

CORRESPONDENCE

Editor's Note: Soon after the publication of the July/August 2011 issue of the NCMJ dedicated to the future of nursing in North Carolina, we received correspondence from Dr. Matthew Kanaan, who responded to the issues and proposed solutions that were raised in that issue of the NCMJ. We felt his remarks merited a response and invited Drs. Debra Barksdale and Kristen Swanson to, in turn, respond to Dr. Kanaan. We subsequently received a letter from Drs. Brian Forrest, Robert Monteiro, Karen Breach, and Edward Treadwell that also commented on that issue of the NCMJ. We are publishing these three responses together as they touch on similar themes and controversies.

Encouraging Collaboration Between Physicians and Advanced Practice Registered Nurses in North Carolina

Matthew Kanaan

To the Editor—In the July/August 2011 issue of the NCMJ there were several articles that discussed the topic of advanced practice registered nurses (APRNs) and their ability to practice medicine independently. Reading articles in the issue such as, Removal of Legal Barriers to the Practice of Advanced Practice Registered Nurses, it seemed that there were key elements of the discussion that were not directly addressed. There is still debate as to whether expanding APRN scope of practice would significantly increase the primary care workforce, or decrease the projected primary care shortages in the underserved areas of our state. When considering any increase in the scope of practice of a previously supervised profession, there must be a thorough and adequate discussion of potential risks to the health of the public. Additionally, one cannot overlook the outcomes and cost savings achieved when health care providers work collaboratively in a patient-centered medical home as opposed to working independently in separate silos. I would argue that APRN autonomy, which may further increase fragmentation, is not the best solution. I would suggest that physicians and all of our nursing colleagues across the state focus their efforts more on population health and collaborative health care models to improve the health of North Carolinians.

The Primary Care Workforce

While the articles on APRN autonomy, without physician oversight, suggested improvement in primary care access, this concept is much more complex and the comparisons may not be direct. A graduating family medicine resident can be expected to spend his/her whole career in primary care, while APRNs can more easily leave primary care for other interests or specialty practices. Additionally, APRNs tend to practice in the same areas of North Carolina as physicians. To suggest that independently practicing nurse practitioners would choose to relocate to rural parts of our state is more theoretical than fact [1, 2]. If you examine practice distribution maps from states such as Idaho, Oregon, Arizona, and

Utah, which have granted APRNs independent practice and feature metropolitan areas and large, rural areas similar to North Carolina, the actual distribution suggests that autonomy does not significantly change APRN practice location preferences [3].

Why Do We Have Supervision Requirements?

Physicians are subjected to the most heavily regulated certification and credentialing processes of any of the health professions. After completing 4 years of medical school, all family medicine residency graduates will complete around 20,000 hours of supervised training, including over 1,650 patient encounters before they can practice independently. While becoming an advanced practice nurse is also a very rigorous process, most APRN organizations do not require any significant clinical patient interaction beyond the minimum 500 clinical hours required within their graduate programs [4]. APRNs do not have the equivalent academic preparation or supervised training experiences as physicians. The current system of supervision serves to protect public safety and health, particularly when dealing with complex patients with multiple co-morbidities.

Inadequate Research

The NCMJ articles on APRN autonomy often cited flawed research studies. The research involved too few subjects and most followed patients for short timeframes (1 year or less), when true outcomes of chronic disease are measured over decades. Some studies were actually set in collaborative environments with physician oversight. Others were self-funded by various APRN groups. These flaws make the

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external validity and application of the concepts to the entire state of North Carolina challenging.

Collaboration, Not Further Fragmentation

To make important improvements the health of the public, North Carolina health policy must focus on more collaborative models of care such as patient-centered medical homes (PCMH), not more independent providers. The PCMH model, as coordinated locally by Community Care of North Carolina (CCNC), has been proven to yield lower rates of emergency department visits and hospital admissions, and improved management of chronic disease when compared to the traditional model of independent care delivery [5, 6]. North Carolina was one of only 3 states in the nation to reduce total Medicaid spending between fiscal years 2008 and 2009. While total Medicaid spending decreased by 2.5% in North Carolina, it increased by 7.8% nationwide [7, 8]. With the upcoming influx of uninsured North Carolinians into the health care system, several aspects of primary care delivery must be optimized.

Health care providers must reexamine the way patients receive care. The professions must collectively acknowledge that an organized, team-based approach is superior to a disorganized, fragmented network of individual providers. The future of primary care in the state is at stake and we will only succeed through collaboration, not further fragmentation. **NCMJ**

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