POLICYMAKERS, RESEARCHERS, and healthcare providers have reached a consensus that advanced practice registered nurses such as nurse practitioners (NPs) can significantly contribute to the alleviation of the major quality, access, and cost challenges facing our healthcare system. The National Academy of Medicine’s (NAM) landmark report, Future of Nursing: Leading Change, Advancing Health, which was published in October 2010, concluded that optimal utilization of NPs could transform the U.S. healthcare system and increase patients’ access to timely high-quality, cost-effective, patient-centered care (Institute of Medicine, 2010). However, despite this consensus and the fact NPs have been delivering primary care for decades, little is known about how to better utilize NPs as primary care providers and maximize their contributions to the national health policy goals.

The NP workforce is expected to grow by 93% between 2013 and 2025 and constitutes the fastest growing workforce of primary care providers (U.S. Department of Health and Human Services, 2016). However, many barriers at federal, state, and organizational levels affect the ability of this workforce to care for the American public in a safe and cost-effective manner. A wide range of organizations including the Federal Trade Commission (FTC, 2014), NAM, and National Governors Association (NGA, 2012) have all recommended removing barriers on NP practice to effectively utilize them in our healthcare system and assure optimal care delivery to the American public, particularly for the underserved who lack timely, high-quality, safe primary care. Elimination of these barriers at federal, state, and organizational levels can maximize contributions of the NP workforce to creating a high-functioning healthcare system and accomplishing important national health policy goals.

Policies Limiting NPs’ Contributions to Critical National Health Reforms

Outdated federal policies affect the day-to-day practice of NPs and potentially prevent accountable and safe care. For example, disparate reimbursement rates by Medicare for physicians and NPs (NPs are reimbursed at 85% the Physician Fee Schedule for the same services) incentivizes primary care practices to bill for NP services under the physician’s name. While this billing practice is financially beneficial for healthcare organizations as they will receive higher reimbursement if the care that is delivered by an NP is billed under a physician National Provider Identifier, such practice prevents accountability by not producing tracking data in Medicare claims about the care provided by NPs. Furthermore, it gives NPs “invisible provider” status and makes it difficult to measure the quality of NP care and link it to patient outcomes, a necessary step for performance reviews (Poghosyan et al., 2013).

Similarly, despite the fact NPs are now the largest type of healthcare providers delivering home care and cover the largest geographical service area (Yao, Rose, LeBaron, Camacho, & Boling, 2017), federal regulations still require physicians to sign NP orders in order for them to be valid. Furthermore, these restrictions do not allow NPs to order or authorize home health care even though they deliver face-to-face care to patients. In 2013, about 3,300 NPs performed over 1.1 million home and domiciliary care visits, accounting for 22% of all residential visits to Medicare fee-for-service beneficiaries (Yao et al., 2017). The growing workforce of NPs can play a major role in caring for the elderly, especially those with
multiple chronic diseases receiving home healthcare services. Regulatory advocacy is needed to remove the barriers between NPs and patients receiving home care.

In addition to federal restrictions, states also create additional barriers for NPs. Despite the uniformity in NPs’ educational preparation across the country, there is a variation in state-level scope of practice regulations, which determine the type and breadth of services NPs can provide. Currently, 22 states and the District of Columbia allow NPs to practice independently from physicians (Robert Wood Johnson Foundation, 2017). Twenty-nine states, however, impose a restriction on NPs by requiring them to have supervisory or collaborative relationships with physicians to deliver care. The NAM report made it clear that such laws and policies that prevent NPs from delivering care to the fullest extent of their training and education do not serve the needs of the American public. Contrary, they create barriers between these highly qualified healthcare providers able to deliver care and millions of Americans needing their care. Policy organizations (FTC, 2014; NGA, 2012) criticize care and millions of Americans needing their care. Evidence is available regarding attributes of organizational interventions to improve patient care and outcomes and reduce costs.

One study showed physicians receive support in primary care practices from medical assistants in care delivery, whereas NPs lacked such staff support in these same practices (Poghosyan, Nannini, Stone, & Smaldone, 2013). This lack of support led to NPs taking on tasks typically delegated to medical assistants or registered nurses, which is an underutilization of NPs’ advanced skills and competencies. In a subsequent study, researchers found cost of serving a patient can be reduced 9%-12% if medical assistants are hired to support NPs in care delivery (Liu, Finkelstein, & Poghosyan, 2014). These findings are fundamental in exposing inefficiencies in care delivery and can have a profound impact on guiding management and resource allocation in primary care practices. The findings suggest providing NPs with necessary staff will enable NPs to provide not only more efficient, higher-quality but also more cost-effective patient care. Moreover, they emphasize supporting NP practice is a good investment for patients, NPs, organizations, and payers.

Furthermore, organizational leadership plays a critical role in expanding or restricting NP practice. By collecting data from 163 organizations and using theories from management studies and sophisticated multilevel models, Poghosyan and Liu (2016) found practice managers (often nonphysicians) exert serious constraints on NP practice, potentiality resulting in less-effective and more expensive patient care. These findings expose the extent to which poor relationships negatively affect teamwork. Allowing NPs to practice independently and promoting NP autonomy would not undermine teamwork between physicians and NPs, but rather, bolster it.

This evidence base enhances understanding of the mechanisms by which primary care capacity can be improved through reform of institutional policies and removal of organizational barriers on NPs. These findings also have national implications. In 2016, the U.S. Department of Veteran Affairs (VA) issued a new rule to provide full practice authority to advanced practice registered nurses, including NPs, working in the VA system. This new rule means that even in states where NP care must be supervised by physicians, NPs working in the VA system can independently assess, diagnose, and prescribe medications to their patients while acting within the scope of their VA employment. However, the law gives organizations a right to opt out from the federal policy and emerging evidence shows organizations are doing just that, demonstrating that more than a regulation change is needed to optimally utilize the NP workforce.

Organizational Attributes of Primary Care Practices Employing NPs Are Critical

Not only do federal and state regulatory policies restrict NP practice, but also the organizations employing NPs create barriers and prevent success of health reforms aimed at increasing access, reducing costs, and improving quality in primary care. Evidence is available regarding attributes of organizations employing NPs that should be modified by healthcare administrators through systematic organizational interventions to improve patient care and outcomes and reduce costs.

Comprehensive Reform Is Needed

In 2016, Poghosyan, Boyd, and Clarke developed a comprehensive model to demonstrate the interplay of federal, state, and organizational barriers affecting NPs and mechanisms through which they also affect access to and quality of care, patient outcomes, and NP job dissatisfaction and turnover – critical factors in workforce management (Poghosyan et al., 2016). This model can guide future initiatives to remove artificial barriers on NP practice and maximize the contribution of this critical workforce to our healthcare system.

In conclusion, times have never been so critical for the NP workforce to take a central role in the delivery of primary care and help millions of Americans to have access to high-quality cost-effective primary care. However, comprehensive efforts are necessary to mobilize policymakers, healthcare executives, and clinicians to remove artificial barriers that constrain the potential of this rapidly growing workforce, to maximally utilize their advanced education and training, and help the American public access high-quality safe primary care.
REFERENCES


