REPORT OF THE
JOINT COMMISSION ON HEALTH CARE ON

STUDY OF THE OPTIMUM USE OF NURSE PRACTITIONERS PURSUANT TO SJR 164 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 25

COMMONWEALTH OF VIRGINIA
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Preface

Senate Joint Resolution (SJR) 164 of the 1994 Session requested the Joint Commission on Health Care to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners.

This report summarizes the current status, education, and distribution of nurse practitioners in our state. Nurse practitioners, nurse midwives, and nurse anesthetists are licensed and regulated by the Virginia Boards of Nursing and Medicine. Virginia is one of seventeen states which grant to nurse practitioners the authority to prescribe Schedule VI controlled substances. Virginia educates approximately 3% of the country's total nurse practitioner graduates each year. The distribution of nurse practitioners reflects an urban and suburban predominance, with 55% practicing in three major metropolitan areas of the state. Salaries of Virginia nurse practitioners are comparable to national averages. Nationally, twenty-five states (including two of Virginia's five border states) require direct reimbursement by third party insurers to nurse practitioners.

This issue brief discusses the numerous barriers to optimum utilization of Virginia nurse practitioners in primary care settings, and outlines various options to address these barriers. Options for consideration include:

- reconsideration of restrictive statutory requirements for supervision of nurse practitioner prescriptive authority;
- inclusion of nurse practitioners as mandated non-physician health service providers for the purposes of accident and sickness insurance policies;
- development of a method for collecting data on the services provided by nurse practitioners;
- analysis of including NPs as primary care providers under Key Advantage and Medallion, and expanding the categories of NPs eligible for reimbursement under Medicaid;
- examination of state-sponsored incentives to practice in underserved areas;
- an increase in the amount of state scholarships for nurse practitioner education;
- provision of support for collaborative training models for physicians and nurse practitioners in the state academic medical centers.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

January 12, 1995

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Authority for Study

Senate Joint Resolution (SJR) 164 of the 1994 Session of the General Assembly of Virginia requests the Joint Commission on Health Care, in cooperation with the Joint Boards of Medicine and Nursing and other related public and private agencies and associations representing the affected health care professions, to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners. The study was to specifically address: (1) the extent to which, if any, existing statutes and regulations governing nurse practitioners create barriers to cost-effective care; and (2) the social and financial impact and medical efficacy of direct reimbursement to nurse practitioners, as well as the effect such reimbursement would have on access to primary health care services in the Commonwealth.

Introduction

Health care reform seeks to provide the population with access to high-quality, cost-effective health care services while limiting currently spiraling costs. A major component of reform proposals is the provision of adequate primary care services. Accomplishment of this goal will require expanded use of physician extenders such as nurse practitioners, nurse midwives, and physician assistants, in addition to increased production of generalist physicians. The role of nurse practitioners in the provision of primary care, especially to underserved populations and in rural areas, is vital to the overall health reform effort.

In Virginia, there are barriers to the maximal utilization of primary care nurse practitioners. This paper provides an overview of nurse practitioners, outlines their major barriers to practice, and suggests options for decreasing these practice restrictions.

Background

Virginia Defines a Broad Category of "Nurse Practitioners" Which Includes Nurse Practitioners, Nurse Midwives, and Nurse Anesthetists

In Virginia, a licensed nurse practitioner is defined as follows:

> a registered nurse who has met the requirements for licensure as stated in . . . regulations and has been licensed by the boards.
>
> VR495-02-1, §1.1

An applicant for initial licensure as a nurse practitioner shall:

1. Be currently licensed as a registered nurse in Virginia; and
2. Submit evidence of completion of an educational program designed to prepare nurse anesthetists, nurse midwives or nurse practitioners that is either:
   a) Approved by the boards . . .; or
   b) Accredited by an agency . . .; and
3. Submit evidence of professional certification by an agency . . . accepted by the boards; and
4. File the required application; and
5. Pay the application fee prescribed in . . . regulations.

VR495-02-1,§2.3

A licensed nurse practitioner shall be authorized to engage in practices constituting the practice of medicine under the supervision and direction of a licensed physician in accordance with . . . regulations.

VR495-02-1,§3.1

The practice of licensed nurse practitioners shall be based on specialty education preparation as outlined in . . . regulations and in accordance with written protocols . . .

VR495-02-1,§3.2

The term "Nurse Practitioners" refers to advanced practice nurses in fourteen categories prescribed by regulation: certified nurse midwives (CNMs), certified nurse anesthetists (CNAs), and twelve specific categories of nurse practitioners (NPs). (VR495-02-1 and VR465-07-1, Part II, Section 2.2). Nurse practitioners are jointly licensed by the Virginia Board of Nursing and the Virginia Board of Medicine and are regulated through a Committee of the Joint Boards of Nursing and Medicine. (Code of Virginia Section 54.1-2957) Virginia is one of five states which license or certify and regulate nurse practitioners through joint Boards - Virginia, Idaho, Massachusetts, Nebraska, and Pennsylvania.

Virginia Has 2 - 3% of the Total Numbers of Advanced Practice Nurses in the Country

Most recent data on the numbers of advanced practice nurses in Virginia and at the national level are as follows:

	1994 Virginia Data	1992 National Data
NP's	1,148 (49%)	32,611 (65%)
CNM's	95 (4%)	2,930 (6%)
CNA's	1,097 (47%)	14,316 (29%)
Total	2,340 (100%)	49,857 (100%)

According to National Council of State Boards of Nursing 1992 data, Virginia ranked sixth from the top in total numbers of active advanced practice nursing licenses. (12)

Virginia Has Conservative Supervision Requirements for NP Prescriptive Authority

Section 54.1-2957.01 of the Code of Virginia grants to licensed nurse practitioners the authority to prescribe Schedule VI controlled substances and devices, as outlined in a Joint Boards-promulgated formulary, under the authority of a written agreement between the licensed nurse practitioner and a licensed physician "which provides for the direction and supervision by such physician of the prescriptive practices of the nurse practitioner." The supervising physician must make required periodic site visits to the location where the nurse practitioner is prescribing, if that location is different from where the physician regularly practices. Physicians may supervise the prescriptive authority of up to four nurse practitioners in a public setting (health department, federally funded comprehensive primary care clinic, or nonprofit health care clinic); supervision is limited to two nurse practitioners in other (private) settings.

Regulations for prescriptive authority for licensed nurse practitioners are contained in VR495-03-1 and VR465-12-1. Nurse practitioners may prescribe Schedule VI drugs and devices as outlined in a Joint Boards-promulgated formulary. The supervising physician must conduct monthly, random review of patient charts on which the NP has entered a prescription for an approved drug or device.

Virginia Educates Approximately 3% of the Country's Total Nurse Practitioner Graduates Each Year

There are currently five Nurse Practitioner training programs in Virginia: Virginia Commonwealth University/Medical College of Virginia, University of Virginia, Old Dominion University, George Mason University, and Hampton University. These five programs graduate approximately sixty nurse practitioners each year. (22) Nationally, there are 90 programs which together produce approximately 2,000 nurse practitioners annually.

Virginia NP programs are 12 to 18 months in length, depending upon course of study, and tuition ranges from $8,000 to $11,000 per student. The state currently provides five $5,000 scholarships per year for nurse practitioner students who agree to pay back each award with one year of service in a medically underserved area of the state. All five scholarships have been awarded each year since the program's inception. Most of the recipients have not been residents of medically underserved areas.

The Distribution of Nurse Practitioners in Virginia Reflects an Urban and Suburban Predominance

Available data from a 1990 Virginia Health Planning Board study shows the largest numbers of primary nurse practitioners located in the Fairfax/Alexandria/Arlington/Prince William County (19.3%), Tidewater (18.6%), and Richmond/Chesterfield/Henrico (17.2%) areas. (19) Recent Virginia nurse practitioner graduates have chosen similar practice locations:

urban/inner city	51%	
suburban	33%	
rural	16%	
	100%	(1991-92 averages) (22)

The explanation for this urban/suburban concentration is multi-factorial. More attractive employment opportunities and salaries in metropolitan areas, difficulty finding a collaborating physician in rural areas, difficulty finding spousal employment in rural areas, and the professional and cultural "isolation" of rural practice all contribute to this practice distribution pattern. Many of these factors contribute to physician maldistribution in Virginia as well.

There is No Comprehensive Data on Current Nurse Practice Descriptions

There is no comprehensive data as to the types and settings of practice and numbers of patients seen by Virginia's 1,148 licensed nurse practitioners. Licensure categorization only suggests their practice settings and distribution:

Adult Nurse Practitioner	228	Geriatric	39
Family	396	School	1
Pediatric	215	Medical	2
Family Planning	4	Maternal/Child	1
OB/GYN	162	Neonatal	71
Emergency Room	27	Women's Health	2

(DHP, May 1994)

Salaries of Virginia Nurse Practitioners are Comparable to National Averages

The majority of nurse practitioner employment opportunities are salaried positions. Preliminary data from the 1994 Virginia Hospital Association Workforce Survey (19) show the following salary ranges:

hospital-employed NPs:	$33,228 - 50,538
physician office salaried NPs:	$37,157 - 51,844 (Family NPs)
	$39,228 - 49,316 (other NP categories)

Virginia Department of Health nurse practitioner positions are Grades 14 and 15 with a salary range of $37,431 to $57,151. The 1992 national salary **averages** for NPs primarily employed in ambulatory settings were $45,520 (lowest - Midwest) to $50,174 (highest - West). (23)

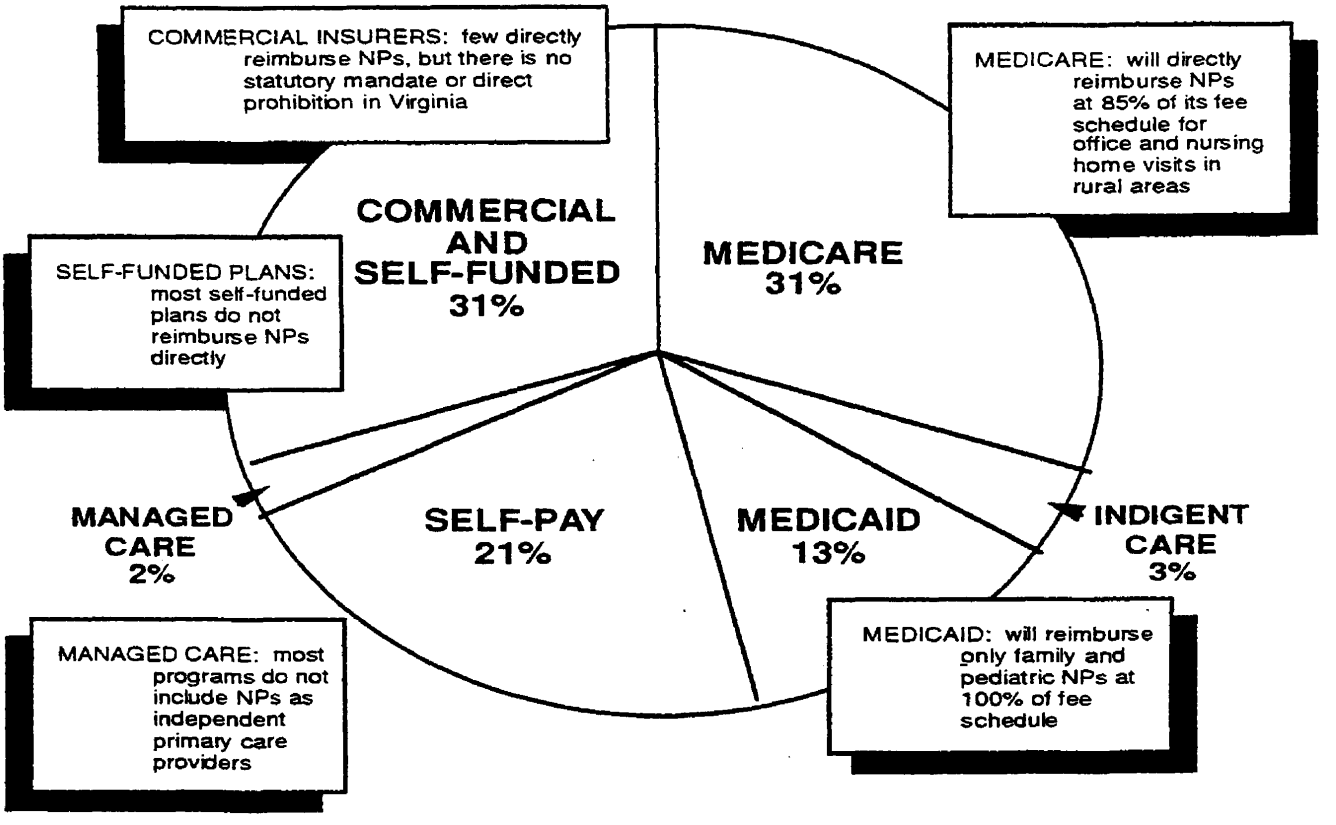
There are Numerous Financial Barriers to NP Reimbursement in Virginia

SJR 164 specifically addresses third party reimbursement to nurse practitioners. A statutory mandate for direct reimbursement to NPs would not impact public payors or self-funded plans unless such plans chose to conform their practices to commercial products. There are substantial barriers to reimbursement by the other major payers as well. The financial success of NPs who bill and receive direct reimbursement would depend on their location of practice and numbers of patients covered by each payer.

The 1989 profile of health care coverage by payer class from a Medical Society of Virginia survey of rural Virginia family practitioner practices is contained inside the circle of Figure 1. The boxes describe potential reimbursement to NPs from each of these payers.

Some rural Virginia family physicians report that as much as 60 - 80% of their patient population is covered by Medicare. (18) NPs practicing in rural areas would be subject to the same financial disincentives as rural physicians - an average of 14% less reimbursement from Medicare than their urban counterparts and a larger percentage of Medicare and self- pay patients. Additionally, under Medicare, NPs have the option of being reimbursed at 85% of fee schedule for office visits in rural areas. State mandated reimbursement to NPs by third party payers would not affect these financial barriers with Medicare.

Figure 1



Nationally, twenty-five states have statutes requiring direct reimbursement by third party insurers to NPs, usually through mandated benefits laws or non-discrimination provisions. (Appendix C) Virginia's border states are summarized below:

Maryland - mandates direct third party reimbursement to certified nurse practitioners.

West Virginia - mandates offer of coverage to nurse practitioners.

Kentucky - no mandated coverage of nurse practitioners.

Tennessee - no mandated coverage of nurse practitioners.

North Carolina - passed mandated reimbursement/non-discrimination legislation for nurse practitioners in its 1993 General Assembly Session. This act became effective October 1, 1993, and has a sunset provision for October 1, 1998.

There Have Been Several Analyses of Advanced Practice Nursing Issues to Date

The existence of barriers to expanded utilization of mid-level providers is not a new issue. Since 1990, there have been five major Virginia studies which have addressed advanced practice nursing issues. A brief summary of recommendations from these studies is included in Appendix D. Optimizing the use of nurse practitioners, particularly in underserved areas of the state, will continue to be an important goal for health reform in our Commonwealth.

Discussion of Issues

On a national level and in Virginia, numerous barriers to optimum utilization of nurse practitioners in primary care settings have been identified. These barriers may be categorized as:

Statutory
Regulatory/Operational
Financial
Educational
Public and Professional

To accomplish our goal of access to high quality primary care services for all Virginians, these barriers must be addressed.

Statutory Barriers

Discussion of these barriers is classified by regulating or administrating agency or department:

<u>Department of Health Professions</u>

Virginia's Statutory Requirements for Supervision of Prescriptive Authority Are Very Conservative

Virginia is one of fifteen states whose NPs have dependent practice (required collaboration with or supervision by a physician) and prescriptive authority, excluding controlled substances Schedules II-V.

CLASSIFICATION OF STATES BY TYPES OF NP PRACTICE AND PRESCRIPTIVE AUTHORITY

	Independent Practice	Dependent Practice
Prescriptive Authority including Schedules II - V	Alaska Delaware Montana New Hampshire New Mexico Oregon	Arizona California Colorado Connecticut Indiana Massachusetts Maryland Minnesota Nebraska New York North Carolina North Dakota Pennsylvania Texas Utah Vermont West Virginia Wisconsin Wyoming
Prescriptive Authority excluding Schedules II - V	Iowa Washington	Florida Idaho Kansas Kentucky Maine Michigan Mississippi Missouri Nevada New Jersey Rhode Island South Carolina South Dakota Tennessee **Virginia**

NOTE: States with very limited or no prescriptive authority (8): Alabama, Arkansas, Georgia, Hawaii, Illinois, Louisiana, Ohio, and Oklahoma.

The statutory limitation of two NPs per supervising physician in private practices and four NPs per physician in public settings is felt by nurse practitioners to be arbitrary and to serve as a barrier to employment and/or obtaining prescriptive privileges. Similarly, the requirement of periodic site visits is seen by physicians as an onerous burden and an inefficient use of physician time, especially in busy or remote practices. The apparent intent of these restrictions was to prevent "nurse practitioner mills" - satellite facilities staffed by NPs whose collaborating physician was located at a distant site, supervising several NPs, with no significant first-hand knowledge of their practice or prescribing unless consulted by phone for questions.

The extent to which these requirements are a barrier to recruitment of NPs and full utilization of their services is unknown. As of August 1, 1993, only 370 nurse practitioners in Virginia (approximately one third of licensed NPs in the state) had obtained prescriptive privileges. (DHP, August 1993) Reasons for this

ould include the above-mentioned barriers, lack of sufficient pharmacology continuing education, and no requirement for prescribing in the present employment situation. The Virginia Department of Health notes no problems at this time with the four-to-one ratio for public facilities.

Options for Consideration:

(1) Maintain the current ratios and site visit requirements
(2) Reconsider the physician-to-NP ratios for prescribing supervision in private practice settings
(3) Reconsider the statutory requirements for periodic site visits by supervising physicians

Bureau of Insurance

Nurse Practitioners are Excluded From Mandated Provider Status in Virginia

Sections 38.2-3408 and 38.2-4221 of the Code of Virginia list the mandated non-physician health service providers for the purposes of accident and sickness insurance policies: licensed chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, chiropodists, clinical nurse specialists who render mental health services, audiologists, and speech pathologists.

Statutory inclusion as mandated providers would allow NPs to bill under their own names and receive direct reimbursement from state-regulated products for their services. In the present situation, NPs must bill for their services under their collaborating physicians' provider numbers. This system of "closeted billing" makes tracking of NP patient data impossible, does not recognize nurse practitioners for their professional services, and forces physicians to submit claims for services which they have not personally performed.

SJR 164 specifically requested a study of direct reimbursement to nurse practitioners and the effect such reimbursement would have on access to primary health care services in the Commonwealth. In general, the populations with limited access to primary health care services are those groups without any form of health insurance coverage. These populations are located in inner city and rural areas of the state - areas with inadequate numbers of physicians and nurse practitioners. Seventy-four of Virginia's 131 communities are designated health professional shortage areas or medically underserved areas. As primary care providers in rural areas, NPs are subject to the same financial disincentives to practice which plague physicians - lower Medicare reimbursements for larger Medicare populations, more self-pay, Medicaid, and indigent patients than urban

practices, and higher professional expenses. The solutions for increased access to high quality, cost-effective care for these Virginians extend far beyond direct reimbursement to nurse practitioners.

Options for Consideration:

(1) Maintain the current system of reimbursement to nurse practitioners under their collaborating physicians' provider numbers
(2) Introduce legislation to add primary care nurse practitioners to the list of mandated providers for health insurance reimbursement
(3) In association with current physician payers, develop a method for collecting data on the numbers of patients seen by NPs and the types of services provided

Regulatory/Operational Barriers

Discussion of these barriers is classified by regulating or administrating agency or department:

Department of Health Professions

Virginia Needs An Appropriate Definition of "Collaboration" and Other Terms Affecting Interdependent Health Care Practices

Pursuant to the request of SJR 164, the Committee of the Joint Boards of Nursing and Medicine has developed an appropriate definition of "collaborative practice" between advanced practice nurses and physicians. Many concerns have been expressed about the regulatory requirement of physician supervision for NP practice. Advanced practice nurses cite this requirement as a major disincentive for physicians to collaboratively practice with them (an employment barrier) and for insurance companies to reimburse them for their services (a financial barrier). In response, this committee has re-evaluated the current regulatory definition and requirement of "supervision" for advanced nursing practice, as well as other terms affecting interdependent practice between NPs and physicians. The Joint Boards of Nursing and Medicine have passed revised regulatory language and will be publishing these changes for public comment.

Options for Consideration:

* options will be developed after the Joint Boards of Nursing and Medicine make their recommendations.

Department of Medical Assistance Services

Current Virginia Medicaid Policy Reimburses Only Family and Pediatric Nurse Practitioners

Current Medicaid policy allows nurse practitioners to obtain provider numbers and receive reimbursement at 100% of payment schedule for their services. Provider status is limited to family and pediatric NPs only. The AHEC Nursing Task Force Study identified this limitation as a barrier and recommended changing state policies in the DMAS "to be consistent with the federal Medicaid intent allowing reimbursement to all NPs providing services to families and children." Presumably, this change would increase the numbers of Medicaid providers and enhance access to primary care services for this population of patients.

Of the 611 licensed FNPs and PNPs in Virginia who could potentially qualify as Medicaid providers, only 50 (8.2%) have received Medicaid provider numbers. This is felt to reflect the large numbers of these NPs in salaried positions billing under physician providers numbers, as well as their exclusion from the Medallion program (discussed below).

Options for Consideration:

(1) Maintain the current Medicaid policy
(2) Consider amending Medicaid policy to reflect federal intent to reimburse all NPs providing services to families and children

Nurse Practitioners Cannot Be Primary Care Providers for the Medallion Program

At this early stage, the Medallion managed care program for Medicaid clients has limited its primary care provider group to physicians. Addition of primary care mid-level providers may occur as the program becomes more established. Because of the large numbers of young women and children who will be covered by Medallion as the program expands throughout the state, exclusion from provider status for primary care NPs effectively excludes them from billing for services to a significant number of their patients who are currently Medicaid recipients.

Options for Consideration:

(1) Maintain the current Medicaid policy
(2) Request the Department of Medical Assistance Services to examine the fiscal impact of including primary care NPs as Medallion providers

Department of Health

The Virginia Department of Health is a large employer of NPs, utilizing their training and expertise to provide primary care services in local health departments. Current figures show that approximately 30% of NP positions at the local level are vacant. Lack of a staff NP decreases the range of primary care services that the local department is able to provide. This difficulty with recruitment and retention is generally attributed to the availability of more attractive employment opportunities and salaries in the private sector. Currently, the VDH and the Department of Personnel and Training are piloting innovative solutions for filling these vacant local health department jobs in medically underserved areas. These efforts include matching private sector salary offers and securing positions for health department nurses who wish to pursue NP training.

Options for Consideration:

(1) Support VDH and DPT development of innovative solutions to the problems with recruitment and retention of NPs to local health department jobs in medically underserved areas of the state

Department of Personnel and Training

At this time, the Virginia state employee health benefits program (Key Advantage) does not recognize NPs as primary care providers and does not reimburse directly for their services. The level of demand for this coverage is unknown.

Options for Consideration:

(1) Maintain current designation of primary care providers
(2) Request the Department of Personnel and Training to evaluate the feasibility of the Key Advantage health benefits program providing coverage for NP primary care services

Financial Barriers

Currently There are Numerous Financial Barriers to Expanded NP Practice in Virginia

NPs face numerous financial barriers to practice in Virginia:

- lower Medicare reimbursement than physicians receive
- Medicare reimbursement for office visits in rural areas only
- limitations on Medicaid provider status (family and pediatric NPs only)
- exclusion from Medallion provider status
- exclusion from Key Advantage provider status
- exclusion from provider status for most managed care plans
- lack of reimbursement from most commercial insurers
- lack of reimbursement from most self-funded insurance plans

Inclusion of NPs as statutorily mandated providers would only require direct reimbursement on commercial insurance products - those products regulated by the state. It would not impact Medicare and Medicaid reimbursement limitations nor affect these other barriers. Clearly, the solutions to NP financial barriers are more numerous than mandated direct reimbursement. Options for state-controlled solutions have been suggested in earlier sections of this paper.

Rural and underserved areas of the state cannot compete for NP recruitment with urban and suburban employment opportunities.

With the increasing emphasis on primary care in managed care settings, the more attractive employment opportunities and higher salaries for NPs are located in the areas of highest managed care penetration - urban and suburban settings - largely in physician group practices with middle or upper middle class patients. The rural and underserved portions of the state are at a distinct recruitment disadvantage in both private and public practice settings. Several of the state's 34 community and migrant health centers as well as the VDH have unfilled staff NP positions.

The AHEC Nursing Task Force Report suggested several innovative financial strategies to enhance recruitment of NPs to underserved areas, including a loan repayment program similar to that for physicians, a $1,500 Medically Underserved State Tax Credit for primary care providers, and salary and /or reimbursement differentials for NPs practicing in underserved areas. Recruitment and retention of health care providers, including NPs and physicians, to underserved areas will be the focus of Virginia's recently received Practice Sights grant from the Robert Wood Johnson Foundation.

Options for Consideration:

(1) Maintain the status quo
(2) Examine the feasibility of state-sponsored incentives to practice in underserved areas

Educational Barriers

Major educational barriers to the expansion of NP practice include costs of tuition for educational programs and lack of experience working with physicians and medical students in the educational environment.

State Scholarship Funding for NP Education is Inadequate to Cover Tuition Costs

According to the AHEC Nursing Task Force Report, three major barriers with the state scholarships have been noted, and have resulted in difficulty placing the awards. In 1993, there were 14 applications for these scholarships; 8 awards were made to get 5 acceptances. The problems with these scholarships include:

a. the amount of $5,000 per year is not sufficient to cover tuition costs of $8,000 - 11,000;
b. the requirement of payback service in a medically underserved area is a disincentive to some applicants;
c. the triple payback penalty for failure to fulfill the service obligation is too severe.

These service requirements and default penalties for these scholarships are the same as for the other categories of state scholarships.

Options for Consideration:

(1) Maintain the status quo
(2) Increase scholarship amounts to cover full tuition costs for NP educational programs in the state

Collaborative training of medical students and nurse practitioner students would foster improved working relationships and promote knowledge of each other's professional roles and education.

Nationally, few programs are collaboratively training nurse practitioners and physicians. Innovative solutions which provide joint curricular and clinical

experiences are needed to encourage good working relationships between these groups of providers. Research shows that the greatest resistance to collaborative practice comes from physicians who have never worked with a nurse practitioner. (17) Co-training and academic models for collaborative practice would provide knowledge about and experience with each group's attributes and would promote collegial practice after training, thus surmounting both a professional attitudinal barrier and an employment barrier for NPs.

Options for Consideration:

(1) Provide support for collaborative training models for physicians and nurse practitioners in the state academic medical centers

Public and Professional Barriers

Public and professional barriers to the expansion of NP practice include limited knowledge and uninformed attitudes of physicians and limited knowledge and uninformed attitudes among the public, both of which lead to unsubstantiated concerns for public safety.

Lack of Knowledge By the General Public About NP's Professional Roles Is the Most Frequently Experienced Barrier for NPs

According to a December 1992 survey, lack of knowledge by the general public about their professional roles was the most frequently experienced barrier for NPs. (23) Patients who see NPs and are familiar with their services are generally pleased with the care they receive. Anecdotal evidence from rural settings in which NPs are working within their full scope of practice demonstrate high patient and colleague satisfaction, an increase in the amount of preventive health care and patient education provided, and a decrease in waiting time for both acute and preventive services. Clearly, the optimal practice model is one of a cooperating team of physicians and nurse practitioners, each working to the full extent of their education and expertise, providing high quality, efficient, cost-effective care for their patient population.

Physician Resistance to Collaborative Practice is a Major Barrier to the Expanded Utilization of NPs

Physician resistance is cited as a major professional barrier to expanded utilization of NPs, especially in rural and underserved areas. Because of the regulatory burdens discussed previously, as well as the sparse distribution of physicians in some areas, finding a physician with whom to collaboratively

practice may be impossible in the most underserved remote areas of the state. These areas tend to have very few, overworked physicians, often in solo practice, who may find the expense of employing a NP prohibitive and fear the added time burdens involved with supervising another professional's practice. Research indicates that physicians who have had direct experience with nurse practitioners are more supportive of their practice and comfortable in the role of collaborator/supervisor.

One point relevant to this issue of physician resistance would be the impact, if any, of NP collaboration on medical malpractice premiums. Because direct reimbursement does not materially alter the liability relationship between the nurse practitioner and collaborating physician, there should be no significant increase in malpractice premiums for the NP or for the collaborating physician.

Lack of Knowledge About the Professional Roles of NPs Promotes Unsubstantiated Concerns for Public Safety

There is no evidence to support fears that NPs have inadequate education and experience for the level of services they provide within their defined scope of practice. Successful malpractice suits against nurse practitioners are extremely rare, and there have been only two complaints to the Virginia Joint Boards of Nursing and Medicine requiring action against NPs.

The 1986 Office of Technology Assessment study "Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis," while noting the inherent problems of comparing quality of nurse practitioner care with physician care, concluded that "the quality of care provided by NPs functioning within their areas of training and expertise tends to be as good as or better than care provided by physicians." NPs "appear to have better communication, counseling, and interview skills" than physicians and were noted to be "especially good at assisting ambulatory patients with chronic problems such as hypertension and obesity." "Physicians, however, appear to provide better care in managing problems that require technical solutions." (17) Clearly, each profession has specialized education, skills, and expertise. Physicians and nurse practitioners working together can provide a broad range of safe, comprehensive, cost-effective health care services for the greatest number of patients.

Options for Consideration:

(1) Maintain status quo
(2) Provide support for various educational programs to enhance: (a) the public's understanding of the roles of NPs in primary health care provision, (b) physicians' understanding of the roles of NPs in practice settings, and (c) collaborative training which will give physicians early and lengthy exposure to NP practice
(3) Support for an in-depth discussion of these professional barrier issues in a statewide conference or forum format

CONCLUSION

Nurse practitioners are key members of the health care team, providing and promoting cost-effective, high quality health care services for the citizens of Virginia. Their service is underutilized by our present system of care and its value is under-recognized by our present system of reimbursement. Several barriers to optimum NP practice exist: supervision requirements, reimbursement limitations, educational financing and access, and, perhaps most important, cceptance by the public and by physician colleagues. The solutions to these problems are complex and multi-faceted. One purpose of this paper has been to examine these barriers and suggest possible state interventions that would minimize their effects, thus expanding and promoting the use of nurse practitioners in the provision of primary care services for the citizens of Virginia.

APPENDIX A

SENATE JOINT RESOLUTION NO. 164

Requesting the Joint Commission on Health Care to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners.

Agreed to by the Senate, February 14, 1994

Agreed to by the House of Delegates, February 25, 1994.

WHEREAS, in order to provide cost-effective, accessible, quality, health care it is necessary to coordinate teams of health-care practitioners in all delivery settings; and

WHEREAS, relationships between and among members of regulated health occupations and professions are governed by statute and regulations which define terms, such as "collaboration," that affect interdependent health-care practices; and

WHEREAS, national studies and studies in the Commonwealth, including studies conducted by the Area Health Education Center Nurse Task Force, have identified barriers to cost-effective care that are created or fostered by these regulatory definitions and relationships; and

WHEREAS, nurse practitioners in the Commonwealth are regulated by the Joint Boards of Medicine and Nursing within the Department of Health Professions; and

WHEREAS, the Joint Commission on Health Care is charged to "study, report and make recommendations on all areas of health-care provision, regulation, insurance, liability, licensing, and delivery of health-care services"; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be requested to study the strategies and incentives necessary to promote cost-effective health care delivery by making optimum use of nurse practitioners within the Commonwealth. The study shall specifically address: (i) the extent to which, if any, existing statutes and regulations governing nurse practitioners create barriers to cost-effective care; and (ii) the social and financial impact and medical efficacy of direct reimbursement to nurse practitioners, as well as the effect such reimbursement would have on access to primary health-care services in the Commonwealth.

The Joint Boards of Medicine and Nursing, the Area Health Education Centers program and other related public and private agencies and associations representing the affected health-care professions shall be requested to provide support to the commission in carrying out this study. Pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.), the Joint Boards of Medicine and Nursing be requested to promulgate proposed appropriate definitions of the term "collaboration" and other terms affecting interdependent health-care practices that describe and govern the relationship between physicians and nurse practitioners. By October 1, 1994, the joint boards shall report to the Joint Commission on Health Care on the progress in developing such definitions.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 7: Optimum Use of Nurse Practitioners

Draft Issue Brief 7 provided background information on the current status and utilization of nurse practitioners in Virginia. The brief then identified and discussed the major barriers influencing advanced nursing practice and its impact on primary care services in Virginia. These barriers were categorized as:

Statutory
Regulatory/Operational
Financial
Educational
Public and Professional

Policy options for consideration were presented following the discussion of individual barriers.

Written comments were received from sixteen interested parties: five nursing organizations in the state [Virginia Chapter of American College of Nurse-Midwives (ACNM), Virginia Nurses Association (VNA), Virginia Association of Nurse Anesthetists (VANA), Virginia Organization of Nurse Executives (VONE), and Virginia Council of Nurse Practitioners (VCNP)], two medical organizations [Medical Society of Virginia (MSV) and Virginia Academy of Family Physicians (VAFP)], two state schools of nursing [University of Virginia (UVA) and Medical College of Virginia (MCV)], the state Board of Health, the state Secretary of Health and Human Resources, Planned Parenthood, one health insurance provider (HealthPlus), one practicing nurse practitioner, one private practice Certified Registered Nurse Anesthetist (CRNA), and one private Family Practice physician.

A brief summary of the comments on each issue is provided below. This is followed by a summary of specific comments by each individual and organization.

Summary of Comments by Issue

ISSUE 1 - Supervision of Nurse Practitioner Prescriptive Authority

Options for consideration on this issue were:
(1) maintain the current ratios (1:2 private, 1:4 public) and site visit requirements;
(2) reconsider the physician-to-nurse practitioner ratios for prescribing supervision in private practice settings; and
(3) reconsider the statutory requirements for periodic site visits by supervising physicians.

COMMENTS:

Option (2) was supported specifically by four nursing-related respondents and the Secretary of Health and Human Resources. An additional two nursing-related respondents voiced support for the upcoming 1995 regulatory review of nurse practitioners prescriptive authority. Option (3) was supported by three nursing-related respondents and Planned Parenthood. Both options were opposed by the Medical Society of Virginia (MSV), HealthPlus, and the private family physician. The other respondents were silent on this issue.

ISSUE 2 - Mandated Provider Status for Nurse Practitioners

Options for consideration on this issue were:
(1) maintain the current system of reimbursement to nurse practitioners under their collaborating physicians' provider numbers;
(2) introduce legislation to add primary care nurse practitioners to the list of mandated providers for health insurance reimbursement; and
(3) in association with current physician payers, develop a method for collecting data on the numbers of patients seen by nurse practitioners and the types of services provided.

COMMENTS:

Eight respondents (seven nursing-related groups or individuals and Planned Parenthood) specifically supported option (2). The VCNP and both schools of nursing also supported option (3). The MSV, HealthPlus, and the private family physician supported option (1), maintenance of the status quo.

ISSUE 3 - Definition of Collaborative Practice

Options for consideration on this issue will be developed after the Joint Boards of Nursing and Medicine make their recommendations. Their preliminary report for the Joint Commission on Health Care is planned for October 1, 1994.

Several responding organizations expressed their involvement with the Joint Boards committee. The MSV and the VAFP expressed support for the adoption of specifically worded definitions, as outlined in their organizational summaries below.

ISSUE 4 - Medicaid Reimbursement Policy

Options for consideration on this issue were:
(1) maintain the current Medicaid policy; and
(2) consider amending Medicaid policy to reflect federal intent to reimburse all nurse practitioners providing services to families and children.

COMMENTS:

Option (2) was supported by six nursing-related respondents, the Secretary of Health and Human Resources, and Planned Parenthood. Option (1) was supported by the MSV.

ISSUE 5 - Medallion Primary Care Provider Status

Options for consideration on this issue were:
(1) maintain the current Medicaid policy; and
(2) request the Department of Medical Assistance Services to examine the fiscal impact of including primary care nurse practitioners as Medallion providers.

COMMENTS:

Option (2) was supported by five nursing-related respondents and Planned Parenthood. Option (1) was supported by the MSV.

ISSUE 6 - Recruitment and Retention of Nurse Practitioners in Local Health Departments

The sole option for consideration on this issue was support for the Virginia Department of Health (VDH) and the Department of Personnel and Training (DPT) development of innovative solutions to the problems with recruitment and retention of nurse practitioners to local health department jobs in medically underserved areas of the state. This option was supported specifically by the

state Board of Health and four nursing-related respondents. The other respondents were silent on this issue.

ISSUE 7 - Key Advantage Primary Care Provider Status

Options for consideration on this issue were:
(1) maintain current designation of primary care providers; and
(2) request DPT to evaluate the feasibility of the Key Advantage health benefits program providing coverage for nurse practitioner primary care services.

COMMENTS:

Option (2) was supported specifically by five nursing-related respondents, the Secretary of Health and Human Resources, and Planned Parenthood. Option (1) to maintain the current designation of physicians as primary care providers was supported by the MSV.

ISSUE 8 - Incentives to Practice in Underserved Areas

Options for consideration to this issue were:
(1) maintain the status quo; and
(2) examine the feasibility of state-sponsored incentives to practice in underserved areas.

COMMENTS:

Option (2) was supported by five nursing-related respondents, the state Board of Health, and the Secretary of Health and Human Resources. The other respondents were silent on this issue.

ISSUE 9 - Nurse Practitioner Scholarships

Options for consideration on this issue were:
(1) maintain the status quo; and
(2) increase scholarship amounts to cover full tuition costs for nurse practitioner educational programs in the state.

COMMENTS:

Option (2) was supported specifically by five nursing-related respondents, the state Board of Health, and the Secretary of Health and Human Resources. Option (2) was supported generally by the MSV as well.

ISSUE 10 - Collaborative Training for Physicians and Nurse Practitioners

The sole option for consideration on this issue was provision of support for collaborative training models for physicians and nurse practitioners in the state academic medical centers. Nine respondents, including the MSV, the state Board of Health, the Secretary of Health and Human Resources, Planned Parenthood, and five nursing-related respondents, specifically supported this option. The Secretary of Health and Human Resources and the ACNM called for the establishment of a Certified Nurse Midwifery program in Virginia.

ISSUE 11 - Educational Programs and Discussion of Public and Professional Barriers to Nurse Practitioner Practice

Options for consideration on this issue were:

(1) maintain the status quo;

(2) provide support for various educational programs to enhance: (a) the public's understanding of the roles of nurse practitioners in primary health care provision; (b) physicians' understanding of the roles of nurse practitioners in practice settings, and (c) collaborative training which will give physicians early and lengthy exposure to nurse practitioner practice; and

(3) support for an in-depth discussion of these professional barrier issues in a statewide conference or forum format.

COMMENTS:

Options (2) and (3) were supported specifically by three nursing-related respondents and the Secretary of Health and Human Resources. The MSV specifically opposed options (2) and (3), stating the "utilizing state dollars to gain acceptance by the public is not a responsible solution to increase acceptance. . . the Medical Society believes that collaborative training of medical and nurse practitioner students would (be) the best expenditure to foster improved working relationships and to prepare for the formulation of future collaborative practices.."

Summary of Comments by Individual Organization

American College of Nurse-Midwives, Virginia Chapter (ACNM)

Judith S. Castleman, Legislative Liaison, commended the issue brief and specifically supported the following options:

1. reconsidering the physician-to-nurse practitioner ratios and statutory requirement for periodic site visits by physicians supervising the prescriptive authority of nurse practitioners;
2. introducing legislation to add primary care nurse practitioners to the list of mandated providers, and reimbursing at 100% of physician fees;
3. amending Medicaid policy to reimburse all nurse practitioners providing services to families and children;
4. requesting the Department of Medical Assistance Services to examine the fiscal impact of including primary care nurse practitioners as Medallion providers;
5. targeting recruitment of LPNs and RNs from within medically underserved areas for scholarships and incentives to pursue advanced practice nursing education;
6. requesting DPT to evaluate the feasibility of including nurse practitioners as primary care providers under Key Advantage, as "the state employees' plan is a benchmark for other self-insured employers;"
7. examining the feasibility of state-sponsored incentives to practice in underserved areas;
8. increasing scholarship amounts to cover full tuition costs for nurse practitioner educational programs;
9. supporting collaborative training models for physicians and nurse practitioners in the state academic medical centers or community hospitals, including the establishment of a nurse midwifery program in Virginia; and
10. supporting educational programs and in-depth discussion of professional barriers as described.

Commonwealth of Virginia Health and Human Resources

Kay Coles James, Secretary of Health and Human Resources, commented specifically:

1. supporting the increase of the private sector supervision ratio from 1:2 to 1:4 "to allow greater flexibility for nurse practitioner service in underserved areas:"
2. that she has directed the Medicaid program to study "how to more fully support the use of nurse practitioners;"

3. that she has requested DPT to evaluate the feasibility of Key Advantage providing coverage for nurse practitioner primary care services;
4. that "the Practice Sights Initiative will investigate the use of financial strategies to attract and keep nurse practitioners in underserved areas;"
5. in support of additional scholarships for nurse practitioners who agree to practice in underserved areas;
6. in support of the establishment of a nurse midwifery course;
7. in support of collaborative training experiences among physicians and nurse practitioners; and
8. in support of public information about how nurse practitioners provide care.

Commonwealth of Virginia State Board of Health

Diane L. Hanna, Chairwoman of the Board of Health, wrote in support of the issue brief. Citing the provision of available and affordable primary health care for all Virginians as a leading Board of Health priority, she specifically supported:

1. the VDH and DPT development of innovative solutions to nurse practitioner recruitment and retention in local health departments, citing that "both the development of competitive salary scales and securing of positions for health department nurses pursuing nurse practitioner education are critical;"
2. examining the feasibility of state sponsored incentives to practice in underserved areas;
3. integrating nurse practitioners into the Practice Sights program;
4. increasing scholarship amounts to cover full tuition;
5. supporting collaborative models for the preparation and practice of physicians and nurse practitioners in the state academic medical centers; and
6. increasing the capacity of educational programs to prepare nurse practitioners.

Ms. Barbara Dunn, Nurse Practitioner

Ms. Barbara Dunn expressed her general support of those options that require change in the status quo as defined in the issue brief.

L. Trice Gravatte, IV, MD

Dr. Gravatte wrote as a family physician experienced in working with nurse practitioners. Dr. Gravatte expressed support for maintaining current requirements for supervision of nurse practitioners.

HealthPlus (a subsidiary of Sanus, a wholly-owned subsidiary of New York Life Insurance Company)

Denise C. Savage, Manager of Regulatory and Legislative Affairs, commented in favor of maintaining the current regulatory framework for nurse practitioners.

Gene Hensleigh, Certified Registered Nurse Anesthetist (CRNA)

Mr. Hensleigh commented in support of listing CRNAs mandated providers for reimbursement by third party insurance products regulated by the state.

Medical College of Virginia School of Nursing

Nancy F. Langston, Dean, commented in favor of:

1. reconsidering the physician-to-nurse practitioner ratios and statutory requirement for periodic site visits by physicians supervising the prescriptive authority of nurse practitioners;
2. introducing legislation to add primary care nurse practitioners to the list of mandated providers;
3. amending Medicaid policy to reimburse all nurse practitioners providing services to families and children;
4. requesting the Department of Medical Assistance Services to examine the fiscal impact of including primary care nurse practitioners as Medallion providers;
5. the VDH and DPT development of innovative solutions to nurse practitioner recruitment and retention in local health departments;
6. requesting DPT to evaluate the feasibility of including nurse practitioners as primary care providers under Key Advantage;
7. examining the feasibility of state sponsored incentives to practice in underserved areas;
8. increasing scholarship amounts to cover full tuition; and
9. supporting collaborative models for the preparation and practice of physicians and nurse practitioners in the state academic medical centers.

Medical Society of Virginia (MSV)

James A. Shield, MD, President of the MSV, commented that:

1. there is no compelling reason to change the scope of practice of nurse practitioners;
2. the Code of Virginia should be amended to define "collaboration" as the process by which a nurse practitioner works with a physician to deliver health care services within the scope of practice of the nurse practitioner's professional expertise and with medical direction and appropriate

supervision, consistent with the jointly prescribed regulations of the Boards of Nursing and Medicine;"

3. responsibility for supervision, as defined in the Code, should remain with the physician;
4. the primary care providers for Medicaid, Medallion and Key Advantage should be physicians;
5. Virginia's patients should always have access to a primary care physician with health care complimented by a nurse practitioner;
6. financial incentives may be required to encourage both physicians and nurse practitioners to practice in underserved areas; and
7. collaborative training of medical and nurse practitioner students should be supported;

Planned Parenthood Advocates of Virginia (PPAV)

PPAV stated its support for the inclusion of certain OB/Gyns as primary care providers. PPAV specifically endorsed:

1. reconsidering the periodic site visit requirements:
2. adding primary care "and primary GYN care" nurse practitioners to the list of mandated providers for health insurance reimbursement;
3. adding "and primary GYN care" to the description of services and amending Medicaid policy to reflect federal intent to reimburse all nurse practitioners providing services to families and children;
4. requesting the Department of Medical Assistance Services to examine the fiscal impact of including primary care "and primary GYN care" nurse practitioners as Medallion providers;
5. with the addition of primary GYN care language, requesting DPT to evaluate the feasibility of providing coverage for nurse practitioner care under Key Advantage; and
6. supporting collaborative training models for physicians and nurse practitioners in the state academic medical centers.

University of Virginia School of Nursing

Jeanette Lancaster, Dean of UVA School of Nursing and Chair of the AHEC Nursing Task Force, wrote in support of:

1. the upcoming 1995 regulatory review of the Rules and Regulations governing prescriptive authority;
2. inclusion of primary care nurse practitioners as mandated providers for health insurance reimbursement;
3. development of a tracking system for nurse practitioner patient data;
4. amending Medicaid policy to reflect federal intent to reimburse all nurse practitioners providing services to families and children;

5. requesting the Department of Medical Assistance Services to examine the fiscal impact of including primary care nurse practitioners as Medallion providers;
6. VDH and DPT development of innovative solutions for recruitment and retention of nurse practitioners to local health department jobs in medically underserved areas of the state;
7. requesting DPT to evaluate coverage for nurse practitioner primary care services under "whatever health program the State supports;"
8. examining the feasibility of state sponsored incentives to practice in underserved areas;
9. increasing scholarship amounts to cover full tuition and fees;
10. collaborative models for the preparation and practice of physicians and nurse practitioners in the state academic medical centers.

Virginia Academy of Family Physicians (VAFP)

Roger Hofford, MD, President-Elect of the VAFP, commented in favor of the following definition of collaboration: "the process by which a nurse practitioner works with a physician to deliver health care services within the scope of practice of the nurse practitioner's professional expertise and medical direction and appropriate supervision, consistent with the jointly prescribed regulation of the Board of Nursing and Medicine."

Virginia Association of Nurse Anesthetists (VANA)

Dean C. Weil, President-Elect of the VANA, wrote in support of inclusion of CRNAs under Mandated Provider Status in Code of Virginia sections 38.2-3408 and 38.2-4221 and legislation mandating Medicaid payment to CRNAs.

Virginia Council of Nurse Practitioners (VCNP)

Nancy S. Harvey, President of the VCNP, specifically supported:
1. the upcoming 1995 regulatory review of the Rules and Regulations governing prescriptive authority;
2. inclusion of primary care nurse practitioners as mandated providers for health insurance reimbursement;
3. development of a tracking system for nurse practitioner patient data;
4. amending Medicaid policy to reflect federal intent to reimburse all nurse practitioners providing services to families and children;
5. requesting the Department of Medical Assistance Services to examine the fiscal impact of including primary care nurse practitioners as Medallion providers;

6. VDH and DPT development of innovative solutions for recruitment and retention of nurse practitioners to local health department jobs in medically underserved areas of the state;
7. requesting DPT to evaluate coverage for nurse practitioner primary care services under Key Advantage;
8. examining the feasibility of state sponsored incentives to practice in underserved areas;
9. increasing scholarship amounts to cover full tuition;
10. collaborative models for the preparation and practice of physicians and nurse practitioners in the state academic medical centers; and
11. public educational opportunities and in-depth discussions as described in the issue brief.

Virginia Nurses Association (VNA)

Mark E. Rubin, on behalf of VNA, wrote in support of:

1. reconsidering the physician-to-nurse practitioner ratios and site visit requirements, suggesting that these should be removed from statute and placed in the regulations, thus allowing "the standards to be more responsive to the changing health care environment and individual practice site circumstances;"
2. introducing legislation to add primary care nurse practitioners to the list of mandated providers for health insurance reimbursement;
3. amending Medicaid policy to reimburse all nurse practitioners who provide services to children and families;
4. including primary care nurse practitioners as Medallion providers;
5. including nurse practitioners as primary care providers under Key Advantage;
6. extending to nurse practitioners the same incentives to practice in rural and underserved areas that the state has created for physicians;
7. increasing the state scholarship fund to parallel those incentives for primary care physicians;
8. supporting collaborative educational models; and
9. supporting educational opportunities and in-depth discussions as described in the issue brief.

Virginia Organization of Nurse Executives (VONE)

Elizabeth Woodard, Chair of the VONE Legislative Committee, commented in support of modifying physician supervision requirements by eliminating the restriction on the number of nurse practitioners to be supervised by a physician, and by examining the potential of treatment protocols or practice guidelines for the nurse practitioner and physician supervisor.

APPENDIX C

STATES WHICH MANDATE OR PROHIBIT DISCRIMINATION IN DIRECT REIMBURSEMENT TO NURSE PRACTITIONERS

1. Arizona
2. Colorado
3. Connecticut
4. Delaware
5. Hawaii
6. Kansas
7. Maryland
8. Michigan
9. Minnesota
10. Mississippi
11. Missouri
12. Nevada
13. New Hampshire
14. New Jersey
15. New Mexico
16. New York
17. North Carolina
18. North Dakota
19. Oregon
20. Pennsylvania
21. Rhode Island
22. Utah
23. Washington
24. West Virginia
25. Wyoming

APPENDIX D

The 1990 Virginia Health Planning Board Report ***"Alternative Providers in Medically Underserved Areas"*** recommended:

(1) the expanded utilization of mid-level providers in local health departments;
(2) the implementation of innovative primary care models;
(3) an increased effort to educate physicians about the roles and benefits of utilizing mid-level providers in primary care practices; and
(4) financial incentives to mid-level providers to locate in medically underserved areas.

In response to this study, Virginia established its Nurse Practitioner state scholarship program, which provides five $5,000 scholarships per year for NP students who agree to practice in a medically underserved area of the state upon completion of their educational program.

The Department of Health Professions put forth its ***"Report of the Task Force on Practice of Nurse Practitioners: Access and Barriers to the Services of Nurse Practitioners"*** in January 1991. This report examined the various regulatory structures for advanced nursing practice and affirmed "the joint (Board of Nursing and Board of Medicine) regulatory program, including supervision and protocol requirements, and practice within special boundaries, as the appropriate mechanism" for Virginia. This report also recommended that the Committee of the Joint Boards "consider the need for definition and delineation of the scopes of practices of nurse anesthetists, nurse midwives, and primary care nurse practitioners in regulations promulgated by the two boards."

Pursuant to 1991 House Joint Resolution 431, the Department of Health Professions and the Virginia Health Planning Board authored 1992 House Document 12 on ***"The Potential for the Expansion of the Practice of Nurse Midwives."*** This report identified several barriers to the practice of nurse-midwifery in Virginia:

(1) lack of direct third party reimbursement by private insurers;
(2) difficulty finding a collaborating physician;
(3) difficulty obtaining hospital privileges;
(4) affordability of malpractice insurance; and
(5) lack of a nurse-midwifery education program in Virginia.

The issue of direct third party reimbursement was studied by the Special Advisory Commission on Mandated Benefits (see below). Two educational institutions, Medical College of Virginia and Shenandoah University, are currently considering the development of a nurse-midwifery education program.

House Document 38 (1993) was the ***Special Advisory Commission on Mandated Health Insurance Benefits Report on House Bill 1089 (1992): Direct Reimbursement to Certified Nurse-Midwives.*** The Special Advisory Commission recommended that HB 1089 revising the Code of Virginia to require direct reimbursement by third party payers to certified nurse midwives <u>not</u> be enacted. In its

review of the social and financial impact and medical efficacy of this issue, the Commission found that "mandating direct reimbursement has not been determined to be an effective or necessarily appropriate means of encouraging expansion of the practice of certified nurse-midwives, and therefore, increasing access to care."

Senate Joint Resolution 343 (1993) requested the Virginia Statewide Area Health Education Centers to (a) identify strategies to increase the supply of nurse practitioners and reduce practice barriers in rural and underserved areas, and (b) develop cooperative relationships with schools of medicine to educate nurses and physicians for collaborative practice partnerships. ***"Advance Practice Nursing: Meeting the Primary Health Care Needs of Virginians"*** (November 1993) was the AHEC Nursing Task Force's report to the Joint Commission on Health Care. This report enumerated the following strategies:

(1) expansion of educational support for advanced practice nursing training:
- establish a loan repayment program for NPs and CNMs;
- increase current scholarships for NP education to $10,000 each and increase the number from five to twenty-five;
- establish five $10,000 scholarships for nurse midwifery training;

(2) establishment of ten $1,500 Medically Underserved Tax Credits (state tax credits) for primary care providers practicing in state-designated, medically underserved areas;

(3) statutory prohibition of discrimination against NPs, CNMs, and other nonphysician providers for services that are currently reimbursed if provided by physicians;

(4) designation of NPs and CNMs as primary care providers under all health insurance plans;

(5) establishment of salary and/or reimbursement differentials for NPs and CNMs practicing in underserved areas;

(6) provision of incentive payments (12 @ $5,000) to physicians who collaboratively practice with a NP or CNM;

(7) provision of a tax incentive for physicians who allow NPs and CNMs to charge at the lower designated rates for Medicare and Medicaid;

(8) inclusion of NPs and CNMs in any state-related primary care initiatives;

(9) review by the Committee of the Joint Boards for the Licensure of Nurse Practitioners of barriers related to titling, scope of practice, supervising relationships with physicians, and prescriptive authority;

(10) application for waivers of federal requirement under Medicare and Medicaid which interfere with the optimal use of NPs and CNMs, particularly in rural and other medically underserved areas;

(11) changing state policies in the Department of Medical Assistance Services to be consistent with the federal Medicaid intent allowing reimbursement to **all** NPs providing services to families and children (not current limitation to family and pediatric NPs);

(12) development of strategies to improve recruitment and retention of nurse practitioners in the Virginia Department of Health;

(13) creation of a state class code position for CNMs;

(14) authorization and funding for the Department of Health Professions Board of Nursing and Bureau of Health Statistics to develop a Nursing Workforce Database;

(15) development of innovative educational recruitment programs for minority and other disadvantaged students;

(16) increase collaborative, multidisciplinary ("co-training") efforts in Schools of Nursing and Medicine;

(17) establishment of a NP Program Consortium under the auspices of the AHEC Nursing Task Force;

(18) examination and re-allocation of resources within the health sciences centers to increase the capacity of existing NP programs 10 percent/year until current capacity is increased by 50% by the year 2000;

(19) development of a strategic plan to provide additional resources for the expansion of primary care NP programs;

(20) establishment of midwifery services at each of the academic health sciences centers;

(21) provision of incentive payments to primary health care providers who precept NP students;

(22) development of a public information and education program about the effective use of NPs and CNMs;

(23) development of a consultation/technical assistance service to provide information to entities considering the development of collaborative interdisciplinary practices;

(24) establishment of a primary care task force to develop policy and recommend strategies across disciplines, organizations, and AHEC;

(25) establishment of a staff position in the Statewide AHEC office to coordinate implementation of SJR 343.

APPENDIX E

REFERENCES

1. Bureau of Insurance, Mandated Benefits: Nurse, Nurse Midwife, Nurse Practitioner, unpublished search, Richmond, Virginia, July 1994.

2. DeAngelis, Catherine D., MD, "Nurse Practitioner Redux." Journal of the American Medical Association 271(11):868-871, March 16, 1994.

3. Department of Health Professions, Board of Nursing Statutes and Regulations, Richmond, Virginia, July 1993.

4. Department of Health Professions, Board of Nursing, unpublished data on Categories of Licensed Nurse Practitioners, May 17, 1994.

5. Department of Health Professions, Board of Nursing, unpublished data on Nurse Practitioners with Prescriptive Authority by County or City, August 1, 1993.

6. Department of Health Professions, Report of the Task Force on the Practice of Nurse Practitioners - Access and Barriers to the Services of Nurse Practitioners, Richmond, Virginia, January 1991.

7. Department of Health Professions and the Virginia Health Planning Board, The Potential for Expansion of the Practice of Nurse Midwives, House Document No. 12, Richmond, Virginia, 1992.

8. Joint Commission on Health Care, Annual Report, Senate Document No. 60, Richmond, Virginia, 1994.

9. Kassirer, Jerome P. MD, "What Role for Nurse Practitioners in Primary Care?," The New England Journal of Medicine 330(3):204-205, January 20, 1994.

10. McGrath, Susan, M.S., "The Cost-Effectiveness of Nurse Practitioners," Nurse Practitioner 15(7):40-42, July 1990.

11. Meehan, Joan, "Consumers Willing to See a Nurse for Routine 'Doctoring', "The American Nurse, October 1993.

12. National Council of State Boards of Nursing, 1992 Licensure and Examination Statistics, pages 21-22.

13. North Carolina Statutes, Chapter 347, Sections 58-50-25, 58-50-30, 58- 65-1, and 58-65-35, effective October 1, 1993.

14. Pearson, Linda J., F.N.P., "Annual Update of How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice," Nurse Practitioner 19(1):11-53, January 1994.

15. Safriet, Barbara J., "Health Care Dollars and Regulatory Sense: The Role Advanced Practice Nursing," Yale Journal on Regulation 9(2):417-488, Summer 1992.

16. Special Advisory Commission on Mandated Health Insurance Benefits, House Bill 1089 (1992): Direct Reimbursement of Certified Nurse Midwives, House Document No. 38, Richmond, Virginia, 1993.

17. U.S. Congress, Office of Technology Assessment, Health Technology Case Study 37 - Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A policy Analysis, Washington, D.C., December 1986.

18. Virginia Academy of Family Practice, unpublished survey, Richmond, Virginia, November 1993.

19. Virginia Health Planning Board, Alternative Providers in Medically Underserved Areas, Richmond, Virginia, 1990.

20. Virginia Hospital Association, 1994 Workforce Study, unpublished data, July 1994.

21. Virginia Hospital Research and Education Foundation on behalf of Health Care Workforce 2000, Barriers to Expanded Utilization of Health Care Practitioners, Richmond, Virginia, January 21, 1994.

22. Virginia Statewide AHEC Nursing Task Force, Advance Practice Nursing: Meeting the Primary Health Care Needs of Virginians, Richmond, Virginia, November 1993.

23. Washington Consulting Group, Survey of Certified Nurse Practitioners and Clinical Nurse Specialists: December 1992, Washington, D.C., 1992.

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