Council of Medical Specialty Societies

CMSS RESPONSE TO THE FUTURE OF NURSING REPORT

The *Future of Nursing* report recently released by the Institute of Medicine (IOM) addresses a wide range of legitimate concerns held by many in the healthcare community. The stated committee charge to "develop a set of bold national recommendations, including ones that address the delivery of nursing services in a shortage environment and the capacity of the nursing education system"[1] is laudable and timely. The Council of Medical Specialty Societies (CMSS), which represents 34 societies with an aggregate membership of more than 650,000 U.S. physicians, believes that non-physician clinicians are critical stakeholders in the health of our nation and that nurses are irreplaceable members of a high-performing, patient-centered healthcare team.

Under the Affordable Care Act of 2010, millions more Americans will be visiting their primary care physicians to receive preventive care services such as immunizations, dietary counseling, and cholesterol, blood pressure, colorectal and cervical cancer screenings at no out-of-pocket cost. CMSS believes that nurses, within the context of the physician-led medical home, are ideally suited to help deliver these newly covered preventive services. CMSS further believes that mutually respectful and inter-professional cooperation improves both patient satisfaction and health outcomes.

CMSS would like to call critical attention to the scope of practice recommendations made by the IOM report. The report touches only lightly on the existing dramatic shortage of registered nurses (RN). Instead, the report focuses on a proposal to expand the scope of practice for advanced practice nurses (APNs). Critically, the report lacks detail concerning the necessary clinical and educational standards which would undergird such an expansion, and does not give sufficient attention to the cost ramifications associated with its recommendations. Unfortunately, the report fails to address existing data regarding the practice patterns of APNs. These flaws all have real implications for patient safety and quality of care.

THE SPIRALLING RN SHORTAGE

Health researchers, demographers, planners, government agencies, professional associations and others agree that there is a significant nationwide shortage of RNs who provide nursing in team-based settings. New technological advances, an aging patient population, the aging of the RN workforce itself, and an influx of patients seeking and receiving preventive care under the Affordable Care Act of 2010 all will drive the need for additional RNs. The Health Resources and Services Administration (HRSA) predicts that the current shortage of RNs will only become more severe over the next 20 years. HRSA writes, "Comparing the baseline supply and demand projections suggests that the U.S. had a shortage of approximately 168,000 FTE RNs in 2003, implying that the current supply would have to increase by 9 percent to meet estimated demand. By 2020 the national shortage is projected to increase to more than 1 million FTE RNs, if current trends continue, suggesting that only 64 percent of projected demand will be met." [2] Further perpetuating the nursing shortage is the existing nursing education infrastructure, which is insufficient to educate the number of nurses currently needed. Tens of thousands of qualified applicants are turned away every year because of a paucity of adequately qualified nursing faculty.

CMSS believes that it is critically important to the health of our nation to retain and increase the number of RNs working in all environments and particularly to augment the capacity of nurse educators. According to the U.S. Department of Health and Human Services, the largest proportion of RNs active in the workforce today holds an associate degree,[3] earned in 2 to 3 years of post-high school training. CMSS

therefore urges the healthcare community to focus on public policy efforts that support the training of more baccalaureate-prepared nurses, especially as multiple sources link improved health outcomes with the presence of nurses educated to this level. Furthermore, within the context of the physician-led medical home, CMSS believes that all providers—including nurses—should be held to the highest standards of their education, training, and examination, coupled with an ongoing demonstration of their skills and competencies.

STANDARDIZED EDUCATION AND TRAINING, DEMONSTRATION OF CLINICAL COMPETENCY, MEDICAL LIABILITY, AND REIMBURSEMENT

CMSS is concerned that the IOM report advocates for an expanded scope of nursing practice without specifying the standard minimum amount of supervised clinical experience and documented clinical competency that must be achieved before an APN would be permitted to treat and prescribe without physician guidance. Medical Doctors (MDs) and Doctors of Osteopathy (DOs) complete 12,000 to 20,000 hours of supervised post-graduate clinical training. Standardized certifications of competencies are embedded throughout physician training and are responsible for the high levels of care physicians provide. Nurse practitioners, among the most highly educated nurse professionals, receive less total clinical experience during their entire formal education than is obtained in the first year alone of a three-year physician medical residency. Yet according to the recommendations laid out by the IOM report, a recently graduated APN with only 500 hours of clinical experience would be permitted to legally admit patients to a hospital or hospice, lead the patient-care team, and receive the same level of reimbursement as a physician.

In response to the IOM report, several nurse advocacy groups have posited that APNs can deliver physician-level treatment at a lower cost to the patient and the payer. This calculation does not address the issue of professional and medical liability that must accompany any discussion of scope of practice. In states that currently allow non-physician clinicians to practice without a written collaborative agreement with a physician, public policy should require exclusive professional responsibility for the care non-physician clinicians provide and adequate liability insurance to allow appropriate financial remedy for adverse settlements or decisions. States that license APNs, nurse practitioners (NPs), physician assistants (PAs), and other non-physician clinicians should require that they abide by the same expectations regarding liability insurance as do physicians. If APNs, for example, commence practicing independently in significant numbers, as the report calls for, payers will be obliged to modernize their liability arrangements, a step that is likely to neutralize any financial advantage associated with nurse-led care. Of course,, any cost savings would further erode if, as the report suggests, APNs were compensated at the same rate as physicians.

EXPANDING NURSING SCOPE OF PRACTICE IS UNLIKELY TO ASSIST MEDICALLY UNDERSERVED POPULATIONS

Proponents of an expanded nursing scope of practice argue that care for medically underserved individuals, especially those in rural areas, would be more accessible via a nurse-led care team. The IOM report, however, does not provide data indicating that APNs or NPs are currently filling or are prepared in the future to fill the nation's physician shortage. Existing studies of the geographic distribution of NPs in the United States show that they are more concentrated in urban areas than are physicians: 85 percent of NPs work in metropolitan counties and only 5.5 percent of NPs practice in remote rural counties.[4] Recent primary care data further support these findings. A 2008 study by the American Nurses Credentialing Center revealed that only 3 percent of pediatric nurse practitioners (PNPs) practice in rural areas,[5] and

states which allow independent PNP practice do not have a higher density of PNPs per child population than states which do not allow independent practice.[6]

The report's authors acknowledge these data deficits. They write, "As the [IOM] committee considered how best to inform health care workforce policy and development, it realized it could not answer several basic questions about the workforce numbers and composition that will be needed by 2025. How many primary care providers does the nation require to deliver on its promise of more accessible, quality health care? What are the various proportions of physicians, nurses, physician assistants, and other providers that can be used to meet that need?"[7] CMSS believes that it is rash to propose sweeping workforce-related legislative policy recommendations without the data required for their support, and furthermore, in the absence of that data, it is inaccurate to conclude that an expanded scope of nursing practice would lead to a more equitable distribution of care.

SUMMARY

The extraordinary value that nurses add to the team-based, physician-led medical home model in an ever-growing and progressively more complicated healthcare system is irrefutable. Nurses should not be restricted from providing patient care according to their educational preparation and documented skills. However, the *Future of Nursing* report fails to include data verifying the need for an expanded scope of nursing practice. Increasing numbers of medical students already exist in the physician pipeline:[8] a corresponding increase in the number of residency positions would begin to address the physician shortage and provide the public with appropriately trained physician providers.

A cooperative and structured relationship, in keeping with the significant differential in training and experience, recognizes the consumer-driven and professionally acknowledged dictum that patient safety is paramount. To ensure safe and effective care, all members of the healthcare team must be required to demonstrate adequate education, training, skills, and competencies within their scope of practice, and all members of the healthcare team must provide care that is consistent with their education, training, and licensure.

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[1] Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press, 2010.

[2] Health Resources and Services Administration. *What Is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* Washington, DC: Health Resources and Services Administration (accessed October 26, 2010: http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/index.htm).

[3] Health Resources and Services Administration. *The Registered Nurse Population: Initial Findings from the 2008 National Sample Survey of Registered Nurses*. Washington, DC: Health Resources and Services Administration (accessed October 26, 2010: http://bhpr.hrsa.gov/healthworkforce/rnsurvey/initialfindings2008.pdf).

[4] Lin GE, Burns PA, and Nochajski TH. "The Geographic Distribution of Nurse Practitioners in the United States." *Applied Geographic Studies* 1 (1997): 287–301.

[5] American Nurses Credentialing Center. 2008 *Role Delineation Study: Pediatric Nurse Practitioner*. Silver Spring, MD: American Nurses Credentialing Center, 2009.

[6] Freed GL et al. "Pediatric Nurse Practitioners: Roles and Scope of Practice." *Pediatrics* published online Oct 18, 2010; DOI: 10.1542/peds.2010-1589.

[7] Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press, 2010.

[8] AAMC Releases New Physician Shortage Estimates Post-Reform [press release]. Washington, DC: Association of American Medical Colleges; September 30, 2010.