Your Diabetes Care Provider in the Future Is Probably an NP or PA!

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It is well known that the physician shortage is bad and getting worse with an influx of newly insured patients. To make matters worse for people with diabetes, the numbers of endocrinologists treating people with diabetes is decreasing. Some estimate that there are only ~4,000 practicing endocrinologists, and the number is dropping.[1] The need for qualified health care professionals (HCPs) has never been greater.

The rapidly aging population, coupled with longer life expectancies, will result in an increasing number of people with diabetes who will need both primary and specialty diabetes care. The current health care system is challenged to ensure accessibility to quality, affordable care for people with diabetes. Some health care organizations, HCPs, and government officials believe at least part of the solution lies in expanding the scope of practice of nurse practitioners (NPs) and physician assistants (PAs). A key message in the Institute of Medicine (IOM)'s *The Future of Nursing: Leading Change, Advancing Health*[2] is that NPs should be used to the full extent of their education

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and training and that they need to become full partners with physicians and other HCPs. As stated in that document, "The United States has the opportunity to transform the health care system, and nurses can and should play a fundamental role in this transformation." To achieve this transformation, "Nurses should practice to the full extent of their education and training."

One reason many NPs are unable to practice to the full extent of their education and training is rooted in history and traditions that are no longer appropriate for today's rapidly advancing health care system. Physicians were the first group of HCPs to be regulated through state licensure. As a result, the medical scope of practice is all encompassing with regard to the ability to diagnose, prescribe, treat, and cure.[3] As other health care professions began to require regulation, they had to carve out tasks or functions from those belonging to the medical scope of practice.[3] Currently, multiple health care professions such as psychologists, optometrists, pharmacists, advanced practice nurses, PAs, and physicians have overlapping scopes of practice. Organized medicine has supported scope of practice regulations to safeguard patient safety and to ensure that NPs are only allowed to practice primary care with physician supervision.[4]

The ability of NPs and PAs to provide safe, cost-effective, high-quality care is well documented in many studies conducted during the past 30 years. One landmark study published in the *Journal of the American Medical Association* in 2000[5] demonstrated the quality of care provided by NPs. In this study, researchers evaluated the health status of patients receiving care from physicians or NPs. The NPs being studied practiced independently, without a mandatory relationship with a physician. The patients were assigned to a physician or NP for primary care after an urgent care or emergency room visit. The results indicated that the status of the patients treated by an NP and those treated by a physician were comparable at the initial, 6-, and 12-month visits. In a follow-up study 2 years later by some of the same researchers,[6] the outcome was the same. The researchers determined that NP care was comparable to that of physicians in all areas, including health status, satisfaction, and use of specialists.

Individual state boards of nursing, along with state legislatures, determine each state's Nurse Practice Act—the rules and regulations that codify the professional scope and standards of practice for NPs. The scope of practice for NPs in each state reflects a dynamic interaction between the regulatory body for the nursing profession and the policymakers.[7] Scope of practice is what the law allows an NP to do in providing patient care.[8] Although simple, the definition of scope of practice is the crux of the issue when it comes to full practice authority and independent practice. One of the most pressing issues is the lack of standardization and existence of discrepancies in the level of practice among NPs in different states.[9]

The most consistent barrier to full practice authority and independent practice by NPs is the requirement for physician input into NP diagnosing, treating, and prescribing. According to Safriet,[10] when physician supervision/direction of NP practice is required, the state has essentially privatized a core governmental function: assessing competence for licensed practice. When physician supervision/collaboration is required, the scope of practice is no longer determined by the state, but rather by the physician supervisor. The scope of practice determines the activities that are reimbursable by third-party payers and directly affects the independent practice of NPs.[10] When physician collaboration/supervision is required, NPs are less likely to be empanelled by insurers and are unable to directly bill for the services they provide.[11] Instead, their services are billed under the physician's provider number. Eliminating the requirement for physician involvement will allow NPs to be credentialed as providers and to be directly reimbursed for services. Another issue related to scope of practice is the lack of universal, federal recommendations for mobility across states for practitioners involved in telemedicine. The significant discrepancy in NP scopes of practice across states limits the ability of expert NPs and PAs to serve as consultants across state lines, thereby directly affecting the ability of individuals to get specialty consultation that may not be available locally.

The need for consistency in state regulations has never been more relevant and has significant implications. The American Academy of Physician Assistants (AAPA) anticipates continued improvements to PA practice laws in the second half of 2014. Several more states are seeking to implement one or more of the AAPA's Six Key Elements of a Modern PA Practice Act—components identified by AAPA as essential to enabling PAs to practice medicine.[12] These include:

- "Licensure" as the regulatory term
- Full prescriptive authority
- Scope of practice determined at the practice level
- Physician-on-site requirements determined at the practice level
- Chart cosignature requirements determined at the practice level

- No restriction on the number of PAs with whom a physician may practice

It is a significant barrier to quality care when NPs and PAs are not recognized as primary care providers in all programs and settings. The IOM's definition of primary care ("the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community")[2] should serve as a benchmark for any legislation to expand access to primary care services.

I suggest that payers should provide coverage of NP and PA services as physician services are covered. Several outdated regulatory barriers to NP practice could be removed simply by correcting the interpretation of the term "physician" to be consistent with current Medicare payment policies that authorize Part B payment to NPs for services within their scope of practice and that "would be covered if furnished by a physician."[13] This simple change would enable NPs to certify Medicare beneficiaries for home health and hospice services and conduct examinations to admit patients to skilled nursing facilities. There are a number of other unfair regulations in Centers for Medicare & Medicaid Services regulations that affect the ability of NPs and PAs to care for people with diabetes, including not being allowed to certify patients for home care or to refer for medical nutrition therapy. Nineteen states now allow advanced practice registered nurses (APRNs) to practice without physician supervision, and, hopefully, we will see this increase to allow APRNs to practice to their full scope of practice.

It is important in this era of physician shortages to allow the > 90,000 PAs and 160,000 NPs to carry out the full scope of their practice and contribute more effectively to the primary and specialty care of people with diabetes. Talk to your legislators about this important issue at every opportunity.

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