Testimony
Committee on Health
Senator David Y. Ige, Chairman
Senator Josh Green, M.D., Vice Chairman

Wednesday, February 11, 2009

S.B. 1045
Relating To Advanced Practice Registered Nurses

Good afternoon Senator Ige, Senator Green, and members of the Senate Committee on Health. My name is Nancy McGuckin and I am testifying in strong support of S.B. 1045 Relating To Advanced Practice Registered Nurses.

It has been a long time since I have testified before a Senate Committee on legislation related to advanced practice registered nurses as providers of care and their ability to prescribe. It was in 1994 after 4 years of hard work by all involved that prescriptive authority for advanced practice registered nurses was authorized by the Legislature and signed by Governor John Waihee. It took almost another 4 years for the regulations to be adopted by the Department of Commerce and Consumer Affairs. The Board of Medical Examiners also contributed to the delay in developing a formulary by which the APRNs could prescribe. Now 15 years later we have around 182 APRNs recognized by the Board of Nursing as being able to prescribe in the State of Hawaii. From no APRNs with prescriptive authority to 182 in 15 years is progress but not what I would consider to be the growth needed to meet the growing needs of our population. SB 1045 is another step in the policy process – allowing consumers to access APRNs as primary care providers and providing APRNs the statutory authority to prescribe within their scope of practice without unnecessary and artificial barriers to the care they can provide.

Studies from 1979 to the present consistently find that the practice and prescribing by APRNs is safe for consumers and allows for increased access to primary care services. Here in Hawaii there has been no revocation of an APRNs prescriptive authority by the Board of Nursing. Consumer access to primary care will reduce costs, decrease morbidity, and increase quality of life – this is in line with Healthy People 2010 initiatives.

Your support of this bill is requested. Thank you for this opportunity to testify.

February 11, 2009

The Honorable David Ige, Chair
The Honorable Josh Green M.D., Vice Chair
Senate Committee on Health

Re: SB 1045 – Relating to Advanced Practice Registered Nurses

Dear Chair Ige, Vice Chair Green and Members of the Committee:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of seven (7) member organizations:

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Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
MDX Hawai'i
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Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify in opposition to Sections 1-4 of SB 1045 which could have the effect of requiring health plans recognize Advance Practice Registered Nurses (APRNs) who are not contracted with the plan as participating providers. HAHP takes no position on the remainder of the language in the measure.

We believe that language contained in Sections 1-4 of SB 1045 could undermine many of the consumer protections that are in place currently. Participating providers contracted with any health plan undergo a process whereby their credentials are checked to ensure that they are properly licensed and appropriately trained. Participating providers also sign a contract and agree to accept the health plans' payment as payment in full for services rendered and cannot "balance bill" the member for additional costs. The enactment of the language in sections 1-4 of this measure would award any APRN the benefits of participating with a plan without having to undergo a contracting process and agreeing to accept the responsibilities that are included when participating with a plan. We believe that this could potentially to put consumers at risk since health plans will have no way of verifying the ability of an APRN to practice in the State.

As such we would respectfully request that the Committee remove Sections 1-4 from the measure to continue to ensure consumers are receiving appropriate care from licensed and credentialed APRNs and are not forced to pay additional out-of-pocket amounts.

Thank you for the opportunity to offer comments today.

Sincerely,

Rick Jackson
President

American Academy of Nurse Practitioners

Quality of Nurse Practitioner Practice

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Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965. For over 40 years, research has consistently demonstrated the high quality of care provided by NPs. The body of evidence regarding the quality of NP practice supports that NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important reports of research supporting the NP, the majority of which are published by observers and researchers outside of the discipline of nursing.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. Archives of Internal Medicine, 151 (4), 694-698.
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44 (6) 332-9.
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. Journal of Advanced Nursing, 40 (6).
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., Cowan, M. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. Medical Decision Making, 26, 9-17.
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. BMJ, 324, 819-823.
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of *x*-rays were identified.

Larkin, H. (2003). The case for nurse practitioners. Hospitals and Health Networks Aug 2003, 54-59.
The author describes compelling statistics supporting the case of NPs, including several studies demonstrating decreased inpatient days, decreased ventilator days, improved heart failure outcomes, and decreased complications such as skin lesions, urinary tract infections, and pneumonia.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. Cochrane Database of systematic reviews. 2006, Issue 1.
This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. Medical Care Research and Review 61 (3), 332-351.
The outcomes of care in the study described by Mundinger, et al in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. Nursing Economics, 20 (4), 174-179.
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast, PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., Friedewald, W.T., Siu, A.L., & Shelanski, M.L. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. JAMA, 283 (1), 59-68.
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. At six months, physicians rated higher on one component of the satisfaction scale.

Office of Technology Assessment (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have." (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

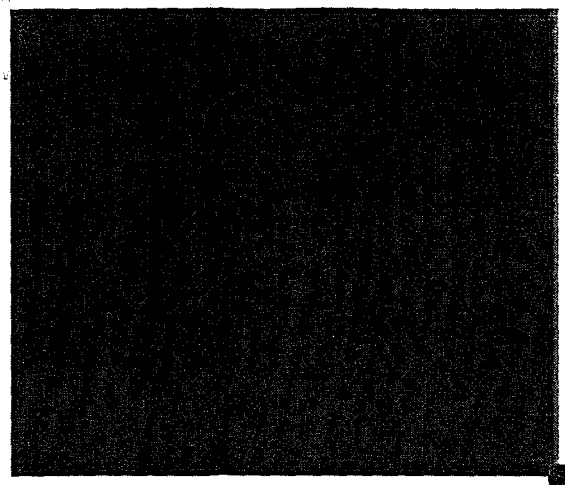
Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. Nurse Practitioner, 1 (1), 28-32.
The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? Medical Care, 42 (6), 579-590.
A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sacket, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. Annals of Internal Medicine, 80 (2), 137-142.
A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9 (2).
The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA Study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes, "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country." (p. 487).

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hacket, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. NEJM, 290 (3), 252-256.
This report provides further details of the Burlington trial, also described by Sackett, et al (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician." (p. 255)



American Academy of Nurse Practitioners

Nurse Practitioner Cost-Effectiveness

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Cost-Effectiveness

Nurse Practitioners (NPs) are a proven response to the evolving trend towards wellness and preventive health care driven by consumer demand. For over four decades, NPs have been proven to be cost-effective providers of high-quality care.

Over 25 years ago, the Office of Technology Assessment (1981) conducted an extensive case analysis of NP practice and reported that NPs provided equivalent or improved medical care at a lower total cost than physicians. The authors determined that NPs could manage up to 80% of adult primary care and 90% of pediatric primary care needs at that time. NPs in a physician-practice were found to have the potential to decrease the cost per patient visit by as much as one-third, particularly when seeing patients in an independent, rather than complementary manner. Since that time, continued reports have supported ongoing cost-effectiveness of NP practice. When OTA later re-examined the role of NP practice, the positive analysis was confirmed (OTA, 1986)

In 1981, the OTA reported that the hourly cost of an NP was one-third to one-half the cost of a physician. The median total compensation for primary care physicians in 2004 ranged from $130,000 to $208,700, depending on type and size of practice (Lowes, 2005). The median 2004 salary for NPs across all specialties who practiced full-time was $71,000, with a mean of $73,630. (AANP, 2004). NP preparation currently costs 20-25% that of physician preparation (AACN, 2000). When productivity measures, salaries, and costs of education are considered, NPs are cost-effective providers of health services.

A recent study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs per visit and total labor costs per visit were lower in practices where NPs and physician assistants (PA) were used to a greater extent (Roblin et al, 2004).

A cost analysis comparing the cost of providing services at an NP managed center for homeless clients with other community alternatives showed earlier and less costly interventions by the NP managed center (Hunter, et al, 1999). NPs delivering care in Tennessee's state-managed MCO, TennCare, delivered health care at 23% below the average cost of other primary care providers with a 21% reduction in hospital inpatient rates and 24% lower lab utilization rates compared to physicians ((Spitzer, 1997). Jenkins & Torrisi (1995) performed a one-year study comparing a family practice physician managed practice with an NP managed practice within the same managed care organization. The NP managed practice had 43% of the total emergency department visits, 38% of the inpatient days, and a total annualized per member monthly cost that was 50% that of the physician practice.

A study conducted in a large HMO setting found that adding an NP to the practice could virtually double the typical panel of patients seen by a physician. The projected increase in revenue was $1.28 per member per month, or approximately $1.65 million per 100,000 enrollees per year (Burl, Bonner, & Rao, 1994).

Chenowith et al (2005) analyzed the health care costs associated with an innovative on-site NP practice for over 4000 employees and their dependents. Compared with claims from earlier years, the NP care resulted in significant savings of $ .8 to 1.5 million, with a benefit-to-cost ratio of up to 15 to 1. Paez and Allen (2006) compared NP and physician management of hypercholesterolemia following revascularization. Patients in the NP-managed group were more likely to achieve their goals and comply with prescribed regimen, with decreased drug costs.

When comparing the cost of physician-only teams with the cost of a physician-NP team in a long-term care facility, the physician-NP team's cost were 42% lower for the intermediate and skilled care residents and 26% lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stays, and fewer specialty visits (Hummel & Pirzada, 1994).

A collaborative NP/physician team was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al, 2006; Ettner et al, 2006). Larkin (2003) cites a number of studies supporting decreased costs, complication rates, and lengths of stay associated with NP-managed care. For instance, he cites University of Virginia health System's 1999 introduction of an NP model in the area of neuroscience, resulting in over $2.4 million savings the first year and a return on investment of 1600 percent. The NP model has been expanded in this system, with similar savings and improved outcomes documented. Another example cited includes an NP model introduced at Loyola University Health System's cardiovascular area, with a decrease in mortality from 3.7% to 0.6% and over 9% decreased cost per case (from $27,037 to $24,511).

In addition to absolute cost, other factors are important to health care cost-effectiveness. These include illness prevention, health promotion, and outcomes. See Documentation of Quality of Nurse Practitioner Practice (AANP, 2007) for further discussion.

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Burl, J., Bonner, A., Rao., M. (1994). Demonstration of the cost-effectiveness of a nurse practitioner/physician team in primary care teams. *HMO Practice*, 8 (4), 156-7.

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Hummel, J., Pirzada, S. (1994). Estimating the cost of using non-physician providers in an HMO: where would the savings begin? *HMO Practice*, 8 (4), 162-4.

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Spitzer, R. (1997). The Vanderbilt experience. *Nursing Management*, 28 (3), 38-40.

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