

TALKING POINTS

APN PRACTICE, THE HEALTH CARE ENVIRONMENT, and BARRIERS TO CARE IMPOSED BY THE JOINT PROTOCOL REQUIREMENT

- National health care reform and recent NJ state legislation have increased the number of individuals in this state seeking access to primary and specialty care providers, particularly those who provide psychiatric care. It is estimated that only 8% of NJ citizens are currently without health care insurance. APNs are skilled professionals capable of meeting these health care needs.
- In the United States currently, there are 270,000 Nurse Practitioners, 60,000 CRNAs (certified registered nurse anesthetists; in NJ, also known as APNs-anesthesia) and 72,000 clinical nurse specialists. Close to 10,000 of these APNs are licensed and certified by the NJ Board of Nursing, and actively practicing in NJ.
- Advanced Practice Nurses (APNs) are not new to NJ; they have been providing safe, cost-effective, and high quality care to health care consumers including those in underserved areas of the state, for close to five decades.
- In NJ, there are too few Board Certified Psychiatrists and there is an average 3-month wait time for new patients seeking mental health care. Psychiatric APNs can help fill this mental health care gap.
- Studies comparing care given by APNs to that of physicians when patients have comparable conditions or complaints, demonstrate comparable quality and intensity of that care.
- APNs are affordable to educate and affordable to employ for the primary and specialty care they are prepared to provide, and they are typically reimbursed at 85% of a physician's rate for providing care for the same conditions or complaint, all of which contribute to their cost-effectiveness. Requirements for physician collaboration or supervision add to the cost of care, costs that are borne by patients, insurers, state and federal government, and ultimately, US taxpayers.
- Medicaid and Medicare both directly empanel and credential nurse practitioners and clinical nurse specialists.
- APNs emphasize disease prevention and health maintenance. Because of their communicative skills, patients are likely to understand the information they receive related to self-care and medication management. Recipients of APNs' services are less likely to require costly emergency room and hospital-based care. Given the dramatic rise in the number of Americans with chronic diseases like diabetes and asthma, increasing the number of APNs employed both in primary care and diseased-focused specialty care can be expected to result in major cost-savings for the United States as a whole.
- The APRN Consensus model disseminated by the National Council of State Boards of Nursing (NCSBN) in 2009, and a January 2019 follow-up article by members of the NCSBN in the *Journal of Regulation*, recommends the removal of all existing language requiring collaboration, supervision or direction in statutes or regulations impacting APN practice, nationally.

- 22 states and the District of Columbia have increased access to APN care by eliminating statutory and barriers imposed by requirements for supervision, collaboration and direction, without any evidence of a diminution in patient safety; they have achieved what is known as Full Practice Authority (FPA). These states include neighboring New York, Connecticut and Delaware.
- Studies show no higher malpractice rates for APNs working in states with Full Practice Authority than in those states that continue to require physician collaboration or supervision. This reflects the fact that APNs in states with Full Practice Authority continue to provide safe and high quality care.
- No function of NJ APN practice except the *prescribing of drugs* requires a joint protocol with a collaborating physician.

Barriers to Practice Imposed by the Joint Protocol Agreement Interrupt Safe and Timely Care:

- The collaborating physician-now legally required for an APN to prescribe legend drugs-may not be directly familiar with the patient, and may not be in the same office setting or even in the same town as the APN who is providing care to the patient.
- Lab tests ordered by the APN may be sent to the collaborating physician instead of to the APN, creating confusion in the physician's office, frustration for the patient and the APN, and delaying proper patient care where timeliness may be essential to successful treatment.
- When APNs refer a patient to a specialist, the consulting report may go to the collaborating physician's office instead of to the APN, again creating confusion in the both the physician's and the APN's office and delaying proper patient care.
- Despite current pharmacy law, many pharmacists continue to list the collaborating physician on the medication container label creating confusion and a potentially unsafe situation for the patient when they seek clarification about a prescribed drug.
- When a collaborating physician retires or leaves the state, the APN risks losing her practice. If a new collaborating physician is hired by the APN, the MD may not be credentialed and empanelled by the same health insurance plans as the APN, the insurance company may refuse to continue to empanel and reimburse the APN, resulting in consumer loss of access to that APN's care; gaps in care occur as the APN seeks a different collaborating physician and/or another practice site and as the APNs' patients are forced to wait, travel further to obtain care or inappropriately utilize emergency rooms for health care