urban sites. Reasons include:
 - A decline of medical students choosing primary care (it is not as lucrative)
 - Financial problems which they seek to resolve with implementation of:
 - Patient Centered Medical Homes (PCMH)
 - Reimbursement reform
 - Creation of financial incentives.

An example of Patient Centered Medical Homes:

- Patient Centered Medical Homes have been developed and studied, it should be noted that in fact Nurse Practitioners already lead PCMH models in some areas (Maine, NH).
- Much health policy discussion on medical homes is framed as ways to ‘save primary care’, and ‘recruit primary care physicians’ because of the financial incentives and improved reimbursement.
- PCMH's were designed *to improve patient care* – not physician payment.

- Many plans involve physicians at the lead (getting reimbursement) with NPs and RNs providing care as their employees. Fears exist that NPs will also be able to independently run PCMH programs.

Will this requirement change negatively impact physician fees or wages? Some physicians fear their fees or wages will be negatively impacted. Here is some evidence:

- Recent studies show that in states where APRN’s practice independently, **physician wages have actually increased**. (see Figure below, from: Pittman 2012; full SOP=Full Scope of Practice; data from Bureau of Labor Statistics). The authors state, “These data again reveal no statistically significant differences between primary care physicians (family practice and physicians and general pediatricians), whose practice might be in competition with NPs in states with more liberal SOP laws, and that of surgeons, whose practice does not overlap with that of NPs”.

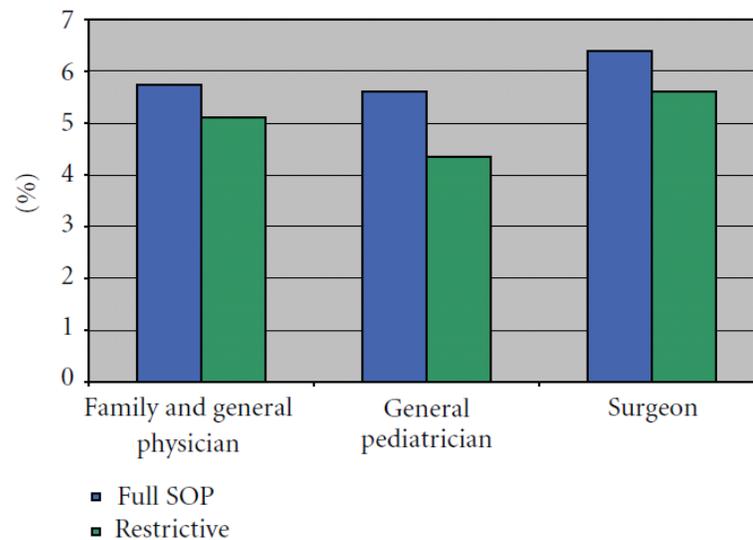


FIGURE 4: Average annual percent change in physician wages, 1999–2009. Source: [16].

[16] Bureau of Labor Statistics (BLS) and United States Department of Labor, “Occupational Outlook Handbook,” 2010-11 Edition, 2009, <http://www.bls.gov/oco/ocos074.htm#emply/>.

- In fact the Institute of Medicine, in its 2010 report, recommends removing Scope of Practice barriers for APRN’s suggesting that they be allowed to “practice to the full extent of their education and training”.

An Example of APRN practice: There is good evidence that approving this change will lead to more cost effective care in the state of Connecticut. Let me tell you a bit about my experiences as a Psychiatric Mental Health Nurse Practitioner (PMHNP) serving the severely mentally ill in CT. I worked as a Clinician in the Acute Services Department at the Connecticut Mental Health Center in New Haven. CMHC sees our most vulnerable citizens, who often are homeless and have great difficulty accessing health care. Many are acutely psychotic, hear voices, suicidal, and disenfranchised from care. Without the dedicated APRN’s and other clinicians who provide

care, these patients would have no place to go. I am proud of the care I provided at CMHC.

Typically we work to help the patient set goals and improve both their psychiatric symptoms and their lives. Helping them to find housing, engage in healthcare (it is rare that these individuals have seen a health care provider in recent years), and stabilize their mental health problems. The need for services for these citizens has only increased. As my work exemplifies, APRN's are an important provider of care to those most vulnerable in many healthcare settings.

We serve patients in primary care, community mental health centers, school based health centers and a variety of other inpatient and outpatient settings.

With the graying of America, APRN's are an important source of providing care, and we typically remain actively working in *general health settings* (vs. specialization where incomes are more lucrative). Research evidence also suggests that APRNs provide improved access to care.

This bill *will also retain APRN's providing care in CT* – many choose to leave to work in states with less restrictive practice. In fact many of my graduates leave CT to practice elsewhere – they and their experienced colleagues and mentors are a resource our state cannot afford to lose.

If I can be of service in helping you to better understand these issues, I would enjoy meeting with you to provide further assistance.

Thank you,

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