NJ APN Consortium Response to ATC Coalition Statement re S1522/A2286

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The "Access to Care Coalition" (hereafter ATCC) statement incorrectly claims that removing the Joint Protocol from APN law means that APNs will no longer cooperate in providing team-based care or in consulting with physician colleagues in the provision of care. This contention has no basis in reality. No health care provider works "independently;" rather all work interdependently. Mutual collaboration is a professional responsibility and will continue. The most effective team-based care does not depend on a hierarchy where the physician is always at the top, but effectively utilizes the skills of all its members. There is widespread agreement that effective teams require a clear leader, and these teams recognize that leadership of a team in any particular task should be determined by the needs of the team and not by traditional hierarchy.

A point-by-point response to the ATCC's "Fact" Sheet Follows:

APN Response to APNs working without JP: Health Systems that have not implemented Executive Order #112 waiving physician oversight requirements for APNs during the pandemic, are failing to adhere to the still-in-place government mandates designed to make the provision of care more flexible and efficient in New Jersey. Of 108 NJ APN respondents surveyed in Nov 2020, 66.80% respondents work in various primary care clinical settings and populations and 38.20% are psychiatric mental health APNs. 37% worked without a Joint Protocol while 59% did not. Some feedback we obtained from the survey: "I temporarily left my regular practice to work in the COVID ICU in a hospital. I don't know if I had one [Collaborating Physician]. If I had a collaborating physician, I don't know who it was." "We had a reduced fee during Covid to keep him on retainer. If I didn't pay it, then he would drop me totally. He fears we will get independence in the end and told me he wants to collect while he can". (*JPSG Impact Survey Report. Nov 30, 2020)

APN Response to Physician substitution: APNs are not physician substitutes but nursing professionals with advanced degrees who are nationally board certified in specialty areas and licensed by the NJ Board of Nursing. The care that APNs and physicians provide may be parallel in some instances and complementary in others; that is the nature of overlapping practice between health care professionals. APNs practice within the scope of practice boundaries established by the profession of nursing and regulated by the NJ Board of Nursing.

APN Response re. quality and cost: The statement that APNs "do not know what they do not know," is false. Repeated studies including those cited in the White Paper, demonstrate that APNs write fewer prescriptions, order fewer tests, and that their patients experience fewer office-based and specialty care visits, emergency room visits, and hospitalizations.

The Coalition cites a Mississippi study which they interpret to mean that APNs and physicians do not provide comparable "value-based care." In fact, that longitudinal evaluation does not compare the care of Nurse Practitioners and physicians, but that of Advanced Practice Providers (including optometrists and PAs and APNs, together) to physicians, so no discrete conclusions can be drawn. Still the authors use the study in support of their opposition to a Full Practice Authority bill for Mississippi APNs. More than 25 years of research has documented that APNs provide high quality, cost effective care, whose outcomes are comparable to physicians when caring for similar conditions. For example: Liu and colleagues examined 806,434 VA patients assigned to either a primary care NP or a primary care physician and found no differences in patient care outcomes and costs, except that NP assigned patients experienced fewer hospitalizations.

APN Response re. filling shortages in underserved areas: The statement that APNs in Full Practice States practice almost exclusively in high income areas, is a distortion of facts. Medicaid reimbursement rates are typically set so low for APNs, that it may be difficult for them to sustain a practice when those patients make up the preponderance of the practice. Health care insurers have been slow to allow reimbursement to APNs unless they have a collaborative physician. Still, APNs are more likely to serve vulnerable populations including the disabled and women, and those in rural and health care shortage areas. NJ leads the nation in physicians who do NOT accept Medicaid (18.9%) and are 3rd in the country in physicians (32.2%) who do not accept Medicare. 78.7% of APNs,

nationwide see Medicaid patients and 82% see Medicare patients. Patients are more than twice as likely to be seen by APNs for mental health visits in FPA states. Nurse practitioners see Medicaid patients 13% more often in FPA states, and this rises to 20% in states paying APNs 100% of the physician's rate, demonstrating that autonomy and reimbursement can positively impact accessible care. Workforce shortages do exist in NJ, as do healthcare deserts. According to the NJ Collaborating Center for Nursing, 84% of NJ APNs practice in primary care (compared to 33% of NJ physicians). NJ counties with lower income levels and poorer health outcomes are associated with a shortage of primary care physicians. When APNs are counted as primary care providers, as well, the counties in shortage areas are reduced from 13 to 6.

APN Response re. APN Self Owned Practices and Teams: The Coalition statement makes the erroneous claim that it is an "extremely rare exception" for APNs to maintain self-owned practice in NJ. In fact, an increasing number of APNs in this state own and operate their own practices, particularly those specializing in psychiatric-mental health. Increasingly Family Practice, Adult, and Gerontological APNs are doing the same, most frequently in underserved areas, and for the homebound elderly. (*JPSG Impact Survey Report. Nov 30, 2020)

APNs with self-owned health care practices do not provide care in isolation. They establish a full cohort of fellow providers-physicians, psychologists, social workers, physical and occupational therapists, pharmacists, radiology services, laboratory technicians, and so forth, with whom they regularly communicate regarding patients and their care. Their mandated collaborating physician may not be the person with whom they most often need to communicate.

APN Response re. finding a CP: APNs and physicians decide together the degree of involvement the physician will have in an APN's prescribing practice. The Joint Protocol agreement is limited to prescribing. The ATCC statement mentions risk, suggesting that physicians assume a significant risk when agreeing to be the contractual physician of an APN. In fact, relaxing scope-of-practice laws could mitigate the adverse extra-regulatory effect on physicians and could also lead to improvements in access to care.

Malpractice suits and settlements are often used as a proxy for evaluating safe care. In NJ, over the last 20 years, approximately 2% of APNs have been named in a suit or settlement, a very low rate and far lower than that of their physician colleagues of 8.7%. Malpractice rates nationwide are no higher among APNs in states with FPA than they are in states with restricted practice.

APN Response re. Cost of JP: The Coalition denies that APNs typically pay a price for the mandated physician collaboration required by the Joint Protocol. In fact, a survey of NJ APNs done in 2021, revealed that they were paying an average of $1000/month to their contractual physician. This is consistent with the $500-$1500/month average described in the literature as what can be expected for a collaborating physician. It is true that some APNs pay nothing for a physician to be their contractual physician. It is more often the case that APNs pay a fee, particularly if they are working in their own practices or in physician-owned private practices. The true cost of collaborative agreements is often hidden from individual physicians because these fees are paid by the hospital or health care systems that employ them. ZipRecruiter, using employee payroll data reports the 2022 salary for a "collaborating physician" in NJ to be $110/year. This is a salary paid to the physician just for the purposes of collaborating, apart from any other job responsibilities.

APN Response re. Joint Protocol: The Coalition seems to have written this oppositional statement without a clear understanding of the Joint Protocol requirement in NJ. Current law requires that APNs prescribe medications only, in accordance with a Joint Protocol (a written agreement) with a collaborating physician. The law specifically requires that the APN and the collaborating physician must review and co-sign the Joint Protocol at least annually. The frequency of communication and extent of chart review is entirely up to the APN and the collaborating physician. Communication can be totally electronic. Institutional health care settings may establish standards of greater frequency for mutual chart review; that is within the institutional purview, but it is not required by law. There are distinct limits to the Joint Protocol requirement: it is confined to one aspect of APN practice alone: prescription writing. Every other component of APN practice is already independent of the Joint Protocol. Many physicians, hospital and health care administrators, health care insurers and ancillary service providers do not understand this. Additionally, APN law is often confused with current law for Physician Assistants (PAs) which requires that PAs work under the direct supervision of a physician, and that their charts be co-signed.