Policy Issue and Analysis: Physician Based Model for Delegation of Prescriptive Authority to

Advanced Practice Nurses

NURS 6043: Policy, Power and Politics

Lori Thompson

Texas Woman's University

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Policy Issue: Physician Delegation of Prescriptive Authority

A shortage of physicians has lead to an increase in unmet health care demands, decreased accessibility and patient satisfaction as well as fear that the present system is untenable (Gould & Wasylkwi, 2007). Though advanced practice registered nurses (APRNs) have been in existence for about forty years, they have only recently been considered a possible solution for the physician shortage, potentially increasing access to care and decreasing health care costs (Fould, Johnstone & Wasylkiw, 2007). A major change in health care systems worldwide is the increasing number of APRNs being educated and practicing in primary care (Imgrund, 2008). APRNs provide a holistic approach to health care, caring not only for the patients' current ailment but providing a focus on health promotion, prevention of diseases, and health education in order to allow patients to make better choices in caring for themselves. Research has shown that APRNs provide high quality care with increased efficiency and at a lower cost than physicians leading to the idea that increasing the number of APRNs in private practice will lead to an increase in accessibility to high quality health care at a lower cost.

Policy Problem

Access to health care has reached critical proportions in the state of Texas. Access to a primary health care provider is a major concern as 13% of the population does not have access to a primary health care provider, 90% of the counties are designated, at least partially, as medically underserved areas and 25 counties have no physician at all (CNAP, 2010). As the Texas population continues to grow at the rate of one million every two years the crisis of primary health care providers will only intensify. Advanced Practice Nurses (APRN) are regulated by laws dating back to 1989 regarding physician delegation for prescription authority. These antiquated laws effectively tie APRNs to physicians geographically, preventing APRNs from

being able to work in rural medically underserved areas and further compounding the provider shortage in these areas. Allowing APRNs to be governed solely by the Board of Nursing (BON) and removing regulations requiring physician delegation would allow APRNs the freedom to practice to the full extent of their education and training thereby contributing to the solution of access care for Texans.

Background

The following policy issue analysis will cover background information addressing social, economic, ethical, and political issues. The stakeholders will be identified along with an issue statement and the inclusion of policy objectives and goals. Further, the options and alternatives related to this policy will be discussed at length. The supporting documentation provided includes a copy of SB 532 (Appendix A), Policy Alternative Scorecard (Appendix B), Talking Points (Appendix C) and a Briefing Paper (Appendix D).

Social

Compounding the lack of access to care Texas also has the highest rate of uninsured persons in the nation (CNAP, 2010). An estimated 40 million Americans are uninsured or underinsured and lack access to the healthcare system (Grindel, 2005). This lack of access has lead to the use of emergency departments (EDs) being substituted for unavailable primary care providers by the urban poor; as many as 60% to 80% of ED visits in the United States are for non-urgent or minor medical problems (Carter & Chochinov, 2007). In rural areas this trend is causing an increased strain on an already limited number of physicians working in the ED and forcing many local EDs to limit their hours of availability or close altogether.

Physician shortages combined with the fact that more medical school graduates are choosing more lucrative specialties and forgoing general practice are leaving large gaps in access

to primary care for a growing number of populations. Failing attempts at recruitment and retention of general practice (GP) physicians is leading to a projected shortage of 150,000 doctors by 2025 impacting all specialties (Hedger, 2008). Nurse practitioners have been a proposed solution to easing the shortage of primary care providers. APRNs have achieved high patient satisfaction, in some cases higher than physicians, related to the increased time they spent with patients and by providing more education allowing patients to make more informed health care choices (Laurant et al., 2009).

Economic

Research has demonstrated that APRNs provide high quality, cost effective care with high levels of patient satisfaction confirming that APRNs can competently fill the gaps and improve access to care (Brooten et al., 2002). APRNs have also demonstrated cost savings providing care at a lower cost than physicians and improving the health of their clients by focusing on prevention and health education. By focusing on preventative and primary health care it is estimated that APRNs can decrease overall health care costs by as much as 20% (CNAP, 2010).

In 1980, in response to changes in the health care climate, a group of researchers at the University of Pennsylvania developed the Quality Cost Model of Advanced Practice Nursing Transitional Care to serve as a safety net for fragile patients discharged early from the hospital (Brooten, et al., 2002). This study conducted a review of seven randomized clinical trials using this model, patient outcomes and health care costs in the United States were reviewed over a 22 year period. The model was initially designed to decrease hospitalization for high-risk, high-cost, high-volume groups of patients by substituting nurse practitioner transitional care for a portion of the hospital stay. The random clinical trials reviewed demonstrated a decrease in hospital charges

ranging from 6% to 44% and a 22% decrease in mean physician charges. The Quality Cost Model of APN Transitional Care demonstrated decreased health care costs and reduced hospital readmissions across all groups tested (Brooten et al., 2002). Additionally, the cost to educate one resident is approximately 200,000 dollars; eight APRN's can be educated and trained for the cost of a single physician (CNAP, 2010). Further, 50% of 961 APRNs polled stated that they would very likely work in a medically underserved area in Texas if the requirement of a delegating physician were removed.

Ethical

When considering ethics the terms beneficence, nonmaleficence and justice must be addressed. The principles of beneficence focus on positive steps taken to help others, whereas nonmaleficence is concerned with the obligation of not inflicting harm (Beauchamp & Childress, 2009). The concept of justice focuses on fairness, desert and entitlement interpreted as what is fair, equitable and appropriate treatment in relation to what is due or owed to persons. The question that must be asked is: During a crisis in access to health care should the valuable, qualified resource of trained APRNs not be used the fullest extent of their education and training? In Texas there are over 7,000 trained and experienced APRNs working today but unable to serve the populations who need them the most based on antiquated laws (CNAP, 2010). The Texas legislators should demonstrate beneficence by allowing APRNs to practice to the full extent of their training and education allowing the public to access the safe, high quality care that can be provided by this profession. Nonmaleficence is often associated with the maxim "Above all [or first] do no harm" (Beauchamp & Childress, 2009). Research has repeatedly demonstrated the safety and quality of care provided by APRNs, legislators only have to access this information to feel confident that APRNs will provide safe, high quality care to their

constituents (Brooten et al., 2002). In light of the concept of justice all Texas residents deserve the right to have access to safe high quality care within their own communities. Physicians need to change their thinking and put the needs of the patient's first, setting aside territorial issues and working collaboratively with APRNs in order to best serve the residents of Texas. Legislators should also recognize the abilities and benefits of removing the restrictions from APRNs and act with beneficence, nonmaleficence and justice for their constituents.

Political

Perry, Thurston, Killey and Miller (2005) conducted a study in the United Kingdom (UK) to evaluate the ability of a nurse practitioner to facilitate access to care that met the patients' needs. The results of this study found that group staff members and patients, felt that access had been improved and patients were satisfied with the services they had received. Appointments were made within the forty-eight hour goal and patients were happy with the care provided by the nurse practitioner.

Some restrictions to access were identified through the course of this study: the nurse practitioners inability to perform full prescribing services as well as referrals not being accepted by local secondary care services "because she was a nurse" (Perry et al., 2005) Further, the staff felt that the nurse practitioner should have the autonomy to organize her own workload and undertake professional development on a level equal to the physicians.

Perry et al., (2005) found APRNs capable of widening access to care and becoming the solution to the physician shortage, however until the legislative, bureaucratic and professional obstacles identified in this study are addressed and resolved this solution cannot be fully implemented. A reconfiguring of professional identities is necessary; work previously provided by a physician can now be provided by a nurse practitioner however, physicians may feel it is

important to sustain hierarchical differences and this may explain the reluctance of physicians to relinquish their control over APRNs.

Stakeholders

The stakeholders in this issue include the underserved residents of Texas, ARPNs, physicians, insurance companies, state and federal payer programs and professional health care organizations.

Issue Statement

Considering the lack of access to health care in Texas would advance practice registered nurses (APRNs) in independent practice lead to increased access to care and increased wellness compared to populations without APRNs in independent practice?

Policy Goals and Objectives

To decrease some restrictions on APRNs in order to establish more retail clinics thereby increasing access to affordable delivery of basic health care. The policy objectives are as follows:

- 1. Expands parameters related to delegated prescriptive authority by decreasing the time physicians must be on site from 20% to 10%.
- 2. Increases the distance allowed between the physician's primary site and alternate site from 60 miles to 75 miles.
- 3. Increases the number of APRNs of physician assistants to which a physician my delegate from 3 to 4.
- 4. Authorizes the development and use of electronic options for the delegation registration and review of medical charts.

Policy Options and Alternatives

Alternatives for resolving the issue of access to health care in Texas' medically underserved areas include the following:

- 1. Do Nothing Option: Continue to restrict APRNs as the Texas population continues to grow and the number of primary care physicians continue to decrease.
- 2. Incremental Change Option: Continue to slowly decrease restrictions on APRNs at a slow pace that is regulated by physicians and not the BON.
- 3. Major Change Option: Place the regulation and delegation of prescriptive authority solely under the BON.

Criteria for Evaluation

- 1. Decrease in the number of medically underserved areas in Texas.
- 2. Increased access to basic medical care as well as a focus on health promotion, prevention of diseases, and health education.
- Decrease in health care costs related to preventative care and decreased misuse of emergency departments.
- 4. Political feasibility.

Analysis of option 1: Do Nothing Option: Continue to restrict APRNs as the Texas population continues to grow and the number of primary care physicians continues to decrease.

Criterion 1: Decrease in the number of medically underserved areas in Texas.

Pro: The numbers of APRNs will continue to rise thereby increasing access to care in urban medically underserved areas. There are now collectively more APRN's and Physician's

Assistants (PAs) providing primary care than there are family physicians. (Hansen-Turton, Ryan, Miller, Counts & Nash, 2007).

Con: The people in rural medically underserved areas will continue to lack access to basic health care.

Criterion 2: Increased access to basic medical care as well as a focus on health promotion, prevention of diseases, and health education.

Pro: APRNs will continue to provide basic medical care as well as provide health promotion, preventative services and health education to as many people as they can serve.

Con: Many areas in Texas will not have access to these services.

Criterion 3: Decrease in health care costs related to preventative care and decreased misuse of emergency departments.

Pro: Areas where APRNs help fill the need of access to health care will see decreased costs in health care related to preventative care provided as well as decreased misuse of emergency departments.

Con: Rural areas where APRNs are not able to serve independently will continue to see increases in health care costs related to preventable illness and misuse of emergency departments.

Criterion 4: Political Feasibility.

Pro: There will be no further action taken saving the legislature time and energy to use in another matter.

Con: Many areas of Texas will continue to go without access to basic medical care. In turn, increasing restriction of access to care by limiting public accessibility to a capable profession designed to provide these services (Hansen-Turton et al., 2008).

Analysis of Option 2: Incremental Change Option: Continue to slowly decrease restrictions on APRNs at a slow pace that is regulated by physicians and not the BON.

Criterion 1: Decrease in the number of medically underserved areas in Texas.

Pro: As restrictions decrease the number of rural and medically underserved patients who receive care will increase.

Con: Many counties in Texas will continue to lack access to health care within their communities.

Criterion 2: Increased access to basic medical care as well as a focus on health promotion, prevention of diseases, and health education.

Pro: Patients will increasingly receive preventative care and health education involving them in their care and improving their health choices.

Con: Patients will continue without preventative care and health education leading to a decline in their health as well as the health of their families. Parents will have to travel far from home just to get basic well child care and immunizations for their children.

Criterion 3: Decrease in health care costs related to preventative care and decreased misuse of emergency departments.

Pro: Regular access to medical care will decrease health care costs by improving the health of the population as well as decrease the misuse of emergency departments.

Con: Lack of regular medical care increases the illness of the population and misuse of the emergency departments driving up the cost of health care.

Criterion 4: Political Feasibility.

Pro: Increasing the number of health care providers is beneficial to all Texans and doing so incrementally will allow politicians to experience the quality of care provided by APRNs.

Con: Politicians voting for APRNs and against the Texas Medical board may lose substantial funding.

Analysis of Option 3: Major Change Option: Place the regulation and delegation of prescriptive authority solely under the BON.

Criterion 1: Decrease in the number of medically underserved areas in Texas.

Pro: APRNs will be free to go in to rural areas of Texas and practice to the full extent of their education and training. APRN graduates enter primary care practice at a rate of approximately 80% (Hansen-Turton et al., 2008).

Con: Texas Medical Board is a powerful organization with influential lobbyists who will fight to prevent this type of legislation.

Criterion 2: Increased access to basic medical care as well as a focus on health promotion, prevention of diseases and health education.

Pro: Ending site-based delegation of prescriptive authority and supervision for APN's will increase access to care allowing patients the opportunity to have reliable, cost effective care within their community. Multiple studies have demonstrated that care provided by APRNs is equal to or in some cases exceeds that of physicians (Hansen-Turton et al., 2008).

Con: Some APRNs may feel uncomfortable with the responsibilities involved with independent practice and may not open independent practices in rural communities.

Criterion 3: Decrease in health care costs related to preventative care and decreased misuse of emergency departments.

Pro: The regulation of APRNs by the BON will allow underserved communities to have regular access to health care improving the health of these communities and decreasing the misuse of emergency departments thereby decreasing the cost of health care. Care provided by APRN's has

been show to result in significantly fewer visits to emergency departments (ED), reduced hospital stays, less visits to specialists, and a decreased risk of delivering low birth weight infants compared with patients in conventional health care settings (Hansen-Turton et al., 2008). *Criterion 4:* Political Feasibility.

Pro: Currently 35 states and the District of Columbia benefit from more accessible, high quality health care because APRNs in these states are regulated via the BON. Allowing medicine and nursing to operate independently within their scopes of practice, yet collaboratively will benefit both professions as well as the patients we serve. Ending these regulations will increase access to care, provide patients with competent, quality care, as well as free physicians from the increased liability associated with these regulations.

Con: Politicians supporting this legislation will lose any funding they normally receive from the Texas Medical board.

Recommendations

The analysis of SB 532, the Policy Alternative Scorecard (Appendix B) and the exploration of three viable options resulted in the major change option being the obvious choice to address the problem concerning access to care in medically underserved areas as well as decreasing the cost of health care. SB 532 has passed and been enacted into law and while it does attempt to alleviate access to care and health care costs it falls short of truly meeting these goals. The major change option of allowing APRNs to practice under the BON and being able working independently in rural area where physicians do not practice is the only option with the potential of reaching the goals outlined.

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Running Head: POLICY ISSUE AND ANALYSIS

Appendix A

SB 532

Legislative Session: 81(R)

Senate Bill 532 Senate Author: Patrick, Dan

Effective: 9-1-09 House Sponsor: Coleman

Senate Bill 532 amends the Occupations Code to clarify the conditions under which a physician is authorized to delegate the carrying out or signing of a prescription drug order for a controlled substance, clarifies the information required to be provided by a physician relating to that delegation under Texas Medical Board rule, and authorizes the development of an online delegation registration process. The bill increases from three to four the maximum number of physician assistants, advanced practice nurses, or nurse midwives to whom certain duties may be delegated by a physician at a primary practice site, alternate practice site, or facility-based practice site. The bill authorizes the board, under the specified circumstances, to modify or waive that limitation, mileage limitations, or on-site supervision requirements.

Appendix B

Policy Alternative Scorecard

Table 1

Policy Alternative Scorecard

Criterion	Do Nothing	Incremental Change	Major Change Option
Decreased Underserved	-	+	++
Increased Access	-	+	++
Decreased Cost of Care	-	-	++
Political Feasibility	-	+	-
Score	-8	3+/1- = 2	6+/1- = 5

⁺⁺ Strongly meets criterion; + Meets criterion; - Does not meet criterion; -- Counter to criterion

Appendix C

Talking Points Paper

SB 532, Improve Texans Access to Health Care

- Increase access to health care to medically underserved areas in Texas by decreasing restrictions on APRNs.
- * Research shows APRNs provide safe, high quality, cost effective health care.
- ❖ APRNs decrease overall health care costs by 20%.
- ❖ Thirty-five states and the District of Columbia have greater access to quality health care as APRNs are regulated by the board of nursing.
- ❖ There will be a physician shortage of 150,000 by the year 2025.
- ❖ 50% of current APRNs state they would likely work in rural areas if restrictions were removed.
- APRNs are highly educated in diagnosing and prescribing as well as board certified in their specialties.

Support APRNs and allow them to care for Texas' medically underserved populations!

References

Carter, A., & Chochinov, A. (2007, July). A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department. *CJEM: The Journal of the Canadian Association of Emergency Physicians*, 9(4), 286-295.

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Appendix D

Briefing Paper

The Issue

Access to health care has reached critical proportions in the state of Texas. Thirteen percent of the population does not have access to a primary health care provider and 90% of the counties are designated, at least partially, as medically underserved areas; 25 counties have no physician at all (CNAP, 2010). As the Texas population continues to grow at the rate of one million every two years the crisis of primary health care providers will only intensify.

- Advanced Practice Nurses (APRN) are regulated by laws dating back to 1989 regarding physician delegation for prescription authority.
- These antiquated laws effectively tie APRNs to physicians geographically, preventing APRNs from being able to work in rural medically underserved areas and further compounding the provider shortage in these areas.
- There is a projected physician shortage of 150,000 by the year 2025.
- 50% of currently practicing APRNs state they would likely work in rural areas if restrictions were removed.

Background

- Lack of access has lead to the use of emergency departments (EDs) being substituted for unavailable primary care providers by the urban poor; as many as 60% to 80% of ED visits in the United States are for non-urgent or minor medical problems.
- Physician shortages combined with the fact that more medical school graduates are choosing more lucrative
 specialties and forgoing general practice are leaving large gaps in access to primary care for a growing
 number of populations.
- Research has demonstrated that APRNs provide high quality, cost effective care with high levels of patient satisfaction confirming that APRNs can competently fill the gaps and improve access to care.
- By focusing on preventative and primary health care it is estimated that APRNs can decrease overall health care costs by as much as 20%.

Alternatives

1. Do Nothing

Advantages: The numbers of APRNs will continue to rise thereby increasing access to care in urban medically underserved areas.

Disadvantages: The people in rural medically underserved areas will continue to lack access to basic health care and as the population continues to grow the lack of access will continue to intensify.

2. Incremental Change

Advantages: As restrictions decrease the number of rural and medically underserved patients who receive care will increase.

Disadvantages: : Many counties in Texas will continue to lack access to health care within their communities.

3. Major Change

Advantages: APRNs will be free to go in to rural areas of Texas and practice to the full extent of their education and training. APRN graduates enter primary care practice at a rate of approximately 80%.

Disadvantages: Texas Medical Board is a powerful organization with influential lobbyists who will fight to prevent this type of legislation.

Recommendation

SB 532 has passed and been enacted into law and while it does attempt to alleviate access to care and health care costs it falls short of truly meeting these goals. The major change option of allowing APRNs to practice under the BON and being able working independently in rural area where physicians do not practice is the only option with the potential of reaching the goals outlined.