APRNs’ Quest for Independence: The Public Health Perspective

By Susan Baek, JD, Director, Health Care Policy and Legislative Affairs

As the 2016 WV Legislative Session approaches, the WVSMA has been working on numerous proposals to protect the public health. One of the most challenging issues we expect to face during the upcoming session is the persistent effort by a small group of advanced practice registered nurses (APRNs) to increase their scope of practice in an attempt to gain the same privileges that physicians have.

The APRNs’ effort represents a step in the wrong direction. A comparison of APRNs’ and physicians’ educational requirements, patient care data, and prescribing habits shows that APRNs need more supervision by physicians, not less. The current laws that APRNs call “barriers” actually provide only minimal safeguards, and they should be strengthened in the interest of the public health.

**Summary of the Issue**

Current WV law allows APRNs to practice independently and is more permissive than laws in the majority of other states. The only statutory limitation on WV APRNs’ practice is regarding their prescriptive authority. To prescribe medications, they must have a written collaborative agreement with a physician in the state, but this requirement is pretty vague: there are no geographic constraints and no mandated guidelines regarding oversight. Also, their formulary is restricted: APRNs cannot prescribe Schedule II medications, and they can only prescribe Schedule III medications for a 72-hour duration with no refill.

WV APRNs have asked legislators to amend the law to remove the collaborative agreement requirement and lift the formulary restrictions. The WVSMA strongly opposes such amendments.

This is a difficult issue. APRNs are an important part of the health care team, and our physician members who work with APRNs have a positive opinion of their work and value their contributions to the team, but the APRN leaders who represent this issue present their policy arguments in a very contentious way. The APRN leaders seem to resent the idea of a physician-led team, even though it is proven to be the optimal health-care model. They characterize the issue as a turf battle and claim that physicians oppose their efforts due to economic concerns. Nothing could be further from the truth. For physicians, the issue is about protecting patient safety and public health.

**The Definition of APRN**

APRN is a broad term that includes certified nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. In West Virginia, an APRN is defined in statute as a registered nurse who has completed a board-approved graduate level education program and passed a national certification test (WV Code §30-7-1(a)). According to www.graduatnursingedu.org, an APRN is “a nurse who has a master’s, post-masters, or doctoral degree in a nursing specialty and can generally practice medicine without the supervision of a physician.” That definition exemplifies the problem with APRNs’ legislative efforts. The problem is that nurses are not allowed to practice medicine. By law, only physicians are allowed to practice medicine. APRNs are licensed to practice nursing, and even an advanced nursing degree does not provide the same qualifications that physicians have earned.

**APRN Education Requirements**

With some exceptions, APRNs are required to have a graduate degree in nursing. Registered nurses often have a 4-year degree, but even those with a 2-year associate degree can qualify for admission to a graduate program. Graduate nursing programs generally can be completed in 18 months, and both the associate and graduate nursing degrees are available from online programs.

That means that an APRN graduating today needs as little as 3.5 years of post-high school education compared to a physician’s minimum of 11 years (4 years of college, followed by 4 years of medical school and at least 3 years of residency training). According to the American Academy of Family Physicians, family practice physicians spend 21,700 hours on medical education compared to a range of 2,800-5,350 for nurse practitioners.¹ By another estimate, primary care physicians spend nearly 50,000 hours,² so physicians have 4 to nearly 20 times as much as education as APRNs.

The difference in clinical experience is even more dramatic. In general, family practice physicians have 30 times more clinical training than the recommended amount for APRNs. Medical students are not allowed to diagnose or treat patients or prescribe medications until they have undergone at least 15,000 hours of clinical education and training.³ In comparison, APRN programs vary, but, if they are in line with the APRN consensus model, they require 500 hours of clinical experience.⁴ Some online...
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programs require a day or weekend on campus; others allow all clinical requirements to be satisfied in the student’s home community.

The difference in education between physicians and APRNs is not only quantitative. Medical school education is not available online. The admissions process to the 141 accredited brick and mortar medical institutions in the country is highly competitive and attracts students from the very tops of their classes. In comparison, there are 420 institutions nationwide that offer APRN programs, and well over 100 of these are online programs. Some of the schools advertise their admission criteria on their websites. Many require a 3.0 average; some have lower requirements. For example, the Mississippi University for Women’s 12-month Family Nurse Practitioner program requires applicants to have earned at least a “C” in Statistics. (A “C” in any undergraduate class, especially a prerequisite, would probably be a deal breaker for medical school.)

Not only do the APRN online programs present some obvious limitations, but the American Association of Colleges of Nursing also reports that there is an ongoing nursing faculty shortage and problems with the limited number of preceptors at clinical sites. This calls into question the adequacy of some of the programs. This is not to say that there are not some exceptional APRNs, but there are also some at the other end of the spectrum. Laws apply to everyone, so it is important that they are tailored to protect the public from those APRNs who are minimally qualified.

Research on Quality of Care

The significant differences between the education of physicians compared to that of APRNs translates to differences in patient care. Research studies show that APRNs are proficient at communicating with patients and managing chronic illnesses, but demonstrate weakness in diagnoses (for example, one study showed that APRNs mis- or under-diagnosed 40% of patients), and they tend to increase costs by ordering more tests.

The data from many studies show that APRNs have a skill set

<table>
<thead>
<tr>
<th>Antibiotic Class</th>
<th>Physicians</th>
<th>Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cephalosporin</td>
<td>-20.7%</td>
<td>+50.0</td>
</tr>
<tr>
<td>Penicillin</td>
<td>-22.7%</td>
<td>+51.2</td>
</tr>
<tr>
<td>Sulfonamides</td>
<td>+12.9%</td>
<td>+132.5</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>+1.6%</td>
<td>+85.7</td>
</tr>
</tbody>
</table>

Table. Percent Changes in Prescribing Rates, 2005-2010

#Rx/#Provider

Hamlin
304.824.5806
Delbarton
304.475.1761
Gilbert
304.664.6270
Logan
304.752.8081
Man
304.583.8585
Salt Rock
304.824.2073
Sand Plant
304.756.1500
Guyan Valley Wildcat Center
304.824.5707
Logan Wildcat Center
304.688.9949
LCHS Panther Center
304.824.6090
CRHS Tiger Center
304.955.9265
Duval Yellowjacket Center
304.524.9242
Man Middle School
Opening soon!
that is complementary to that of physicians. Working together as a team, APRNs and physicians provide optimal patient care and can achieve cost savings.  

Prescribing Habits of APRNs

Data comparing the prescription rates of physicians and APRNs show some disturbing trends and indicate that APRNs require more guidance and supervision than they currently receive.

Antibiotic Prescriptions. Problems associated with overuse of antibiotics are well known, and antibiotic resistance is a serious and expensive healthcare problem. A recent report from the CDC shows that while physicians have generally curbed their rate of antibiotic prescriptions, APRNs have increased the rate of prescriptions per provider by an alarming amount.  

Opioid Prescriptions. For opioid prescriptions, new, unpublished data from IMS shows similar trends. Somewhat surprisingly, and contrary to what is often repeated in the media, the rate of opioid prescriptions by physicians actually decreased from 2010 to 2014—by 10.1% in the United States and by 14.4% in West Virginia. At the same time, the rate of prescriptions written by APRNs has risen dramatically: by 54% in the United States and 27.9% in West Virginia. If APRNs prevail in their legislative efforts, and current formulary restrictions are removed, the numbers could rise exponentially.

Overall Prescription Rates. On the whole, nurse practitioners (NPs) are much more likely to prescribe medications compared to physicians, and they often write as many as five prescriptions at a single visit, according to a study published in the Journal of the American Academy of Nurse Practitioners. The researchers found that physicians are five times more likely than NPs to write zero prescriptions for a patient at a primary care visit (30% vs. 6%). Further, NPs write two or more prescriptions for 88% of their patients (19% of their patients receive five!), while physicians most commonly prescribe one medication (for 30% of patients) or two (for 18%), with only 22% of their patients receiving three or more. This data suggests that more oversight is needed, considering the significant risk associated with drug interactions, to ensure that APRNs are not prescribing potentially dangerous combinations of drugs.

The Need for Increased Supervision

The data indicate that physicians should provide more supervision for APRNs to ensure that they are not over-prescribing medications. It is a critical public health issue. Overprescribing antibiotics leads to the development of more dangerous drug-resistant pathogens; overprescribing opioids is believed to fuel the drug abuse epidemic, which is particularly severe in West Virginia; and prescribing combinations of drugs can lead to potentially harmful drug interactions. As the WV Legislative Auditor recommended in the Performance Evaluation and Research Division (PERD) report from January 2014, the WVSMA believes that the current, restricted drug formulary for APRNs should be retained, and WV Code should be amended to mandate standardized collaborative agreements between APRNs and physicians. These agreements should include specific guidelines promulgated by the WV Boards of Medicine and Osteopathy. The rules should require leadership by physicians, who can use their discretion to determine the amount of oversight necessary to ensure that APRNs are prescribing appropriately.

APRNs tend to focus all of their advocacy efforts on trying to gain more autonomy. Instead, they should concentrate on ensuring that they provide patients with high-quality care, by strengthening their educational requirements and working in collaborative relationships with other providers in physician-led teams.

References

10. Xponent prescription database, IMS Health, Plymouth Meeting, PA. (Data provided to WVSMA by Robert Hunker of IMS Health.)