
Lunch & Learn

Do State Restrictions on APRNs Impact Patient Outcomes?

February 20, 2019

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Presented in partnership by:

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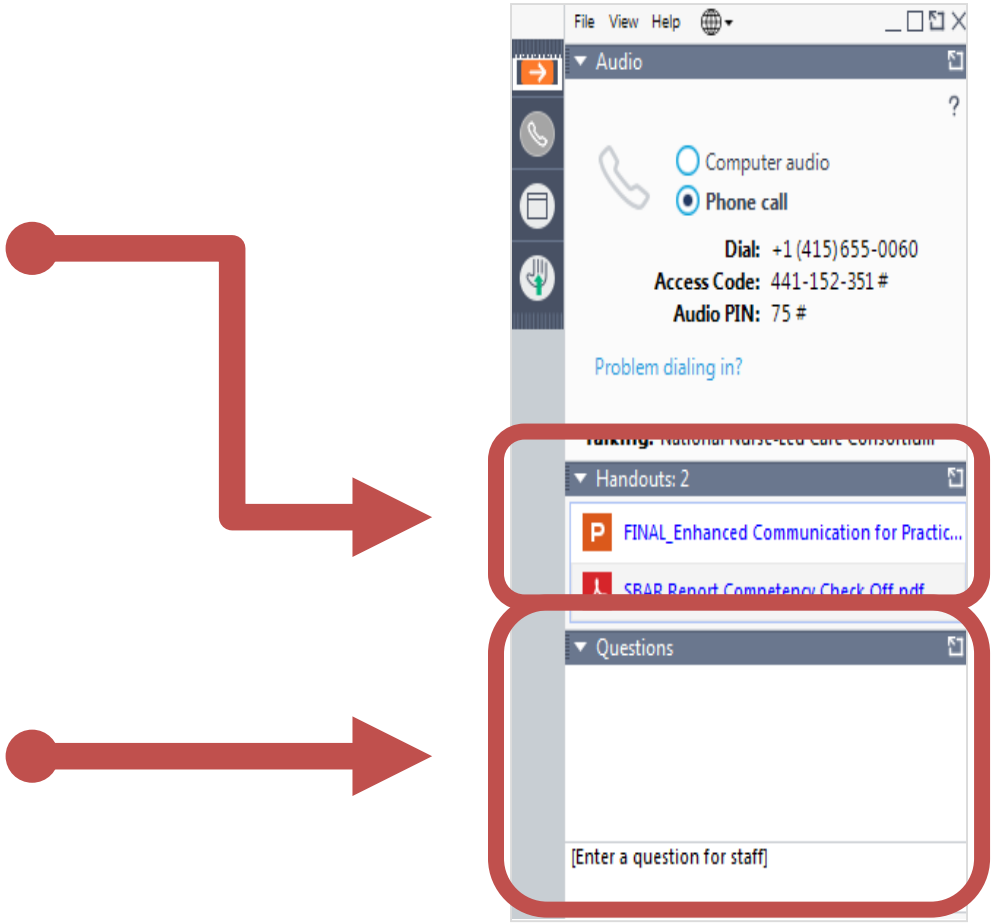

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National Investment in Quality Improvement

- Changes to the health care system are here
- Nurse practitioners (NPs) will play a key role during the critical transition from Fee-for-Service to **Value-Based Reimbursement**
- **NNCC** and the **AANP** have partnered together to create the **Nurse Practitioner Support & Alignment Network (NP SAN)**:
  - Prepare NPs for the upcoming changes to the health care system
  - Provide free continuing education & professional development centered around value-based health care practices
  - Offer key training opportunities that ready practices for **Value-Based Reimbursement**

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Preparing NPs for Value-Based Reimbursement

What is the Quality Payment Program?

Began in 2017 as a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and requires CMS by law to implement an incentive program referred to as the *Quality Payment Program*, that provides for <u>two</u> participation tracks:

Merit-based Incentive Payment System (MIPS)]

MIPS

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

OR

Advanced Alternative Payment Models (APMs)

Advanced APMs

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

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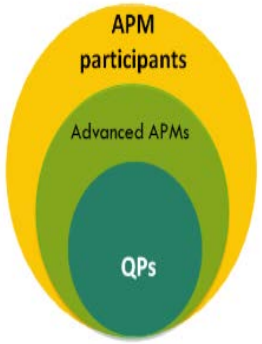
MIPS vs. APMs

[MIPs vs. APMs Timeline]



- Designed for individuals & small practices
- Four (4) performance areas
- Replaces all current incentive programs
- Exempt if practice DOES NOT meet low volume threshold.

- Higher risk model
- Risk is shared throughout the APM
- Number of acceptable payment models is limited
- Rules to being considered a qualified provider (QP)

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Where Can I Go to Learn More?

1. **CMS QPP website** — www.qpp.cms.gov
2. **NPI Lookup for participation status** — https://qpp.cms.gov/participation-lookup
3. **AANP** — https://www.aanp.org/legislation-regulation/federal-legislation/macra-s-quality-payment-program

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DO STATE RESTRICTIONS ON APRNS IMPACT PATIENT OUTCOMES?

A Study Partially Funded by the Robert Wood Johnson Foundation

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Background

- Restricting the scope of APRN practice is alleged to result in better patient outcomes
- There are no published studies of national data to support or negate this allegation
- In 2010 the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM), recommended that nurses practice to the full extent of their education and training.
- The NAM noted that regulations defining scope-of-practice vary widely by state and limit the ability of APRNs to practice.

Background (cont.)

- The IOM (2010) identified the six most restrictive (MR) and ten least restrictive (LR) states according to the scope of NP practice permitted in the state at that time
- Scope of practice was based on: 1) requirement for MD involvement in prescriptions; 2) onsite oversite by MD; 3) MD chart review; and 4) maximum NP to MD ratio
- LR had none of the requirements; MR had all of them

Background (cont.)

Most Restrictive (MR) =

Alabama, Missouri, Nevada, South Dakota, Texas, and Virginia

Least Restrictive (LR) =

Alaska, Arizona, Idaho, Iowa, Maine, New Hampshire, New Mexico, Oregon, Washington, and Wyoming

AIMS

The aim of this study was to examine whether states with the least restrictions on APRN practice have patient outcomes inferior to patient outcomes in the most restrictive states as measured by rates of controlled hypertension and diabetes in patients cared for in Federally Qualified Community Health Centers (FQCHCs)

Design

Cross-sectional analysis of publicly available national data that was reported in 2013

Methods: Setting/Population

- We needed patients with similar characteristics and the same diagnoses treated and evaluated in the same type of setting
  - Federally Qualified Community Health Centers (FQCH) identified according to state (HRSA, 2013)
  - Financed and regulated by the Health Resources and Service Administration (HRSA)
  - Care for similar low-income patients in all states
  - File yearly reports on their patients & outcomes
  - Reports are available on the HRSA website (HRSA, 2013)

Characteristics of Settings

Primary Care Providers and Clinic Visits for Medical Services in 2013 to Federally Qualified Community Health Centers in the 6 Most Restrictive and 10 Least Restrictive States

Service Providers	Most Restrictive States	Least Restrictive States
Number of FTE Primary Care Physicians	596.58	909.65
Number of FTE NP Providers	614.07	691.07
Number of All Medical Service Clinic Visits	6,060,495	6,955,398
Number of Medical Service Clinic Visits to NPs	1,711,848	1,728,261
Percent of All Medical Service Clinic Visits to NPs	28.2%	24.8%

Characteristics of Population

Patients Served by FQCHCs in the MR and LR States in 2013

FQCHC Patient Characteristics	Most Restrictive States		Least Restrictive States	
	Total Patients: 2,307,842		Total Patients: 2,580,201	
	Number	Percent	Number	Percent
Patients over age 65	182,586	7.9%	231,557	8.8%
Women over age 65	110,753	4.8%	133,693	5.1%
Below 100% of poverty	1,235,875	53.6%	1,319,597	49.9%
Between 100% and 200% of poverty	389,040	16.9%	436,175	16.5%
Uninsured	1,041,891	45.1%	869,436	32.9%
Medicare title XVII	198,755	8.6%	259,007	9.8%
Have private insurance	329,190	14.3%	464,673	17.6%
Medicaid and other public insurance	738,006	32.0%	987,085	37.3%

Methods: Data Analysis

- Analysis of Outcomes
  - Outcomes of interest were the % of patients treated for hypertension and the % of patients treated for diabetes that were controlled
  - We accessed the 2013 FQCH reports to HRSA on the HRSA website organized by state. We aggregated the data according to LR or MR states
  - We compared outcomes for hypertension and diabetes control in the LR with those in the MR states
  - Because the outcomes are based on the total population rather than samples, statistical inferences were not necessary

Methods: Data Analysis (cont.)

- Needed to aggregate for each state and then totaled for all LR and MR
- Can aggregate total numbers but not percentages
- We calculated numbers from the HRSA data for 16 states

Total patients served	**HRSA Report**
% of patients with HX	**HRSA Report**
No. of patients with HX	**Calculated from HRSA Data**
% of patients with HX controlled	**HRSA Report**
No. of patients with HX controlled	**Calculated from HRSA Data**
% of patients with diabetes	**HRSA Report**
No. of patients with diabetes	**Calculated from HRSA Data**
% patients with controlled diabetes	**HRSA Report**
No. patients with controlled diabetes	**Calculated from HRSA Data**

Results: Aggregated Data for M R States

State	Total patients served	% of patients with HX	No. of patients with HX	% of patients with HX controlled	No. of patients with HX controlled	% of patients with diabetes	No. of patients with diabetes	% patients with controlled diabetes	No. patients with controlled diabetes
Alabama	330401	0.294	97137.89	0.566	54980.048	0.143	47247.34	0.705	33309.37682
Missouri	442058	0.309	136595.9	0.587	80181.8062	0.142	62772.24	0.71	44568.28756
Nevada	70014	0.258	18063.61	0.638	11524.5845	0.135	9451.89	0.683	6455.64087
S. Dakota	54743	0.17	9306.31	0.625	5816.44375	0.79	43246.97	0.753	32564.96841
Texas	1124022	0.235	264145.2	0.645	170373.635	0.159	178719.5	0.648	115810.2347
Virginia	286604	0.333	95439.13	0.609	58122.4314	0.159	45570.04	0.731	33311.69632
Total	2,307,842	26.9	620,688	61.4	380,998.9	16.8	387,008	68.7	266020.

Results: Aggregated Data for L R States

State	Total patients served	% of patients with HX	No. of patients with HX	% of patients with HX controlled	No. of patients with HX controlled	% of patients with diabetes	No. of patients with diabetes	% patients with controlled diabetes	No. patients with controlled diabetes
Alaska	100595	0.22	22130.9	0.625	13831.8125	0.084	8449.98	0.689	5822.03622
Arizona	438260	0.228	99923.28	0.633	63251.4362	0.133	58288.58	0.659	38412.17422
Idaho	138434	0.176	24364.38	0.609	14837.9099	0.099	13704.97	0.741	10155.37981
Iowa	179599	0.244	43822.16	0.645	28265.2906	0.129	23168.27	0.708	16403.13587
Maine	182546	0.267	48739.78	0.725	35336.342	0.106	19349.88	0.793	15344.45167
N Hampshire	70884	0.242	17153.93	0.678	11630.3632	0.101	7159.284	0.829	5935.046436
New Mexico	290202	0.214	62103.23	0.657	40801.8208	0.125	36275.25	0.681	24703.44525
Oregon	323148	0.237	76586.08	0.653	50010.7076	0.128	41362.94	0.733	30319.03795
Washington	836637	0.197	164817.5	0.633	104329.471	0.119	99559.8	0.69	68696.26407
Wyoming	19896	0.154	3063.984	0.645	1976.26968	0.055	1094.28	0.467	511.02876

Results

Controlled Hypertension and Diabetes in Most Restrictive States		
Most Restrictive	% Hypertension Controlled	% Diabetes Controlled
Alabama	56.6	70.5
Missouri	58.7	71.0
Nevada	63.8	68.3
South Dakota	62.5	75.3
Texas	64.5	64.8
Virginia	60.9	73.1
Weighted Ave.	**61.4**	**68.7**

Controlled Hypertension and Diabetes in Least Restrictive States		
Least Restrictive	% Hypertension Controlled	% Diabetes Controlled
Alaska	62.5	68.9
Arizona	63.3	65.9
Idaho	60.9	74.1
Iowa	64.5	70.8
Maine	72.5	79.3
New Hampshire	67.8	82.9
New Mexico	65.7	68.1
Oregon	65.3	73.3
Washington	63.3	69.0
Wyoming	64.5	46.7
Weighted Ave	**64.7**	**70.1**

Results: Summary on Outcomes

61% of hypertensive patients (380,999/620,688) were controlled in the most restrictive states. 65% of hypertensive patients (364,271/562,705) were controlled in the least restrictive states

69% of diabetic patients (266,020/387,008) were controlled in highly restrictive states. 70% of diabetic patients (216,302/308,413) were controlled in least restrictive states

Conclusions

- There is no evidence that the lack of state restrictions on APRN practice leads to inferior patient outcome for control of hypertension and diabetes in FQCHC patients
- State policies that restrict the practice of APRNs do not improve patient outcomes and should be eliminated

Discussion

Although we know that NPs were employed at the FQCHCs in large numbers in the LR and the MR states, there is no evidence in the data that the patients actually received care from NPs in the FQCHCs. We are assuming, however, that NPs were providing care to patients with hypertension and diabetes.

References

- Institute of Medicine (IOM) (2010). Annex 3-1: *State Regulations for nurse practioners in The Future of Nursing: Leading Change, Advancing Health*, 157-161.
- Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (2013). Health Center Data. National Program Grantee Data.
- http://bphc.hrsa.gov/about/index.html

Any Questions??

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Other QPP or NP SAN Questions?

For more information on the **QPP** or the **Nurse Practitioner Support and Alignment Network (NP SAN)**:

- Email **Joseph Reyes** at **jreyes@aanp.org**
- Email **Cheryl Fattibene** at **cfattibene@nncc.us**
- Visit us **online at https://www.aanp.org/practice/np-san**
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March 27, 2019

Catherine Lyden, PhD, RN

University of Southern Maine

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