PENNSYLVANIA ACADEMY
OF FAMILY PHYSICIANS

On Independence for Advanced Practice Registered Nurses

Winter 2013

Introduction

The Pennsylvania Academy of Family Physicians (PAFP), with its nearly 5,000 members, has been one of the Commonwealth's most dynamic medical specialty associations for over 50 years. The PAFP boasts one of the highest membership rates in the nation with a 75 percent market share and stands on the front line of health care for millions of Pennsylvanians.

Organizations that represent advanced practice registered nurses, or certified registered nurse practitioners (CRNPs) as they are more commonly known, have been successful in advancing state policy changes that now allow CRNPs to practice to the full extent of their education and training with only minimal oversight of a physician. In 2009, the Independent Regulatory Review Commission (IRRC) approved regulatory changes that set new standards for CRNPs' scope of practice through written collaborative agreements with licensed physicians for practice and prescription rights.

With the implementation of the Patient Protection and Affordable Care Act – and the urgency to provide access to an influx of new patients who will obtain health care coverage under the law – advocates across the country are pursuing independent practice for CRNPs.

While it's evident that changes need to be made to our current health care system in order to meet the needs of patients in underserved areas and address the primary care physician shortage, the PAFP has serious concerns about dissolving the current collaborative agreement arrangement between physicians and CRNPs.

Current Law

During promulgation of the current regulations governing the CRNP collaborative system, the House Professional Licensure Committee (HPLC) and IRRC expressed concerns with the Board of Nursing's suggestion to reduce collaborative agreements from written to merely oral agreements. In 2009, HPLC commented that eliminating the regulatory restriction that requires all collaborative agreements to be in writing "does not provide any consumer protection, cannot be proven if called into question, does not protect the physician or the CRNP, and couldcause problems with discipline by the board." IRRC, while not questioning the statutory allowance of oral collaboration, did question the "reasonableness" of permitting oral collaborative agreements.

The Board of Nursing believed state law requires a written collaborative agreement only for CRNPs who have prescriptive authority. Yet, given the Committee's and Commission's comments, it amended its proposed rules to require that all collaborative agreements be in writing ("The Pennsylvania Bulletin," Doc. No. 09-2276, pp. 4-5).

We believe the current system provides important safeguards for patient safety and vital structural resources for CRNPs when faced with diagnostic, treatment and prescription complexities.

Education & Training

A physician's education and training requirements are much more extensive than those of a CRNP and represent solid rationale for the collaborative agreements currently required. A family physician in Pennsylvania must obtain a standard Bachelor of Arts (B. A.) or Bachelor of Sciences (B. S.) undergraduate degree, a four-year doctoral program at medical school, and three years of residency training. In total, family physicians receive 11 years of training compared to 5 1/2 to seven years for a CRNP. CRNP training requires a B. A. or a B. S. degree plus a two-year Master of Science in Nursing (MSN) degree. By eliminating collaborative agreements, policy makers are equating the educational and clinical training requirements of a CRNP with those of a family physician. CRNPs spend a total of approximately 300 hours in direct patient care during training before graduation. Physicians spend that much time in direct patient care during just the first five to six weeks of their third year of medical school, and they have another 54 months (or more than 12,000 more hours) of clinical training before residency graduation. Currently, patients can take comfort in knowing that should the CRNP providing them primary care have critical questions relative to diagnosis, treatment or prescriptions, a collaborative agreement is in place with a licensed MD or DO – an important patient safety measure.

Conclusion & Recommendations

Our position is that this collaborative safeguard helps address issues of both quality of care and access in primary care. It ensures patient safety and a high standard of care. In the United States, we have adopted high standards for our family medicine MDs and DOs so as to provide physicians who are exhaustively educated and trained. Pennsylvania's 29 family medicine residency programs are proudly producing excellent family doctors – and nothing can replace the training and knowledge attained through residency.

In Pennsylvania, we encourage the legislature to explore remedies to the strains on our primary care system, especially in the physician shortage and health professional shortage areas. These remedies include enhancing Pennsylvania's physician retention program or creating a new physician loan program within the Pennsylvania Higher Education Assistance Association (PHEAA), exploring tax incentives to attract physicians to practice in underserved communities, and developing new models of care for Medicaid patients utilizing a patient-centered medical home model.

Policymakers should continue liability reforms and enhance business loan programs to aid independent or small practice physicians. The PAFP looks forward to working with the legislature and all stakeholders to address the primary care needs of Pennsylvanians.