



The Rural Health Connection

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Meeting the Primary Care Needs of Rural America Examining the Role of Non-Physician Providers

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The availability of accessible and efficient primary care in rural America is a substantial and growing concern that is heightened by a combination of demographic trends. Physician supply in rural areas is already low, compared to non-rural areas of the country. Only about 11 percent of the nation's physicians work in rural areas, despite nearly 20 percent of Americans living there.¹ Moreover, physicians providing care in rural areas often serve large geographic areas that require long travel times. These areas may be substantially underserved by hospitals and other health care facilities. Demographic shifts, such as the aging rural physician workforce and the growth in the rural elderly and near-elderly population will increase demand for primary care services. One approach to meeting this increased demand that is under consideration in many state legislatures is a redefinition, and often expansion, of the scope and standards of practice for non-physician practitioners. A recent survey found that 41 percent of rural Medicare beneficiaries saw a physician assistant or nurse practitioner for all (17 percent) or some (24 percent) of their primary care in 2012.² In the 2012 session, NCSL tracked 827 bills to redefine providers' scopes of practice in 29 states, 154 of which were enacted in 24 states and the District of Columbia.³

"Scope of practice" is a term used to describe the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for a health professional. A professional's scope of practice is limited to that which law or regulation allows and is often based on the education, training and experience typical for that profession. Scope of practice regulations vary by state.

State legislatures greatly affect how a licensing board defines a provider's scope of practice—in other words, who delivers what care, in what setting and with what supervision. Scope of practice is an important issue for all health professionals because it affects their revenue and potential client

Non-Physician Practitioners

- The American Association of Nurse Practitioners defines a **nurse practitioner** as a nurse who has completed a master's or doctoral degree program, and who has advanced clinical training beyond their initial professional registered nurse preparation.
- The American Academy of Physician Assistants defines a **physician assistant** as a graduate of an accredited PA educational program who is nationally certified and state-licensed to practice medicine with the supervision of a physician.

base. For example, state Medicaid programs pay providers based on the scope of practice standards for that profession. This brief examines the legislative role, provides an overview of existing research, and describes state activity relating to scope of practice.

The Problem

Estimates about the scope of the provider shortage in rural America vary, but what is generally agreed upon is that thousands of additional primary care providers (PCPs) are needed to meet the current demand in rural America and that, during the coming decade, tens of thousands of additional PCPs will be needed to meet the growing rural population.⁴ Access to appropriate primary care services is important to maintaining and improving health. Those who obtain regular primary care receive more preventive services, are more likely to comply with their prescribed treatments, and have lower rates of illness and premature death, according to research.⁵

However, recruiting and retaining providers in underserved areas is difficult and remains challenging for states, counties and communities. Research shows that financial, professional and cultural factors affect where young doctors choose to practice. Another factor compounding the shortage of phy-



sicians is that the number of medical graduates who choose to practice rural primary care is insufficient to replace the rural doctors who are retiring. A recent study found nearly 30 percent of rural primary care physicians are at or nearing retirement age, while younger doctors (those under age 40) account for only 20 percent of the current workforce.⁶

Meeting the current need is difficult enough, but the demand for services is expected to grow significantly in the coming years. The rural population of those ages 55 to 75 is estimated to grow 30 percent between 2010 and 2020 due, in part, to retiring baby boomers migrating from urban areas.⁷ Since people tend to develop more medical needs as they age, this trend increases the need for services in rural areas.

In addition, the Patient Protection and Affordable Care Act requirement that most people have health insurance will increase demand for health care services, especially for primary care. Some estimates projected an additional 8 million to 9 million rural individuals would be eligible for coverage through Medicaid as a result of the expansion of coverage for those with incomes up to 133 percent of the federal poverty guidelines.⁸ However, since the Supreme Court ruling effectively made the Medicaid expansion voluntary, that number is expected to be lower, since some states may choose not to expand Medicaid.

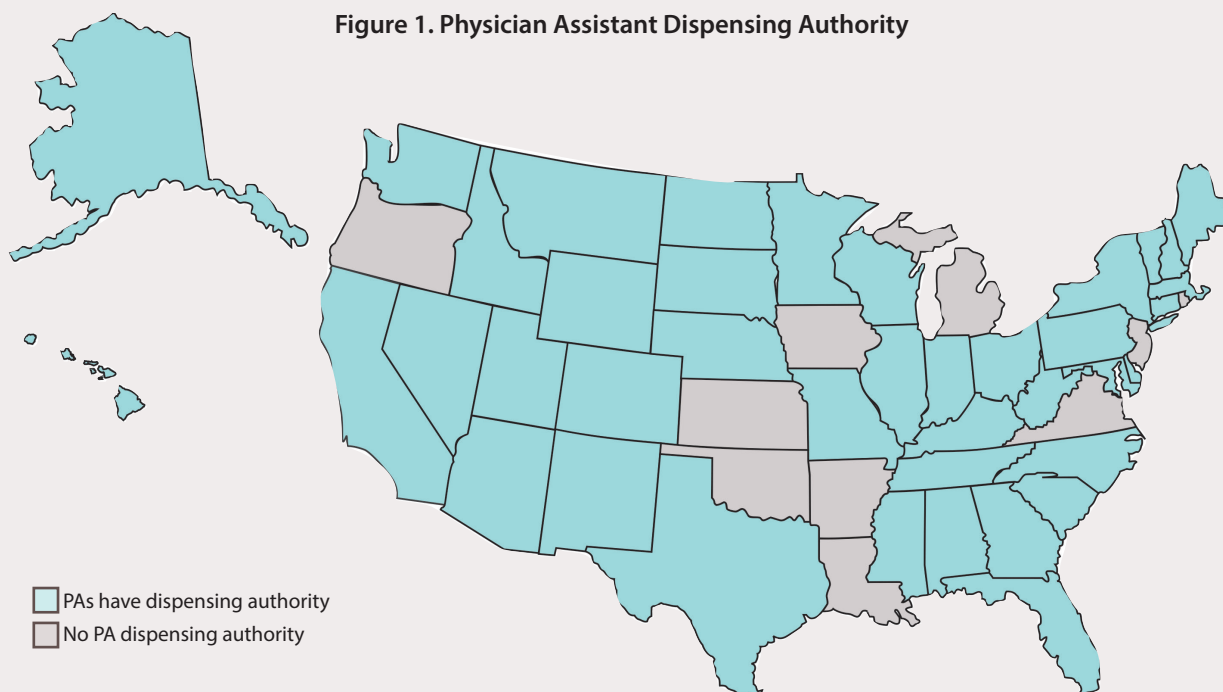
For these reasons, states have been working to find ways to increase the number of primary care providers in rural areas. One option under consideration is to expand the scopes of practice for certain non-physician practitioners, thereby permitting these professionals to furnish a greater array of diagnostic and therapeutic services to patients.

The Research

Studies suggest that access to and the quality of primary care services can be improved and certain costs can be reduced with targeted expansions of scope of practice for non-physician practitioners. However, research also identifies the need for increased educational and licensure standards for providers with expanded scopes of practice, as well as improved data collection in order to increase accountability and ensure quality of care. Here are some brief findings from the research.

- **Access**—Studies examining scope of practice suggest that non-physician practitioners, such as nurse practitioners and physician assistants, play a significant role in providing health care to people living in underserved areas—particularly those living in rural America.⁹ The Institute of Medicine (IOM) found that access to primary care increases when more nurse practitioners deliver those services. The IOM also found that nurses working as care coordinators and primary care clinicians can reduce hospitalization and rehospitalization rates for elderly patients.¹⁰
- **Quality of Care**—A growing body of evidence indicates that the quality of care provided by nurse practitioners and physician assistants in the primary care setting is, in some aspects, comparable to that of physicians. In certain studies, for example, nurse practitioners were found to spend more time in consultation with patients and generate greater overall levels of patient satisfaction.¹¹
- **Cost of Care**—A 2009 RAND study found that, in Massachusetts, visits to nurse practitioners and physician assistants cost 20 percent to 35 percent less than visits to physicians.¹² While such studies estimate cost savings, no empirical studies have been conducted to determine whether costs can be reduced through expanded scopes of practice for non-physician primary care providers in rural areas.
- **Education and Training**—Nurse practitioners and physician assistants are continually asked to coordinate care across disciplines and use more complex technological tools and information systems. As rural and frontier areas increasingly rely on non-physician practitioners to deliver primary care services, research indicates that these providers need to attain higher levels of training and education over the course of their careers.¹³ State policymakers could consider increasing educational and licensing standards for these professionals in order to meet these growing demands. In addition, the IOM recommends creating systems for collecting and analyzing workforce data and that future decisions about the scope and standards of practice for non-physician practitioners be based upon the data collected.¹⁴

Figure 1. Physician Assistant Dispensing Authority



Source: National Association of Boards of Pharmacy, Survey of Pharmacy Law, 2012 (Mount Prospect, Ill: NABP, 2012).

State Actions

Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers.

For instance, physician assistants may prescribe medication in all 50 states and, according to the National Association of Boards of Pharmacy, 40 states have given physician assistants varying degrees of authority to dispense (give or supply) medications to patients; this can be helpful for people who live in rural areas where the closest pharmacist may be many miles away.¹⁵ Also, according to the American Academy of Physician Assistants, all 50 states pay for medical services provided by physician assistants under the supervision of a physician through Medicaid fee-for-service or Medicaid managed care programs, although the payment amount per service may be slightly lower than that paid to physicians.¹⁶

Fifteen states allow nurse practitioners to diagnose, treat and prescribe medications without physician supervision. Another eight states allow nurse practitioners to independently diagnose and treat patients, but not to prescribe medications. The remaining 27 states require either direct or indirect physician supervision of nurse practitioners to diagnose, treat and prescribe. In addition, according to the American Nurses Association, federal law requires that all 50 states provide payment for services furnished by pediatric

nurse practitioners, family nurse practitioners and certified nurse midwives for medical services provided under their Medicaid fee-for-service or Medicaid managed care programs.¹⁷

Legislative Considerations

For states with large rural and frontier areas, finding an appropriate balance between expanding scope of practice for non-physician practitioners while ensuring patient safety, the quality of care and provider accountability are a challenge. Physician groups generally support collaborative or supervisory arrangements with non-physician practitioners. However, these groups generally oppose efforts that allow non-physicians to practice independently.¹⁸ Legislators often are called upon to determine the appropriate balance through scope of practice legislation. As policymakers grapple with increasing access to quality primary health care, they may wish to examine or re-examine the following issues.

- **Independent Practice Authority**—To what extent is physician supervision required for nurse practitioners and physician assistants? Can they practice without direct physician supervision, and under what circumstances? Should the requirements related to the distance between a supervisory physician and a non-physician practitioner be examined for providers practicing in rural areas?

- **Prescription and Dispensing Authority**—Should nurse practitioners and physician assistants have full authority to prescribe and dispense medications? If so, what classes of prescription drugs should they be allowed to dispense? Should non-physician primary care providers in remote areas where there is no physician or pharmacist be given broader authority to dispense medications?
- **Licensure**—In order for non-physician practitioners to practice and receive payment, are revisions needed to current licensure requirements?
- **Education and Training Standards**—How does the state ensure services provided are consistent with education and training? Should educational and licensing standards for non-physician practitioners be increased in order to meet the growing demands placed upon these professionals in rural areas?
- **Medicaid Payment**—Who should receive Medicaid payment for providing which services? Should non-physician practitioners receive lower payment than physicians for comparable services? Should rural providers be reimbursed differently for practicing in underserved areas?

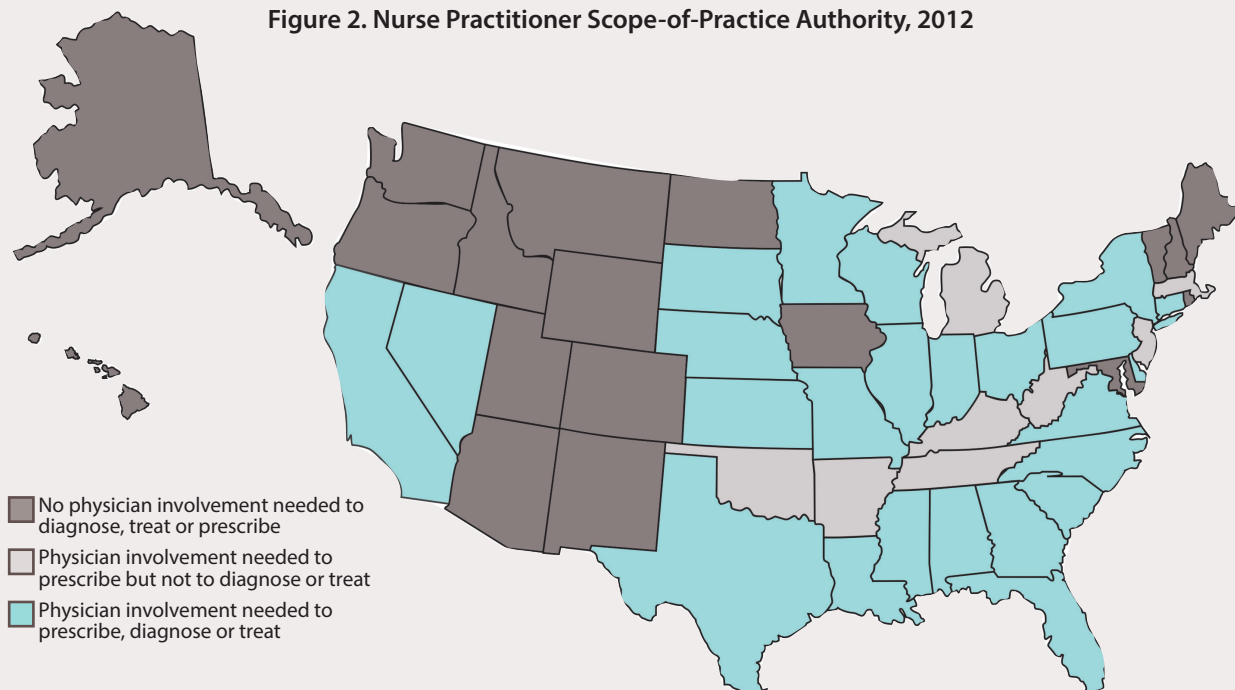
State Examples

States have taken a number of actions in recent years to expand the scope and standards of practice for non-physician primary care providers, many of which are too recent to see results or properly evaluate. This section includes policy examples from Pennsylvania and Connecticut.

Prescription for Pennsylvania. Between 2007 and 2009, the Pennsylvania General Assembly enacted a large package of health reforms, referred to as the *Prescription for Pennsylvania*, which included numerous provisions related to the scopes of practice for health professionals such as certified registered nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives and independent dental hygienist practitioners.

One law gave physician assistants working under the supervision of a physician the authority to order durable medical equipment and physical therapy, dietician, respiratory and occupational therapy referrals; perform disability assessments for the federal Temporary Assistance for Needy Families (TANF) program; issue homebound schooling certifications; and perform and sign for the assessment of methadone treatment evaluation.

Figure 2. Nurse Practitioner Scope-of-Practice Authority, 2012



Note: In Connecticut, Indiana, Minnesota and Pennsylvania, physician involvement is required to diagnose or treat, but written documentation of this is not required. In other states that require physician involvement to diagnose or treat, written documentation is also required.

Source: Linda J. Pearson, "The 2012 Pearson Report," *American Journal for Nurse Practitioners*.

Another law authorizes nurse practitioners who enter into a collaborative practice agreement with a supervisory physician to perform the same duties as a physician assistant and to order home health or hospice care. Walk-in clinics, which were then growing in numbers in Pennsylvania and often are operated by nurse practitioners, were the impetus for this expanded scope.¹⁹

Connecticut's Review Process. Issues related to the scope of practice for health professions can be complex and technical, and passionate stakeholders typically are actively engaged in the legislative process. This can make legislative decisions very difficult, even for the most informed legislator. For these reasons, in May 2009 the Legislative Program Review and Investigations Committee, a bipartisan, statutory committee of the Connecticut General Assembly, initiated a study to examine the state's process for determining scopes of practice for health care professionals. The aim was to discover whether changes to the process were "necessary to make it more useful to legislators and other stakeholders."²⁰

The committee's recommendations, which took effect in July 2011, established a non-partisan review committee at the Department of Public Health to review and submit recommendations to the legislature regarding all scope-of-practice issues.²¹ Changes to providers' scopes of practice must be submitted to the Department of Public Health no later than August 15 of the year preceding the legislative session during which the legislature is to consider the changes, and the department must provide feedback on the proposed changes to the legislature by February of the following year. Five scope-of-practice changes were reviewed under the new process for the 2012 legislative session and one, eliminating a face-to-face supervision requirement for physician assistants, became law.^{22,23}

Conclusion

Thousands of additional primary care providers (PCPs) are needed to meet the current need in rural America and, over the coming decade, tens of thousands of additional PCPs will be needed to meet the growing rural population.²⁴ The growing number of elderly people in rural areas, the aging workforce of doctors and the expected increase in demand for primary care as a result of the Affordable Care Act present serious challenges for states. Consequently, many states continue to look at ways non-physician providers can play a larger role in providing primary care in rural areas.

Research suggests that, by expanding scopes of practice for non-physician primary care providers such as physician assistants and nurse practitioners, access to primary care services can be improved and the quality of those services will be comparable to that provided by physicians. Expanded scope of practice for non-physician practitioners also could potentially result in decreased costs, although more research is needed in this area to determine whether cost-savings can be achieved in rural areas. States also will want to develop better ways to measure the effects of expanded scopes of practice on cost, quality and access to care.

By attempting to find a balance between using non-physician primary care providers to the fullest extent of their education and ensuring that patients can seek treatment in a safe and cost-effective environment, states can potentially work toward meeting the growing health care needs of their rural populations.

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