Eliminating Scope of Practice Regulations for Missouri Advanced Practice Registered Nurses

Expanding the pool of heathcare providers to meet the increasing demand for quality, safe and cost effective health services in Missouri

November 2017

Prepared by the Better Access Better Care Coalition

https://betteraccessbettercaremo.com/

Background

Missouri faces an opportune moment to change the way primary care is provided in the state. Several factors have contributed to this opportunity to allow advanced practice registered nurses (APRN) to practice to the full extent of their education and training. Changes in demographics (increased number of citizens over age of 65), the rising costs of healthcare in a time of limited financial resources for publicly funded health insurance, and the demand that care provided be value-based and cost-effective are key factors. Missouri health care outcomes, as measured by external organization's (United Health Foundation, Commonwealth Foundation), reveal a decline in in the overall health ranking from 2015 (36th) to 2016 (37th) and in 2016 the state ranked 40th for senior care and 35th for the health of women (America's Health Ranking, 2016). The Commonwealth Fund Scorecard on State Health Performance ranked Missouri at 36th in 2015, a decline from the 2014 ranking of 34th. Overall Missouri's ranking placed the state in the 3rd quartile of Overall Performance (Commonwealth Fund, 2015).

Another factor impacting health care outcomes in Missouri is the growing physician shortage, especially in the areas of primary care and psychiatric care. The Association of American Medical Colleges (AAMC) has consistently reported on the growing physician shortage. Their *2017 Update on Complexities of Physician supply and Demand* predicts shortfalls in primary care ranging from 7,300 to 43,000 by 2030. The 2015 AAMC Missouri Physician Profile reported 5,294 primary care physicians, a ranking of 36th in the US, with 28.1% of active physicians in the state age 60 or older (AAMC, 2105). The primary care physician graduation numbers have been flat since 2011, with a ratio of 87.3 active primary care physicians per 100,000 population in 2014. The Missouri Hospital Associations' *Special Report on Primary Care Physicians* (2014) reported that 80% of Missouri is a Health Professional Shortage Area, leaving 1 in 5 Missourians with limited access to primary care and 41 rural communities with no hospital. An analysis of 2017 Missourian State Board of Healing Arts data had 501 psychiatrists licensed in the Missouri to serve the state population of 5.9 million residents (US Censure 2010). Mental health access is severely limited in Missouri.

Defining Advanced Practice Registered Nurses (APRNs)

- APRNs consist of 4 categories of providers: nurse practitioners (NPs), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNAs) and clinical nurse specialists (CNS).
- The education of APRNs in health promotion, disease prevention, diagnosis and treatment is obtained through graduate and doctoral level accredited programs.
- APRNs integrate a wide range of skills sets collaborating with various disciplines, such as medicine, social work, nutrition and therapists.
- In states where APRNs act as independent practitioners (22 states & DC as of 2017), they alleviate primary care shortages, promote the meeting of health care goals and reduce costs for Medicaid and Medicare beneficiaries.
- 22,000 nurse practitioners graduated in 2014-2015; 83.4% were certified in area of primary care

Why Remove the APRN Regulations in Missouri Now?

Changing Demographics

- **Aging Population:** The proportion of the U.S population aged 65 and older is rising as a result of increases in life expectancy and the aging Baby Boom generation. APRNs are prepared to work with this population in the community and long term care settings.
    - **In 2000,** 13% of the Missouri population was age 65 and older (source). By 2030, the percentage of people age 65 or over is projected to be 21% or 1/5 of Missouri population (Missouri Office of Administration, 2010). The projection would equate 1.4 million Missourians age 65 and over.
    - **In FY 2016**, Medicaid spending in Missouri was $9.9 billion. 22% of Medicaid funding went toward long term care services involving the elderly (over $2.1 billion) (Kaiser Family Foundation, 2017).
- **Prevalence of Chronic Diseases:** Health care spending today relates to chronic diseases, such as diabetes, hypertension, arthritis, cardiovascular disuse and mental health conditions. Preventing chronic diseases lowers health care costs, hospital admissions and prevents lost work hours. According to the CDC (2005), one in two Americans is affected by these conditions. APRNs are trained to focus on prevention and research reveals they can manage chronic diseases with the same outcomes as physicians.
- **Increasing Diverse Population:** Minority groups make up 1/3 of U.S. population and are projected to become 54% of the total populations by 2050 (US Census Bureau, 2008). The 2010 Census for Missouri reported ethnicities at 19.9% of total state population. Updated estimates by the Census Bureau in 2014 reported an increase to 19.9%. As the minority population increases in Missouri, practitioners must be prepared to work and communicate in a manner that is understandable and culturally relevant way. The latest national sample of registered nurses reported that approximately 11% of nurse practitioners are nurse of color and that figure is expected to increase.
- **Health Disparity:** "Health disparities are inequities in the burden of disease, injury, or death experienced by socially disadvantage groups relative to either whites or the general populations" (Health & Medicine, 2013). APRNs are providing services in areas facing high rates of health disparities, such as densely populated urban areas or rural areas lacking adequate health resources.
    - In Missouri 2016 Health Rankings by the United Health Foundation, 12.1% of children live in poverty, and infant mortality (deaths per 1,000 live births) were ranked as 30th compared to other states.
    - In premature deaths (years lost in per 100,000 populations), Missouri was ranked 40th.
    - The following diseases increased in Missouri from 2015 to 2016: excessive drinking, obesity, diabetes, frequent mental health and physical distress.

- The counties in the southeastern part of the state, known as the 'Bootheel', have the worst health care outcomes in the state, with the lowest number of primary care physicians.
- 71 counties in Missouri have no psychiatrist available.

Status of Healthcare in Missouri

A key principle of economic science, identifying the least expensive way to produce a specified outcome, is a necessary foundation to any meaningful change in collaborative practice regulations. Costs of health care are held at unnecessarily high levels by regulations that prevent substituting APRNs for physicians in areas that demonstrate equal outcomes of care. APRNs are a proven response to the evolving trend towards wellness and preventive health care driven by insurers and consumers.

The following tables illustrate how Missouri compares to national rates on various health measures and the leading causes of death, which can be improved by increasing access to primary care provided by APRNs (Source: Center for Disease Control & Prevention: National Center for Health Statistics, 2014)

Missouri Birth Data 2014	State	Rank*	U.S.**
Cesarean Delivery Rate	30.1	30th	32.2
Preterm Birth Rate	9.8	19th (tie)	9.6
Teen Birth Rate ‡	27.2	19th	24.2
Low Birthweight Rate	8.2	21st	8.0

[1] Excludes data from U.S. territories

‡Number of live births per 1,000 females aged 15-19

MO Leading Causes of Death, 2014	Deaths	Rate***
1. Heart Disease	14338	194.7
2. Cancer	13067	177.7
3. Chronic Lower Respiratory Disease	3762	51.4
4. Stroke	3110	48.7
5. Accidents	3030	41.0
6. Alzheimer's disease	2053	27.4

MO Leading Causes of Death, 2014	Deaths	Rate***
7. Kidney Disease	1452	19.6
8. Diabetes	1423	19.4
9. Flu/Pneumonia	1321	18.1
10. Suicide	1017	16.

Shortage of Primary Care Physicians

Starting in 2015, the Association of American Medical Colleges (AAMC) publishes annual updates of national physician workforce projections. In the February 2017 annual report by AAMC, it was projected that physician demand will continue to grow faster than supply, leading to a projected total physician shortfall of between 40,800 and 104,900 physicians by 2030. Projected shortfalls in primary care range between 7,300 and 43,100 physicians by 2030. Below is the Projected Total Physician Shortfall Range, 2015-2030 in the 2017 AAMC report

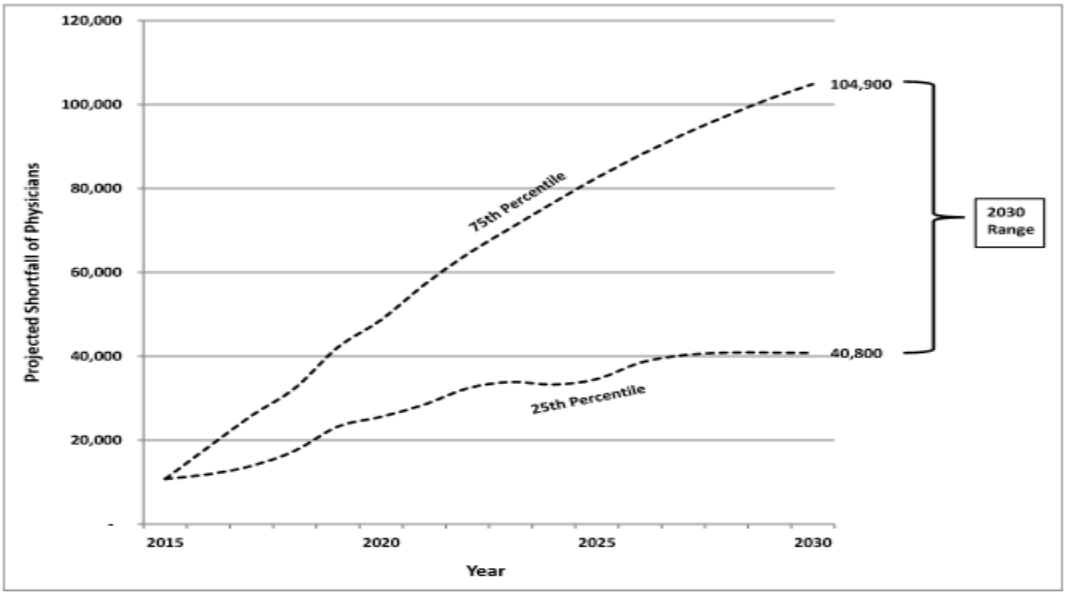

Exhibit ES-1: As complex systems have internal "checks and balances" to avoid extremes, we believe that the 25th to 75th percentile of the shortage projections continues to reflect a likely range for the projected adequacy of physician supply. The projected shortfall of total physicians in 2030 is 40,800–104,700, with the range growing over time to reflect growing uncertainty in key supply and demand trends.

- Missouri has 267 active physicians per 100,000 population in 2016 (AAMC, 2017) and is ranked 21st among the 50 states. Total active primary care physicians per 100,000 population, 2016 was 87, with a state ranking of 28th.

- There are only 590 psychiatric physicians in Missouri to serve the total population of 5.9 million residents (AAMC, 2017).
- 80% of Missouri counties are classified as *Health Professional Shortage areas* in 2014 (Missouri Hospital Association, 2014).
- Despite the physician shortage in Missouri, the number of APRNs in Missouri has steadily increased. An estimated 23,000 new NPs completed their academic programs in 2015-2016 (Fang Kennedy, & Trautman, 2017), a 15.5% increase, from the 2014 – 2015 academic year.
- An estimated 85.5% of new graduates have been trained in primary care. Nearly two out of three new graduates will graduate from family NP programs.
- By 2024, the Bureau of Labor Statistics projects that the NP profession will have grown by 35% compared to 30% for physician assistants and 13% for physicians (this excludes anesthesiologists and surgeons).

Recommendations to remove Scope of Practice Regulations

Missouri citizens have restricted access to APRN care.
• Missouri has many barriers to APRN care and is one of the most restrictive states in the U.S.
• Excessive regulations place barriers to APRN care and have significant costs to the healthcare system and patients.

Missouri APRNs have one of the most restrictive practice environments in the U.S. When regulations are unnecessary they are barriers. These barriers are costly and can impede access to high quality and safe care for APRN patients (Conover, 2004).

REGULATIONS OF COLLABORATIVE PRACTICE:
1. Collaborative Practice Agreements: Missouri APRNs must enter into a collaborative practice agreement with a physician.

- That physician must be located within **50 miles of the APRN in a HPSA or 30 miles in a non-HPSA**. Eighty percent of Missouri counties are considered physician shortage areas and only ten percent of new physicians are going into rural primary care. Many new physicians are not willing to practice in rural, underserved areas. This limits APRNs' ability to practice tremendously as a collaborating physician may not be available within the geographic restriction**. As of 2013, physicians in rural health clinics are exempt from this regulation for 28 days of the year; however, chart review and examination of patients in 2 weeks would restrict this to a maximum of 14 sequential days.**

2. APRNs are required to practice in the same location as the collaborating physician for one month prior to practicing at a separate location. If the collaborator changes, this process must be repeated. During this time, the APRN's availability to see patients is restricted to the location of the new collaborative physician.
3. A physician is limited to collaborating with no more than three full-time equivalent APRNs.
4. An APRN is not allowed to prescribe controlled medications, such as pain medications containing narcotics, unless the collaborating physician allows such prescriptive privileges within the collaborative practice agreement.

If the APRN is delegated controlled substance prescriptive authority by the collaborating physician, the APRN may not prescribe Schedule II drugs and is limited to prescribing a 120-hour supply of narcotics in

Schedule III (Collaborative Practice Rule, 2011). **Patients with chronic disease states such as Cancer, Rheumatoid Arthritis, Hospice patients, and patients across the lifespan with ADHD frequently require Schedule II controlled substances. Restrictions associated with APRN prescriptive authority for controlled substances result in limited patient access to legitimately needed medications.** It is of interest that ambulance personnel have broader access to provide patient relief than APRNs in Missouri (Title 21,CFR Section 1300.01, b28, 2013).

5. If the APRN provides services to a patient for other than an acute self-limited or well-defined condition, the patient is to be examined and evaluated by a physician within two weeks (Collaborative Practice Rule). This creates the burden of an extra visit, extra charges, loss of wages, and a time constraint for the patient. In the majority of practices, it is not feasible to reschedule the patient with the collaborating physician within two weeks.
6. The collaborating physician (or other designated physician) must be immediately available for consultation. If the collaborating physician or designee is unavailable (vacation, on-leave, etc.), patient services cannot be provided by the APRN.
7. When the APRN practices at a separate site from the collaborator, the collaborating physician shall be present at that site at least once every two weeks to review the APRN's services and to provide medical services.
8. A physician must review Ten percent of APRN charts. In 2012 a physician group lobbied to allow any physician (other than the collaborating physician) to sign off on chart reviews.

Results of Regulation Reductions:

- **Removing the 30/50mile rule requirement would increase access to APRNs care and increase access to competent healthcare providers in both rural and urban underserved areas.**
- **APRN practice and patient access to care would not be hindered by the availability of a physician collaborator.**
- **APRNs would be able to provide all indicated prescriptions for all patient populations.**
- **Patient access to care would not be interrupted due to infringement on physician time in completing APRN chart review requirements.**
- **Improved interdisciplinary collaboration as indicated by the patient's needs and provider assessment. Telecommunication allows for real time collaboration when on-site collaboration is difficult or impossible.**
- **The Missouri State Board of Nursing will be solely responsible for promulgating rules and requirements for continuing education including pharmacology.**

Benefits to Missouri Citizens if legislation is enacted:

- Broader access to healthcare in all areas, including rural and urban underserved areas in Missouri.
- Increased APRN availability will increase overall number of healthcare providers to care for a growing number of patients and an aging population.
- APRNs will be able to provide assistance anywhere in the state of Missouri in the event of an emergency. After the Joplin tornado, APRNs from across the state were not able to provide care to storm survivors due to practice restrictions imposed by Missouri collaborative practice regulations.
- Prescriptions will be labeled with the correct APRN provider decreasing the confusion by patients and pharmacies.
- Diagnostic tests will be ordered by and reported to the correct APRN provider, thus decreasing the potential for delayed evaluation and treatment.
- With aligning scope of practice statute and rules with actual practice, a net savings of $1.6 billion from 2012 to 2022 (Missouri Foundation for Health, 2012).

In a time when health care providers access is most needed, **UNNECESSARY regulations negatively impact NPs utilization** by medical groups (The Advisory Board Company, 2014). Missouri is specifically cited in this report.

Despite the declining primary care physician access in all states, states with more restrictive laws, may have a more marked shortage, as nurse practitioners may not be in a position to alleviate the shortage of primary care (Domrose, 2014).

References

1. Association of American Medical Colleges. (2017). 2017 Update: The Complexities of Physician Supply and Demand: Projections from 2015 to 2030. HIS Markit: Washington DC.
2. AANP (2017) More than 234,000 licensed nurse practitioners in the United States. https://www.aanp.org/press-room/press-releases/173-press-room/2017-press-releases/2098-more-than-234-000-licensed-nurse-practitioners-in-the-united-states. Accessed 11/16/2017.
3. Fang D., Li, Y., Kennedy, K.A., & Trautman, D.E. (2017) 2016-2017 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington DC: AACN.)
4. Missouri Hospital Association. (2014). Special Report on Primary Care Physicians. MHA: Jefferson City, Missouri.