STATE OF NEBRASKA

DEPARTMENT OF HEALTH
Mark B. Horton, M.D., M.S.P.H.
Director

E. Benjamin Nelson
Governor

MEMORANDUM

TO: Senator Don Wesely, Chairman
Health & Human Services Committee
Nebraska Legislature

FROM: Mark B. Horton, M.D., M.S.P.H.
Director of Health

DATE: February 14, 1994

SUBJECT: The Final Report by the Director of Health on the Nurse Practitioner Proposal for a Change in Scope of Practice

Recommendations of the Director of Health

Nebraska's Nurse Practitioners submitted a proposal to eliminate the requirement for a practice agreement to the technical committee in the summer of 1993. The technical committee recommended against the proposal. The 407 Committee of the Board of Health met on November 5, 1993, to review the proposal, and recommended against the proposal. The full Board of Health met on November 15, 1993, to review the proposal, and decided to endorse the action taken by their 407 Committee. This action by the full Board means that the full Board of Health recommended against approval of the proposal. I have decided to recommend in favor of the proposal.

Discussion on the Issues Raised by the Review

A decision on whether the nurse practitioner should continue to be required to have a practice agreement with a physician in order to practice should be based on two major considerations: First, the extent to which the proposal to remove the practice agreement addresses the major criteria set out in statute for a change in scope of practice. Specifically, does the proposal address an issue of major public health significance? Does the present circumstance constitute a harm to the public? Is the proposed solution at least as cost effective as the present situation? Secondly, should the proposal satisfy these concerns, we still need to look at the purpose of the practice agreement and consider whether maintaining the practice agreement is necessary to accomplish its intent.

Addressing the first question, clearly there is a great unmet need for primary care services, particularly in the rural areas where the scarcity of physicians requires them to concentrate their energies on more acute and complex care. This unmet need for primary care services represents a major and urgent public health problem for the state of Nebraska. This need can be met, in part, by nurse practitioners who are qualified to provide primary care services. Further, I believe that a credible case has been made that the requirement of a practice agreement has restricted the availability of nurse practitioners, particularly in the rural areas. While those nurse practitioners currently in training apparently have practice arrangements waiting for them, it is reported that there are a number of nurse practitioners who have been unable to secure an appropriate practice agreement. Finally, I believe that there has been ample research and documentation that nurse practitioners are more than adequately prepared and trained to perform the functions within their scope, and that their services are at least as cost effective as a physician providing identical services. Moreover, when available to a community, nurse practitioner services complement, rather than compete with, physician services, allowing physicians to concentrate on providing services for which they are uniquely trained and which are beyond the scope of the nurse practitioner. This allows for an economy of resources, an optimal utilization of all the health professionals in a community. While the case for harm to the public resulting from the present practice agreement, though credible, is not strong, the urgency of the need to develop primary care services in our state requires us to look carefully at every barrier to the further development of adequate primary care services for our citizens.

A second major issue involves the goals and intent of the practice agreement and whether maintaining the practice agreement is necessary to accomplish those goals or intent. It would seem that the purpose of a practice agreement is two-fold: first, to ensure quality, which in this context means to supervise the practice of the nurse practitioner in such a way as to ensure that his or her practice is within a defined scope and that it meets certain standards of care; secondly, to ensure continuity of care, which in this context means to ensure that the nurse practitioner with a limited scope of practice has easy access to other health care professionals that can complement that health care professional's practice.
Every health care professional's practice is in effect limited in scope in one way or another. Assurances that an individual health professional practices within his or her scope are multiple. The licensing system for health professionals relies on the definition of scope of practice in statute, the identification of specific training requirements, and finally, a disciplinary process to ensure quality. In addition to these formal assurances, our health care system relies heavily on professional judgment and the availability of a sophisticated network of specialty practitioners (physicians, mental health practitioners, and allied health professionals, for example) for referral when the limits of personal professional competency have been reached. This system to ensure quality has worked effectively in Nebraska and across the country for many years.

With respect to the nurse practitioners, as long as the training and the scope of practice of nurse practitioners are clearly defined, as long as there is an effective disciplinary system in place, and as long as nurse practitioners can be expected to exert appropriate professional judgment in their practice, there would seem to be little compelling argument for an additional practice agreement to control quality. Whether the goal of continuity of care can be accomplished without the practice agreement is more problematic. While it is clear that the nurse practitioner can competently perform some of the health care responsibilities of a primary care physician, a nurse practitioner can not, nor was there ever any intention that he or she, substitute for a physician. Among the skills of a nurse practitioner is the ability to recognize conditions requiring skills beyond the nurse practitioner's scope and to refer patients with such condition to the appropriate health care provider. Therefore, the availability of a network of such health care professionals is critical to the practice of the nurse practitioner. Absent the practice agreement, such a network and support system will rely heavily on the professional judgment of the nurse practitioner as well as on the availability and willingness of the specialty practitioners in the community or region.

In the end then, I believe that in order for a scope of practice change to be considered four criteria should be met: number one, the change should address an urgent or significant public health need; number two, the change should include adequate assurances that quality of services will not be compromised and that the integrity of established public policy should be preserved; third, that the public would benefit from the change; and fourth, that the proposal is the most cost-effective way to address the issue at hand. I believe that all four criteria are met by the applicant group's proposal, as discussed above. It has been a long-standing public policy that has served Nebraska well that the practice of medicine and surgery is under the aegis of the medical and osteopathic doctor. Sound public policy has also allowed for exceptions only in the case where scope of practice is limited and well-defined, and when appropriate assurances of quality are established by statute in the licensure and disciplinary systems. I feel that the applicant's proposal to eliminate the practice agreement is consistent with this public policy.

In summary, I recommend approval of the applicant's proposal to eliminate the practice agreement. But I do so with the following qualifications: first, that the scope of practice be sufficiently well-defined in statute; second, that the medical profession participate in the oversight of nurse practitioner practice, and third, that we are assured that, absent the practice agreement, that nurse practitioner practice is integrated into and coordinated with the existing health care delivery system in the community or region.

MBH/das