Family Medicine Updates

AAFP From the American Academy of Family Physicians

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INDEPENDENT PRACTICE AUTHORITY FOR NURSE PRACTITIONERS COULD SPLINTER CARE, UNDERMINE PATIENT-CENTERED MEDICAL HOME

The AAFP recently released a report that looks at the future of health care and the importance of health care teams led by physicians. It's important to ensure projected physician shortages don't lead to substituting other health care professionals for primary care physicians, said the AAFP. This could create 2 classes of health care: one run by a physician-led team and the other by less-qualified health professionals.

"The best, most efficient (health) care is provided by teams of health professionals in the patient-centered medical home led by physicians, not independent practice by a single non-physician health professional," says a press release issued by the AAFP in conjunction with its report *Primary Care for the 21st Century: Ensuring a Quality, Physician-led Team for Every Patient.*

The AAFP report takes issue with the movement to grant nurse practitioners (NPs) independent practice authority at a time when the patient-centered medical home (PCMH) model is being rolled out across the nation. NPs are a vital part of the health care team, says the report, but "they cannot fulfill the need for a fully trained physician."

Twenty-two states and the District of Columbia currently allow NPs autonomy in diagnosis and treatment, although about one-half require that a physician be involved to prescribe all or certain drugs. There are ongoing attempts, however, to remove scope-of-practice barriers for advanced practice registered nurses in all states, which likely would lead to them setting up independent practices. If successful, these efforts will undermine the ability of primary care physicians and PCMHs to deliver team-based care, says the Academy.

AAFP members want to improve access to primary care and have better quality outcomes at a lesser cost, AAFP Board Chair Roland Goertz, MD, MBA, said at a telephone press conference announcing the report. However, he added, "We want to do all these things without downgrading care."

"The PCMH model improves the quality of care because it capitalizes on the unique expertise of each member of the patient's health care team," said Goertz in the press release. "It ensures patients are under the care of a physician and expands access to health care services.

"Wholesale substitution of nonphysician health care providers for physicians is not the solution, especially at a time when primary care practices are being called upon to take on more complex care. Patients need access to every member of their health care team—starting with a primary care physician, nurse practitioners, physician assistants, and all the other professionals who provide health care."

According to the report, "The family physician is trained to provide a complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of the patient's overall health condition. Nurse practitioners, on the other hand, are specifically trained to follow through on the treatment of a patient after a diagnosis and to implement protocols for chronic disease management."

Profound Differences

The report addresses the differences in educational and training levels between physicians and NPs, pointing out that NPs only receive 5.5 to 7 years of education compared with 11 years for physicians.

Most NPs typically receive their education through a 1.5- to 3-year degree program that confers a Master of Science in Nursing (MSN) degree, depending on the previous education of the student. "Approximately 77% of nurse practitioners hold an MSN degree," says the report. "Many of the remainder used alternate pathways available in their state to achieve nurse practitioner licensure without an advanced degree."

Family physicians, by contrast, typically receive their education through a 4-year graduate degree program at 1 of the 130 accredited medical schools in the United States and an additional 3-year program of clinical residency. "Medical students spend nearly 9,000 hours in lectures, clinical study, laboratories, and direct patient care," says the report. Training and clinical hours required to become a family physician total 21,700 hours compared with 5,350 hours for NPs.

"I didn't know what I didn't know until I went through 7 more years of training," says FP LaDona Schmidt, MD, of Salina, Kan. Schmidt was an NP before she did further training to become a physician. During the AAFP's telephone news conference,

Schmidt noted that she had thought her further training to become a doctor would be easy because she had already undergone the training to be an NP. It wasn't until she got into the program that she realized how much she did not know about the underlying causes of disease processes.

NPs Are Not Physicians

Most proposals that would allow NPs to practice independently come in response to the ongoing shortage of primary care physicians, according to the AAFP report. However, "Substituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact."

In fact, Kathleen Potempa, PhD, RN, dean of the University of Michigan School of Nursing and president of the American Association of Colleges of Nursing, said in a *New York Times* article that, "Nurses are very proud of the fact that they're nurses, and if nurses had wanted to be doctors, they would have gone to medical school."

"Dr Potempa is right—nurse practitioners do not have the substance of doctor training or the length of clinical experience required to be doctors," says the AAFP report.

The AAFP calls for filling the primary care gap by a continued transition to team-based care in medical homes "with all health professionals playing valuable and appropriate roles."

"Studies show the ideal practice ratio of NPs to physicians is approximately 4 to 1," the report says. "With PCMHs built around that ratio, everyone can have a primary care doctor and receive the benefits of team-based care."

Controlling Costs

The report also dismisses claims that substituting NPs for primary care physicians results in lower costs. It cites a study in *Medical Care Research and Review* that says "the evidence that role revision increases health care efficiency or lowers costs is weak and contradictory."

"Health care planners need to be alert to the possibility that, while nonphysicians cost less to employ than physicians, savings on salaries may be offset by lower productivity and less efficient use of nonstaff resources," says that study.

The AAFP report, meanwhile, acknowledges that "the cost of health care continues to be a major hurdle for our nation."

"While there is no silver bullet, there is growing evidence that the PCMH model—which emphasizes improved access to more robust primary care teams—can reduce total costs," says the AAFP, pointing to a recent report by the Patient-centered Primary Care Collaborative that provides "34 examples of private insurance companies, state and federal entities implementing the PCMH model and finding 'outcomes of better health, better care and lower costs are being achieved.'"

The bottom line, according to Goertz, is that the AAFP is saying the PCMH model and its concepts are the right way to move forward with care in this country. Independent practice standards for NPs vary from state to state, but PCMH standards do not, said Goertz, adding that independent practice for NPs is not the right model with which to move into the future of health care.

AAFP News Now staff

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KNOWLEDGE ASSESSMENT RESPONSES IN THE ABFM SELF-ASSESSMENT MODULES (SAMS)

ABFM introduced self-assessment modules (SAMs) in 2004 with the implementation of Maintenance of Certification for Family Physicians (MC-FP.) The SAMs consist of a 60-item knowledge assessment (KA), including multiple choice, multiple true/false, and fill-in-the-blank formats with references, followed by a clinical simulation keyed to the KA content.[1] The KA items are organized according to competencies (eg, pharmacologic therapy, non-pharmacologic therapy, etc) defined during the SAM development process. ABFM currently offers SAMs covering asthma, care of the vulnerable elderly, cerebrovascular disease, early childhood illness, coronary artery disease, depression, diabetes, health behavior, heart failure, hypertension, maternity care, mental health in the community, pain management, preventive care, and well child care. A SAM covering hospital medicine will be available in September.

During the first few months of use, Diplomates tended to spend substantial time reading and studying the associated reference material prior to engaging the KA items. This approach led to quite lengthy SAM sessions for a number of Diplomates —an average of nearly 10 hours on the hypertension KA[1]—which led ABFM staff to recommend to participants that they take the KA "cold" (ie, without preparation) the first time through. Following this "first pass," Diplomates receive feedback and critiques for the missed items,