



EXPANDING NURSING SCOPE OF PRACTICE TO ADDRESS MICHIGAN'S HEALTHCARE COSTS AND PHYSICIAN SHORTAGES

In Brief

- Patient health outcomes, patient experiences, and costs each are threatened by trends in Michigan's healthcare services. Chronic health concerns coupled with expanded Medicaid and health insurance coverage and an aging population have created a higher demand for physicians, particularly primary care physicians. Healthcare costs are growing faster than the economy as a whole, making quality healthcare less affordable for individuals, businesses, and governments. These and other factors constrict access to healthcare.
- Seven states, including Michigan, require a written agreement with a physician for a nurse practitioner to prescribe medication. Eighteen states plus Washington, D.C., permit nurse practitioners to diagnose and treat patients and prescribe medications without physician oversight, while 25 states require oversight of nurse practitioners' diagnoses, treatment plans, and prescribing of medications. Michigan currently has the most restrictive scope of practice regulations in the Great Lakes Region.
- The FTC position and a great deal of independent research supports that Advanced Practice Registered Nurses (APRNs) practicing independently and with prescriptive authority will likely help reduce primary care physician shortages, improve access to healthcare in underserved areas, reduce healthcare costs, and provide care at or above the quality offered by physicians.
- The primary considerations for policymakers considering expanding the scope of practice for APRNs include threats to patient safety that might result from care by professionals with less education and training, the need to update laws providing for medical malpractice liability for APRNs working independent of physicians, and voluntary or mandatory changes to third-party payment policies to reimburse APRNs for the services provided.
- Michigan's licensing of advanced practice registered nurses (APRNs), the laws allowing for creation of limited liability companies and allowing for the prescription of medications without written authorization from a physician, and the practices of insurance companies to allow for the direct payment APRNs for their services would need be altered to fully allow advance practice nurses to practice to the full extent of their training and certification.
- An ideal healthcare system will create a seamless structure for consumers in which registered nurses, advance practice registered nurses, physician assistants, and physicians create a continuum of care and all health care providers can participate.

Introduction

Physician shortages and rising healthcare costs are just two of the many problems plaguing healthcare today.^a Both challenges constrict patient access

^a See Citizens Research Council of Michigan, *Where are the Primary Care Physicians? A Look at Michigan's Primary Care*

Physician Shortage, Report 390, June 2015. crcmich.org/primary_care_physician_shortage-2015/ and Citizens Research Council of Michigan, *Health Care Costs in Michigan: Drivers and Policy Options*, Report 383, May 2013. crcmich.org/health_care_cost_drivers_policy_options-2013/

and diminish healthcare quality while requiring individuals, businesses, and governments to spend more money to maintain current healthcare service levels. These two challenges have differing causes but have at least one common potential policy response: allowing health professionals to practice to the full extent of their education and certification. This requires state policymakers to change or enact state-level laws that regulate the services that healthcare professionals can provide and the extent to which they can do so independently.

The current healthcare policy environment is marked by several critical aspects – burdensome costs, health insurance expansion, and an aging population – which threaten access to physicians and could be alleviated through an expansion of the scope of practice for non-physician practitioners. In particular, research has focused on advanced practice registered nurses and their potential to deliver many of the same

services as physicians, thereby alleviating physician shortages and, ultimately, increasing patient access while reducing overall healthcare spending.

Though amending Michigan’s Public Health Code to allow other healthcare professionals, such as registered nurses, pharmacists, optometrists, and physician assistants, to practice to the full extent of their training and certification has the potential to increase patient access and health quality outcomes, it is the sheer number of nurse practitioners, their medical knowledge and training, and their ubiquitousness in the health delivery system which make this profession key in a viable public policy response to address physician shortages and rising healthcare costs. This paper serves as a primer for the key issues regarding Michigan’s current scope of practice laws and the benefits and considerations for allowing more permissiveness for advanced practice registered nurse practice.

Background

A successful nationwide and statewide healthcare system builds upon three important pillars: patient health outcomes, patient experience, and cost. Michigan is currently facing obstacles in ensuring residents are obtaining affordable and appropriate healthcare. First, health concerns, such as obesity, heart disease, and diabetes, coupled with expanded Medicaid and health insurance coverage, and an aging population, have created a higher demand for physicians, particularly primary care physicians (primary care specialties include family or general practice, internal medicine, pediatrics, obstetrics and gynecology, general surgery, and psychiatry). Although Michigan has an average number of primary care physicians relative to its population compared to other states, the location of those practicing does not match where people live, creating shortages in many parts of the state, primarily in the northern half of the Lower Peninsula and inner-city Detroit (See **Box** on page 2).¹ Ensuring positive patient health outcomes

is more difficult when access to care is constrained.

Second, healthcare costs are growing faster than the economy as a whole, making quality healthcare less affordable for individuals, businesses, and governments. A growing share of household income is being spent on healthcare as is a greater share of the revenues of businesses and governments that provide health insurance to employees and retirees. Both national and state-level policies can address growing healthcare costs, but unfortunately there is no silver bullet and a number of reforms may need to be implemented.²

Few solutions have the potential to address all three pillars at once, but, according to research conducted over the last century, expanding the role of advanced practice registered nurses in Michigan’s healthcare system may improve patient health and experience and at a lower cost than that of a physician. Although

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Michigan's Primary Care Physician Shortages and Maldistribution

The practices of medical professionals are generally sorted into two broad categories: primary care and secondary care. Primary care generally is defined to include family medicine/general practice, pediatrics, internal medicine, general surgery, psychiatry, and obstetrics/gynecology.

While nationwide and Michigan-specific studies have long identified a growing issue with insufficient numbers of primary care physicians, the Citizens Research Council of Michigan broke the data down to the county level to better identify the geography of primary care physician shortages in Michigan (see *Where are the Primary Care Doctors?*, Report #390, June 2015, crcmich.org/primary_care_physician_shortage-2015/).

The findings from these analyses demonstrate that shortages vary geographically and by primary care specialty across Michigan. Overall, four counties fell below the suggested physician-to-population ratio range in every category of primary care physician CRC examined: Cass, Keweenaw, Lake, and Oscoda. Keweenaw and Oscoda had fewer than one doctor relative to the population in each of these categories. Additionally, seven counties fell below suggested ranges in their supply of physicians in every specialty except family medicine: Alcona, Antrim, Gladwin, Kalkaska, Presque Isle, Roscommon, and Schoolcraft. The majority of these counties are located in the northern half of the Lower Peninsula. Only 19 of Michigan's 83 counties fell within or above the ideal ranges for each of the six specialties CRC examined.

While shortages were more prevalent in the northern half of the Lower Peninsula, they touched every corner of the state. However, more populated counties did have fewer incidences of shortages. For example Wayne, Oakland, Kent, and Washtenaw counties had physician-to-population ratios that were always at least within the ideal ranges. Of the primary care physicians CRC examined, Oakland and Washtenaw counties always had ratios that were above the ideal range.

The CRC report identified options to address the shortages and maldistribution of primary care physicians. Some of those options looked for opportunities and incentives to encourage more primary care physicians to practice in Michigan, specifically in underserved geographic areas. Other options looked for opportunities to provide health services to residents of underserved areas. These options include:

- Expanding the scope of work allowed by alternative primary care providers, or non-physician clinicians, such as nurse practitioners, physician assistants, clinical nurse specialists, and nurse midwives.
- Increasing public health and prevention investments to provide more points of care and improve population health.
- Finding alternative ways to deliver primary care, such that it is delivered more efficiently. Team based care, medical homes, and telemedicine are three examples.

this intervention only applies to health services for which nurses are educated and trained to provide, in many states, including Michigan, nurses are not legally allowed to practice to the full extent of their education and training, limiting the benefits

proffered by this workforce. This raises the policy question, "Should Michigan change its laws to allow advanced practice registered nurses to take on more responsibility in the delivery of healthcare services?"

Nursing Scope of Practice: The Current Landscape

As of July 2016, 170,956 nurses were licensed in Michigan; the largest licensed health professional group in the state.³ Of these, 146,158 (85.5 percent) were licensed as registered nurses, and 9,413 (5.5 percent) were also licensed as one of three recognized categories of advanced practice registered nurses. An advanced practice registered nurse (APRN) is a registered nurse (RN) that also holds a separate license or certification as a Certified Nurse Practitioner, Certified Nurse Anesthetist, Certified Nurse Midwife, or Clinical Nurse Specialist.

While national organizations typically certify APRNs (See **Box** below), states create the policies that determine education and examination requirements for licensure and determine the scope within which APRNs can legally practice. Michigan's Public Health Code, Public Act 368 of 1978, contains the laws that regulate nursing practice. Article 15, Part 172 deals specifically with nursing and defines the qualifications of a RN and allows for the Michigan Board of Nursing to issue a specialty certification for RNs that have advanced training and have demonstrated competency as a nurse midwife, nurse anesthetist, or nurse practitioner. The Board of Nursing, housed in Michigan's Department of Licensing and Regulatory Affairs, is created in statute and is responsible for creating and promulgating the administrative rules that clarify the Public Health Code including qualifications for licensure, continuing education and certification criteria, standards for education, and approval of nurse education programs.⁴

Michigan statute limits the scope of practice for APRNs directly and indirectly, through omission of permission. The laws regulating APRN practice

are found mostly in the Public Health Code, but in other statutes as well, and define what a nurse is, the duties that they are permitted to perform, prescriptive authority, delegation requirements, and parameters for independent practice.

Protected Titles

Part 172 of the Public Health Code (MCL 333.17211) identifies the titles of "r.n.," "registered nurse," "professional registered nurse," and others, when used "with or without qualifying words or phrases" to be restricted in use to those authorized in this section of the law. However, the definition does not define "nurse." This lack of title protection, where "nurse" often is understood to be a registered nurse in the medical field, may lead to confusion for consumers. At least 30 states statutorily define and protect the term "nurse."⁵

Section 172 of the Public Health Code permits the Board of Nursing to issue specialty certifications to RNs with advanced training, who are licensed and meet national certification requirements as a nurse midwife, nurse anesthetist, or nurse practitioner. However, it omits clinical nurse specialists which are a category of APRN and meet the same appropriate and respective national education, training, and licensure requirements.

Independent Practice

The Public Health Code defines the practice of nursing to include, "the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and

Michigan's APRN Education and Licensing Requirements

A Registered Nurse (RN) may have either an associate degree in nursing or a bachelor of science degree in nursing. Advanced Practice Registered Nurses (APRNs) are those that are licensed as an RN and have received specialty training through a masters or doctoral degree in a specific area of nursing practice. APRNs must pass a certification examination from one of five national certification organizations and must meet the minimum requirements of that certification organization, which often includes at least 500 faculty-supervised clinical hours. RNs and APRNs must renew their licenses every two years and complete continuing education or national recertification. Nurses must be licensed by the Michigan Department of Licensing and Regulatory Affairs, upon recommendation by the Michigan Board of Nursing.

the prevention or management of illness, injury, or disability.”⁶ This definition omits “diagnosis” and the Public Health Code does not otherwise explicitly permit APRNs to diagnose illness, injury, or disability. Michigan’s Department of Licensing and Regulatory Affairs, which licenses and regulates nursing, has determined that APRNs must practice under the supervision and delegation of a physician, referred to as a collaborative agreement.⁷

Another barrier to independent practice is that APRNs are precluded from operating their own practice. The Michigan Limited Liability Company Act, Public Act 23 of 1993, only allows members of a “learned profession,” such as a physician, surgeon, or attorney to form a limited liability company or professional services corporation. With this restriction in place, APRNs must either practice under the business license of a physician or hire a physician collaborator in order to own and operate an independent practice.⁸

Prescriptive Authority

When delegated authority is given by a physician, through written permission, APRNs in Michigan can

independently prescribe controlled substances on Schedules III-V, but are not permitted to prescribe those on Schedules I or II (examples include methadone, oxycodone, and codeine). Although APRNs can sign prescriptions, the delegating physician’s name must be on the prescription pad and will be on the patient’s prescription label.

Direct Payment

The Medicaid program, paid through the state government, directly reimburses APRNs for services rendered. Michigan has no specifications in statute that require third-party payers such as health insurance companies to do the same, leaving it to the discretion of payers on whether or not they will directly reimburse APRNs. Third-party payers credential APRNs before they are eligible to be reimbursed, but are not in any way required to do so. Therefore, some APRNs must bill for services through the physician with whom they have a collaborative agreement.

A National Look at Scope of Practice

Since the tasks that APRNs are allowed to perform are not determined by their education and training, but rather by state law, activities performed by nurses vary nationwide. These laws vary in their restrictiveness and specificity. Whether APRNs require physician oversight to diagnose, treat, or prescribe is the standard used to assess the restrictiveness of a state’s scope of practice regulations.

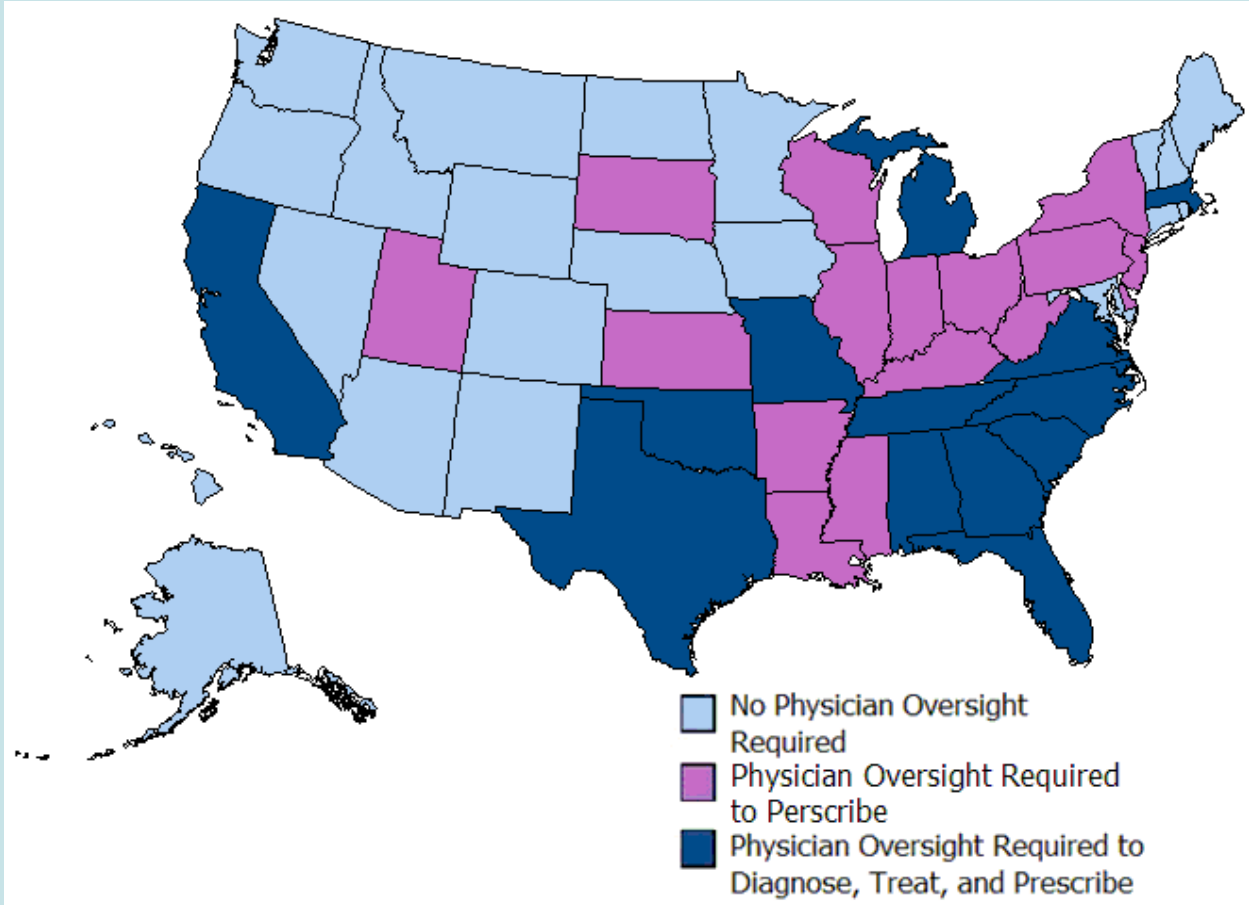
APRN scope of practice regulations vary greatly among the states despite the fact that there are national standards for education, training, and licensing. In Michigan, APRNs are not permitted to: independently diagnose patients without a collaborative agreement with a physician, prescribe drugs without written delegation from a physician, sign a death certificate, or sign workers compensation claims.⁹ However, many states, particularly those in the Northeast, Northwest, and Southwest permit APRNs to do all of these tasks within the scope of their education and training.

Map 1 illustrates the scope of practice laws across the country for nurse practitioners and the degree to which physician oversight is required for nurse practitioners in each state. Seven states, including Michigan, require a written agreement with a physician for a nurse practitioner to prescribe medication. Eighteen states plus Washington, D.C., permit nurse practitioners to diagnose and treat patients and prescribe medications without physician oversight, while 25 states require oversight of nurse practitioners’ diagnoses, treatment plans, and prescribing of medications.¹⁰

In the national perspective, the restrictiveness of APRN practice is seemingly unrelated to the need for primary care in the state. For example, in 14 of the 22 states where at least 20 percent of residents live in a primary care health professional shortage area as defined by the U.S. Department of Health and Human Services Health Resources and Services Administration, APRN practice authority is reduced or

Map 1

State Variation in Scope of Practice Laws Governing Nurse Practitioners



Source: American Association of Nurse Practitioners, *Nurse Practitioner State Practice Environment*, <https://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf>

restricted by requirements for physician oversight.¹¹ Despite a need for more health professionals, policymakers in these states have not yet fully utilized APRNs as a solution to this problem. Seventeen percent of Michigan residents live in one of the 293 designated shortage areas.

Great Lakes Comparison of Scope of Practice

In recent years, several Great Lakes states have amended their scope of practices laws to expand the potential roles for APRNs. As a result, Michigan currently has the most restrictive scope of practice regulations in the Great Lakes Region which includes: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. (See **Table 1.**) In 2015, Minnesota

became the first and only state in the region that grants APRNs full practice authority: APRNs can practice without a collaborative agreement with a physician and can prescribe controlled substances on Schedules II-V. APRNs in Illinois, Indiana, Ohio, and Wisconsin need a collaborative agreement or delegation of authority from a physician in order to practice and/or prescribe. Indiana amended its scope of practice laws in 2015 to no longer require a written practice agreement between an APRN and physician; a written practice agreement is still needed for prescriptive authority. In 2015, Wisconsin updated its statutes to model the principles and terminology contained in the *Consensus Model for APRN Regulation*,¹² including APRN title, role, education preparation, certification, and licensure.

Table 1

Comparison of APRN Scope of Practice Regulations in Great Lakes Region

	<u>Practice Authority</u>	<u>Prescriptive Authority</u>
Illinois	Collaborative agreement with a physician is required in order to diagnose or treat patients.	Collaborative agreement with a physician is required in order to prescribe drugs. NPs have authority to prescribe up to a 30-day supply of Schedule III to V drugs and Schedule II drugs under certain conditions.
Indiana	Can independently diagnose and treat patients without physician involvement.	NPs must submit application to the state board as well as have a collaborative agreement with a physician or physician's supervision in order to prescribe drugs.
Michigan	Recognizes the specialty certifications for qualified RNs but does not officially recognize APRNs. Thus, NPs in Michigan, like RNs, must practice under supervision within physician-led health care teams.	Written authorization is required to prescribe drugs. Can prescribe Schedule III to V controlled substances and Schedule II substances under certain conditions.
Minnesota	Can independently diagnose and treat patients.	Can prescribe Schedule II to V controlled substances.
Ohio	Must enter a standard care arrangement with each supervising physician in order to practice and are subject to periodic performance reviews.	Must enter a standard care arrangement with each supervising physician in order to practice and prescribe.
Wisconsin	Can independently diagnose and treat patients.	Requires a collaborative agreement to prescribe drugs.

Sources: Barton Associates. Nurse Practitioner Scope of Practice Laws. Accessed July 2015. bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/
 Indiana Statute Title 25, Article 27.5
 Minnesota State Legislature SF 511 (2013) – APRN Scope of Practice Bill
 Ohio Administrative Code: Chapter 4723-8 Advanced Practice Registered Nurse Certification and Practice
 Pearson, Linda J. "Pearson Report-State Summary," Michigan, 2012. micnp.org/files/professional/PEARSON%20REPORT.Michigan%202012.pdf
 Senate Fiscal Agency. Senate Bill 2 (2013) Fiscal Analysis as Passed by the Senate, March 2014. legislature.mi.gov/documents/2013-2014/billanalysis/Senate/pdf/2013-SFA-0002-B.pdf

Benefits of Expanding Scope of Practice

A great deal of research over the last several decades provides evidence of many benefits to permitting APRNs to practice to the full extent of their education, training, certification, and licensure. The U.S. Federal Trade Commission (FTC) believes that, absent patient safety data justifying such an arrangement, physician supervision requirements are anti-competitive in that one group of healthcare professionals (physicians) has the ability to restrict

market access of another (APRNs). Consumers are then denied the benefits of competition in this market.¹³ The FTC position and a great deal of independent research supports that APRNs practicing independently and with prescriptive authority will likely help reduce primary care physician shortages, improve access to healthcare in underserved areas, reduce healthcare costs, and provide care at or above the quality offered by physicians.

Reducing Primary Care Physician Shortages

Health insurance expansion and an aging population, combined with a slowing supply of new physicians entering primary care fields has put increased demand on access to primary care physicians; a demand that is expected to grow in the future. APRNs are positioned to alleviate demand on primary care physicians and better distribute primary care services across the state.

Studies show that APRNs can manage 80 to 90 percent of the care provided by primary care physicians.¹⁴ Expanding the scope of legal practice allowed for APRNs can help ease the primary care shortage by increasing the number of providers licensed to perform primary care services and expediting patient visits through coordination of physician and non-physician clinicians. In terms of meeting healthcare demand, the Association of American Medical Colleges assumes that for each additional two nurse practitioners, physician demand is reduced by one.¹⁵

APRNs are also good candidates to address the primary care provider shortage because a higher proportion practice in primary care; approximately 59 percent of nurse practitioners in the state practice in primary care settings versus 48 percent of physicians.^{16,17} Nearly 90 percent of APRNs are trained in primary care.¹⁸ The U.S. Department of Health and Human Services Health Resources and Services Administration projects that the national supply of primary care nurse practitioners will increase by 30 percent between 2010 and 2020, which is greater than the anticipated growth in the supply of physicians. If new nurse practitioners are effectively integrated into primary care practices, the projected shortage of 20,400 physicians by 2020 could be reduced by over two-thirds to 6,400.¹⁹

Finally, APRNs are typically able to complete their education and training in fewer years than a physician. While primary care physicians' education is more time consuming because they are broadly trained in medicine, APRNs do not complete a residency program and train with a specific scope of practice. Educating and training APRNs now would mean that new primary care providers could be placed where they are needed sooner and thus,

more quickly resolve primary care shortages in areas of the state.

Expanding Healthcare Access

When APRNs are limited in their tasks and required to practice under the supervision of a physician, healthcare access remains constricted by the number of physicians rather than the supply of healthcare professionals qualified to perform the work. Two ways through which patient access to care can be improved by allowing APRN's to practice independently of physician supervision are in retail healthcare clinics and in servicing underserved patients.

Retail Clinics. Nurse practitioners are the main providers in the growing number of healthcare clinics in pharmacies and retail stores nationwide. Retail clinics improve healthcare access by having retail based hours that expand past the traditional work day and often on weekends, no appointments are needed, and care, such as immunizations, are typically quick. While there are many disadvantages to these clinics, including fragmented care, they do expand access. With scope of practice restrictions in Michigan, however, nurses are not able to independently staff these clinics (without a collaborative agreement with a physician), which closes one avenue for alleviating the effects of physician shortages.

Expanding Access in Rural Michigan. Access to healthcare in Michigan's rural communities is critical; people who live in rural areas are generally poorer and have higher morbidity and mortality rates than their counterparts in suburban and urban settings.²⁰ Michigan's rural areas are especially hurt by a primary care physician workforce that is more concentrated in the state's urban and suburban areas.^b Statewide, the supply of primary care physicians is on par with the U.S. average, but the supply in many rural areas is below average on a per capita basis, particularly in the northern half of the Lower Peninsula. Despite a sufficient supply of physicians statewide, there are few, if any, practicing in some areas.

^b Citizens Research Council of Michigan, *Where are the Primary Care Physicians? A Look at Michigan's Primary Care Physician Shortage*, Report 390, June 2015. crcmich.org/primary_care_physician_shortage-2015/

Scope of Practice Issues for Other Health Care Professionals

Article 15 of Michigan's Public Health Code defines the scope of practice for many health care professionals including physicians, dentists, chiropractors, counselors, athletic trainers, and dietitians. How the regulations align with each of these professions' education, training, and licensure varies; APRNs are not the only medical profession in which their legal practice is limited to a level below that for which they are trained.

For example, Part 177 of Article 15 deals with pharmacy practice and drug control, addressing the practice of pharmacists or pharmacy technicians. These regulations are fairly general and permissive, without much prescriptive language here or in the administrative rules. However, areas within the law could be strengthened to formally expand the scope of pharmacists' practice, allowing them to play a greater role in patient health management. For example, pharmacists are trained in outcomes of disease management and patient's health and safety could be improved if they were formally integrated into patient care coordination. Pharmacists are not reimbursed for the time they spend with physicians on disease state management as the current payment model does not allow pharmacists to bill for clinical care.

Expanding scope of practice for other medical professionals could alleviate primary care physician visits, better coordinate care, and improve patient health. Examples include allowing optometrists to screen for diabetes, physician assistants to dispense medication, pharmacists to screen for high blood pressure and other chronic diseases, and community health care workers to be better integrated into collaborative disease management.

While 25 percent of the U.S. population lives in rural areas, only 10 percent of physicians practice there.²¹ APRNs are more likely than physicians to work in rural areas and to treat Medicaid patients.²² Nationwide, 20 percent of nurse practitioners work in a rural setting; this number is lower in Michigan because of the more restrictive regulatory environment.²³ The Institute of Medicine, the independent and objective health arm of the National Academy of Sciences, found that when nurse practitioners are practicing in rural areas, access to primary care increases.²⁴

Improving Patient Health Outcomes

A number of studies have found that patient care led by APRNs is at least as good as that of physicians, and in some cases better. Many APRNs work alongside physicians and can be used to effectively and safely expand the efficiency of health services. Nurses are also trained to work with teams of providers and to refer patients to physicians when patient conditions are beyond their scope of education. Many studies have shown that expanding the tasks that APRNs are able to perform results in at least equally beneficial patient outcomes, while also allowing for a greater number of patients to receive care.²⁵ According to the Institute of Medicine, "no studies suggest that APRNs are less able than physicians to deliver care that is safe, effective, and efficient or that care is better in states with more restrictive scope of practice

regulations for APRNs."²⁶

Finally, while APRNs are trained in performing some services that overlap with those provided by physicians (diagnosing conditions, ordering tests, prescribing medication), they also provide a variety of services that physicians are typically not involved in such as social work, nutrition, and physical therapy.²⁷ Addressing these aspects of health can provide more holistic and effective care for some patients.

Reducing Healthcare Costs

Expanding practice for APRNs may lead to healthcare cost savings. Most of the savings would come from lower APRN salaries compared to those of physicians, but some cost savings would also be realized from better care coordination and disease management, leading to fewer hospitalizations and other medical interventions. In 2015, the average full-time salary for a nurse practitioner was \$103,819, whereas primary care physicians earned an average of \$195,000 and specialists earned an average of \$284,000 per year.^{28,29}

Several studies in other states and in specific hospitals have found substantial cost savings. A 2009 study of the Massachusetts healthcare system projected a savings of \$4.2 to \$8.4 billion dollars from 2010 to 2020 if the state removed scope of practice barriers and allowed both nurse practitioners and physician

assistants to practice primary care at the level of their education and training.³⁰ A 2010 Florida study found that expanding the use of APRNs and physician assistants could result in annual savings of \$7 million to \$33 million for Medicaid, \$744,000 to \$2.2 million for state employee health insurance, and a total of \$339 million across Florida's healthcare system.³¹

In a 2009 case study at Virginia Mason Medical Center, researchers concluded that 50 percent of

total office visits for uncomplicated procedures could be delivered by APRNs or physician assistants. Extrapolating this to the national level could result in an annual savings of \$8.3 billion – \$1.2 billion per year in savings for Medicare Health insurance and \$7.1 billion per year in savings for private health insurance.³²

Considerations in Expanding Scope of Practice

Evidence demonstrates that expanding APRN practice is safe and beneficial to patients, however, several concerns still exist. Additionally, some aspects of state law may need to be addressed if the full benefits from autonomous APRN practice are to be realized. Among these are the exposure to malpractice litigation and the possible necessity for legislation that assists in billing.

Patient Safety

Some health policy stakeholders, including physician groups, are concerned about patient safety when patients are treated by any non-physician clinicians, including APRNs, without physician oversight. Physicians receive more education and training than many APRNs, which may aid in accurate and safe diagnosis and treatment, particularly of complex medical conditions. If diagnosis and/or treatment is beyond an APRN's education and training, there could also be delays in diagnosing conditions and there may be higher utilization of medical services if APRNs need to provide more frequent referrals. Therefore, care quality, including patient safety, may be compromised if APRNs perform tasks that are typically performed by physicians.

While research universally supports that APRNs provide care that is comparable to that provided by physicians in terms of safety and quality, some of the studies only observe patient outcomes in the short term, or only assess APRNs as part of a health team and cannot single them out as the reason for better care. Additionally, it is difficult to isolate the effect of APRNs in these studies and research on the outcome of scope of practice changes on cost, quality, and safety at the state level is not yet available.

Malpractice Liability

As the practice of APRNs expands to match their competency, the increase in duties carries a greater liability for medical malpractice. As medical malpractice claims increase, premiums for malpractice insurance would also increase, resulting in higher costs for APRNs. These expenses may offset some of the cost savings from shifting more tasks to APRNs. To avoid this, the Michigan laws dealing with malpractice insurance, claims, and payouts should be appropriately updated to reasonably reduce the liability exposure for APRNs.

Health Insurance Billing Issues

To make the greatest impact in utilizing APRNs to fill healthcare needs, APRNs must be able and willing to practice independently, particularly in underserved areas. Third-party payment policies act as constraints to independent practice for APRNs, even in states where APRNs can practice independently.

Michigan's Medicaid program reimburses APRNs that are designated as primary care providers at the same rate as physicians. Medicare, which is a federal program, reimburses APRNs at 85 percent of the physician rate. Third-party payers determine the services APRNs are paid for, the payment rates, whether they can be paid directly, and whether they are designated as primary care providers.³³ These determinations vary by insurer. If a third-party payer declines to credential the APRN and allow for direct payment, then the APRN must still work with a physician to receive reimbursement for services rendered. Additionally, if the reimbursement rate is insufficient, APRNs are not incentivized to practice independently.³⁴

Several states have laws that mandate third-parties to directly reimburse APRNs for any covered services provided within their scope of practice and prohibit third-party payers from discriminating against them as a class of primary care providers.³⁵ The Institute of Medicine recommends that state laws require third-party payers that participate in fee-for-service payment arrangements to directly reimburse APRNs that are practicing within their scope under the law.³⁶ When states are passive about this process, neither requiring nor prohibiting insurers to credential APRNs, most third-party payers do not allow direct payment.³⁷

Options for Expanding Scope of Practice

If policymakers choose to expand APRNs' scope of practice to address healthcare access and temper cost growth, then APRN practice should be expanded to encompass the tasks with which they are educated and trained to perform and which evidence has shown are safe. The following are a summary of some of the components needed to achieve this within state law.

Defining Scope of Practice

As a first step, Part 172 of the Public Health Code should include a definition of APRN scope of practice that includes a definition of APRNs' tasks. The Institute of Medicine recommends that state legislatures model scope of practice regulations on the National Council of State Boards of Nursing's Model Nursing Practice Act and Model Nursing Administrative Rules.³⁸ This language would allow for APRN practice to evolve with their education and training as well as with changes in technology and the landscape of healthcare delivery in the future. Importantly, this language would include the ability for APRNs to diagnose illness, injury, and disability, making a collaborative agreement with a physician no longer necessary.

Licensure

Including a clear definition of the APRN title and creating statutory licensure would help clear up

General versus Specific Language

Depending on how language is changed to allow for APRNs to practice independently, new regulations may not be beneficial to the APRN profession or to the health of Michigan citizens in the long run. State law that allows for regulatory flexibility assures that the role of APRNs can evolve with changes to training and technology. The advantage to this approach is that the laws do not need to be updated at the same speed as training and technology advances. Additionally, new research is continuously emerging on new models for care and the role of APRNs in a healthcare delivery team.

ambiguity that indirectly limits direct payment from third-party payers and would help clarify the role and authority of APRNs to the public.

Direct Reimbursement

While integrating regulations that clear the way for independent APRN practice makes it more likely that third-party payers will reimburse APRNs directly, it is not guaranteed. Michigan could follow in the footsteps of Hawaii, Massachusetts, New Jersey, and North Carolina, and mandate that third-party payers credential APRNs for all or an appropriate subset of services.

Advanced Practice Nursing as a Learned Profession

To enable APRNs to open practices in underserved areas, policies should address the Michigan Limited Liability Company Act, Public Act 23 of 1993, by including APRNs within the act's definition of a "learned profession." This would allow APRNs to open their own practice without having to work under a collaborative agreement with a physician or hire a physician collaborator.

Prescriptive Authority

APRNs should be given express authority to prescribe medications in accordance with their training, without written delegation from a physician.

Conclusion

Healthcare has undergone many significant changes in recent years including the expansion of health insurance and an aging population which requires more services. With insufficient numbers of physicians entering the field of primary care relative to demand, shortages in Michigan may spread further through the state. While there are several ways to mitigate or address any of these issues, allowing APRNs to practice to the full extent of their education, training, and certification is a solution that holds a great deal of potential for addressing each.

Evidence from other states that allow APRNs to practice independently supports the conclusion that it is safe and results in high patient satisfaction. APRNs can perform up to 90 percent of the care provided by a physician in some fields of medicine, but earn lower salaries, which could result in cost savings. To

benefit from the skillset already held by the state's APRNs, policymakers would need to amend statute to allow APRNs to diagnose patients, prescribe medications without written authorization from a physician, form a limited liability company in order to practice independently, and receive direct payment from third-party payers. Few other solutions are as heavily supported by evidence and cost so little to implement. APRNs are already a fundamental cog in healthcare delivery and can offer further benefits to Michigan citizens if their knowledge and expertise are fully recognized and utilized. An ideal healthcare system will create a seamless structure for consumers in which registered nurses, advance practice registered nurses, physician assistants, and physicians create a continuum of care and all health care providers can participate.

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