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# NURSE PRACTITIONERS IN PRIMARY CARE

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American College of Physicians  
Policy Monograph  
2009



# NURSE PRACTITIONERS IN PRIMARY CARE

A Policy Monograph of the  
American College of Physicians

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## Executive Summary

Anticipated and actual shortages of primary care physicians have led policy-makers to consider the roles of nurse practitioners (NPs) in improving access to primary health care services. Over the past 20 years, an increase in the numbers of NPs, enactment of state laws expanding the scope of practice, prescriptive authority and third-party reimbursement, and national efforts to improve health care access, have resulted in expanded roles for NPs in providing primary care services. Greater autonomy of NPs has been a point of contention between the medical and advanced practice nursing communities. Questions have been raised about the adequacy of NP training and certification, quality of patient outcomes, and perceived intentions to replace primary care physicians. There has also been much controversy concerning the Doctor of Nursing Practice (DNP) degree. While there are differences in the nature and extent of training of physicians and NPs and the scope of practice for NPs varies considerably from state to state, the College acknowledges that NPs are health care professionals with the capability to provide important and critical access to primary care.

The American College of Physicians recognizes that NPs and physicians have common goals of providing high-quality, patient-centered care and improving the health status of those they serve. In addition, physicians and NPs share concerns regarding appropriate reimbursement for services provided, especially related to care coordination, and the decline in the primary care workforce. Acknowledging the critical role NPs play in improving access to care, the College offers the following position statements on physicians, NPs, the DNP degree, primary care, and the patient-centered medical home.

**Position 1: Physicians and nurse practitioners complete training with different levels of knowledge, skills, and abilities that while not equivalent, are complementary. As trained health care professionals, physicians and nurse practitioners share a commitment to providing high-quality care. However, physicians are often the most appropriate health care professional for many patients.**

- A. Whenever possible, the needs and preferences of every patient should be met by the health care professional with the most appropriate skills and training to provide the necessary care.
- B. Patients with complex problems, multiple diagnoses, or difficult management challenges will typically be best served by physicians working with a team of health care professionals that may include nurse practitioners and other nonphysician clinicians.
- C. Patients have the right to be informed of the credentials of the person providing their care to allow them to understand the background, orientation, and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals.
- D. The College recognizes the important role that nurse practitioners play in meeting the current and growing demand for primary care.
- E. The College advocates for research to develop effective systems of consultation between physicians and nurse practitioners as clinically indicated.

**Position 2: Collaboration is defined as ongoing interdisciplinary communication regarding the care of individuals and populations of patients in order to promote quality and cost-effective care. Recognizing the importance of coordinated care to improving health outcomes, we offer the following principles on collaboration between physicians and nurse practitioners:**

- A. Effective interdisciplinary collaboration is critical to ensuring that all patients receive the highest possible quality of care.**
- B. Members of a health care team should understand their complementary roles in the delivery of care as defined through their respective professional practice acts.**
- C. Collaboration among physicians and nurse practitioners can occur during both face-to-face encounters and electronically through the use of technology, including telephone, e-mail, telehealth, and electronic health records.**
- D. Effective collaboration among nurse practitioners and physicians requires appropriate sharing of information and mutual acknowledgment of and respect for each professional's knowledge, skills, and contributions to the provision of care.**
- E. Payment systems should provide sufficient reimbursement for the coordination of care and collaboration between nurse practitioners and physicians.**

**Position 3: Licensing and certification examinations for nurse practitioners should be developed by the nursing discipline and based on standardized training involved in graduating from advanced practice nursing programs as well as scope of practice statutes and regulations. Certification examinations should be carefully constructed so as to avoid any appearance of equivalency of training/certification with physicians. ACP therefore opposes use of test questions (past or present) developed by the National Board of Medical Examiners (NBME) for Step 3 of the U.S. Medical Licensing Exam in the certifying examination of Doctors of Nursing Practice (DNPs).**

**Position 4: In the patient-centered medical home (PCMH) model, care for patients is best served by a multidisciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and consistent with the following:**

- A. Demonstration projects testing the effectiveness of NP-led PCMH practices should meet the same eligibility requirements as those for physician-led practices.**
- B. NP-led PCMH practices should be subject to the same recognition standards to participate in the demonstration project as physician-led practices.**
- C. NP-led PCMH practices should be subject to the same standards of evaluation as physician-led PCMH practices.**

- D. Patients who are selecting a PCMH as their source of regular care should be informed in advance if it is a physician-led or nurse practitioner-led practice and the credentials of the persons providing care within each practice.
- E. All clinicians within the PCMH are operating within existing state practice acts.
- F. Payments and evaluation metrics for both physician-led and nurse practitioner-led PCMH practices must take into account differences in the case mix of patients seen in the practice.

**Position 5:** ACP advocates for research efforts to identify and disseminate effective models of collaboration, referral, and co-management of patients between and among nurse practitioners and physicians.

**Position 6:** Opportunities for professional multidisciplinary training and team development should be incorporated into the education and training of all health professionals.

**Position 7:** Workforce policies should ensure adequate supplies of primary care physicians and nurse practitioners to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more nurse practitioners does not eliminate the need nor substitute for increasing the numbers of general internists and family physicians trained to provide primary care.

## Introduction

Nurse practitioners (NPs) are registered nurses who have completed specialized advanced nursing education and training (1). Over the past 20 years, an increase in the numbers of NPs, enactment of state laws expanding the scope of practice, prescriptive authority and third-party reimbursement, and national efforts to improve health care access have resulted in expanded roles for NPs in providing primary care services. However, greater autonomy of NPs has been a point of contention between the medical and advanced-practice nursing communities. Questions have been raised about the adequacy of NP training and certification, comparisons drawn by NPs to the care delivered by physicians, quality of patient outcomes, and perceived intentions to displace or replace primary care physicians.

The American College of Physicians recognizes that NPs and physicians have common goals of providing high-quality care, improving patient outcomes, and enhancing the health of the U.S. population. In addition, physicians and NPs share concerns regarding the continuing decline in the primary care workforce; the need to provide appropriate reimbursement for services, especially related to care coordination; and the absence, until recently, of new models to deliver primary care, such as the patient-centered medical home. A high-quality and efficient health care system requires effective multidisciplinary teams that collaborate to provide patient-centered care. The ACP hopes that this paper will strengthen the dialogue between the medical and NP communities to improve future health care delivery.

## Overview

In the 1960s, an insufficient physician workforce was one of the factors that led to the development of nonphysician clinicians, primarily NPs and physician's assistants (PAs), to improve access to primary health care services (2,3,4). Other contributors to the rise of NPs were managed care and cost containment, and early efforts in interdisciplinary training (5). The role of NPs and their relationship to primary care physicians was originally envisioned as being collaborative and collegial, not a substitute for physicians (6). Over the past 20 years, several factors have led to increased reliance on NPs as providers of primary health care. An increase in the numbers of NPs, enactment of state laws expanding their allowable scope of practice, a national movement to improve health care access, the rise of retail health clinics, and increased efforts to contain health care costs has resulted in a shift in the provision of some primary care from physicians to NPs and to other nonphysician clinicians.

As the number of medical school graduates entering primary care dwindles, training programs for NPs continue to grow. In 1995, there were 44,200 NPs in the United States. By 2005, the number of practicing NPs in the U.S. had grown to 82,622, reflecting an average rate of increase of 9.44% per year (7). The American Academy of Nurse Practitioners reports that about 6,000 new NPs are prepared each year and estimates that there are as many as 125,000 practicing NPs, approximately one sixth of the health care workforce. About 85% of NPs train in primary care. As the largest group of nonphysician primary care providers, NPs conduct almost 600 million patient visits each year (8). Research has found that NPs are more likely than physicians to provide care to younger patients with few co-morbidities and see patients for acute minor illnesses (9,10,11). While NPs practice in various medical settings, they represent a significant proportion of providers of care for vulnerable populations. NPs have proven integral to improving access to care in rural communities (12).



### ***Education & Certification***

All NPs are registered nurses (RNs), and many have years of clinical nursing experience. There are three pathways for NP education: Master's level programs; post-Master's programs (for persons with a Master's degree in nursing); and the Doctor of Nursing Practice (13). However, most NPs (88%) graduate with a Master's degree (14).

NPs are principally trained in primary care, with special emphasis on such areas as adult health, pediatrics, family health, women's health, or gerontology. These primary care tracks account for 85% of NP graduates (15). The remaining NP students train in acute care, emergency care, and such subspecialty disciplines as oncology or neonatology (16).

The National Organization of Nurse Practitioner Faculties specifies the domains and core competencies for Nurse Practitioner Practice and for programs leading to the NP degree in the primary care specialty areas of adult health, family health, gerontological health, pediatric health, and women's health. These competencies include health promotion/health protection and disease prevention, management of patient illness, the nurse practitioner-patient relationship, the teaching-coaching function, professional role, assisting patients in managing and negotiating health care delivery systems, monitoring and ensuring quality health care practice, and having cultural and spiritual competence (17).

To improve the quality of NP education and to prepare NPs to meet increasingly complex health care demands, leaders of some nursing professional organizations support the Doctorate of Nursing Practice (DNP) as the terminal degree for advanced nursing practice. Currently, there are 83 DNP programs in the U.S. and the goal is to convert all programs for advanced practice nursing from Master's to DNP by 2015. Presently, most DNP programs are only open to current NPs with Master's degrees. Building on their previous training, the DNP with NP entry requires at least 30 credit hours, a 1-year full-time residency, and a final project. The DNP degree is not equivalent to the educational and training requirements for a physician's medical degree. A physician must complete 2 years of clinical rotations during the third and fourth year of medical school (3200 hours of general clinical education) and a minimum of 3 years of full-time clinical postgraduate residency training (minimum 7800 hours) in their specialty.

A growing number of institutions are offering the DNP for postbaccalaureate students, which is the path endorsed by the Association of American Colleges of Nursing. These postbaccalaureate programs combine the Master's and Doctorate programs and take approximately 3 years to complete on a full-time schedule. In the future, the professional nursing community expects the DNP to be the entry level to advanced nursing practice (18,19,20).

### ***Scope of Practice***

Currently, NPs can practice independently (without any requirements for physician involvement) in 22 states and the District of Columbia. In all but 1 of the 28 states that require physician supervision or collaboration, the supervising physician need not be present during the provision of care. However, the nature of these collaborative agreements varies considerably throughout the states (21).

### ***Prescriptive Authority***

In 2006, Georgia became the last state to enact legislation allowing prescriptive authority for advanced practice nurses (22). However, the level of prescriptive authority varies by state. NPs can independently prescribe both controlled and noncontrolled substances in 14 states. At the other end of the spectrum, 3 states (Alabama, Florida, and Hawaii) authorize NPs to prescribe only noncontrolled substances with some degree of physician involvement or delegation. Most states allow NPs to prescribe both noncontrolled and controlled substances with some level of physician involvement. In recent years, there have been more states that have expanded prescriptive privileges for NPs than those that have restricted it. NPs in Kentucky may now prescribe controlled substances, and Nebraska, South Dakota, and Virginia recently extended NP prescriptive authority to include Schedule II controlled substances.

### ***Third-Party Reimbursement***

Medicare reimburses NPs at a rate of 85% of the physician fee schedule amount for services performed in collaboration with a physician as specified by state law. Medicare pays 100% of the physician fee schedule amount for services performed by an NP who is employed by a physician practice when certain conditions are met. The practice receives the full fee schedule amount when an NP provides services, referred to as "incident-to", to a patient after a physician in the same practice conducts the initial visit and devises a care plan related to that episode of care. Also, the physician must provide direct supervision, which Medicare defines as not necessarily being in the same exam room but in the same office suite and immediately available for consultation.

Medicaid reimburses nonphysicians in almost every state at rates varying from 50% to 100% of rates for physicians. In 2006, California enacted legislation allowing certified NPs to bill Medicaid (MediCal) and be reimbursed at 100% of the physician rate. However, if a patient is enrolled with a Medicaid managed care plan, the plan's policies and contracts determine who may be reimbursed for physician services.

In general, managed care plans only reimburse those providers admitted to the plan's provider panel. However, the Medicaid Advanced Practice Nurses and Physician Assistants Access Act of 2009 (S. 63), introduced in the 111th Congress on January 6, 2009, would remove language from the Balanced Budget Act of 1997 requiring states to determine whether they wished to recognize NPs, nurse midwives, and PAs as primary care providers in their Medicaid managed care primary care provider systems. Passage of the legislation would facilitate reimbursement of nonphysician clinicians as primary care providers in Medicaid managed care programs.

While federal law does not mandate private third-party reimbursement for NPs, 29 states require reimbursement for NP services (23).

## Positions

**Position 1: Physicians and nurse practitioners complete training with different levels of knowledge, skills, and abilities that while not equivalent, are complementary. As trained health care professionals, physicians and nurse practitioners share a commitment to providing high-quality care. However, physicians are often the most appropriate health care professional for many patients.**

- A. Whenever possible, the needs and preferences of every patient should be met by the health care professional with the most appropriate skills and training to provide the necessary care.**
- B. Patients with complex problems, multiple diagnoses, or difficult management challenges will typically be best served by physicians working with a team of health care professionals that may include nurse practitioners and other nonphysician clinicians.**
- C. Patients have the right to be informed of the credentials of the person providing their care to allow them to understand the background, orientation, and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals.**
- D. The College recognizes the important role that nurse practitioners play in meeting the current and growing demand for primary care.**
- E. The College advocates for research to develop effective systems of consultation between physicians and nurse practitioners as clinically indicated.**

NPs play an essential role in the provision of primary care. Many physicians rely upon these professionals not only for assistance, but also to efficiently provide direct patient care services within their areas of training, competence, and state-specific practice act. Almost 25% of primary care physician practices employ NPs (24). Some research indicates that NPs can provide care for 60% to 90% of patients in primary care (25). However, the knowledge, skills, and scope of training NPs receive are not equivalent to those of a physician.

Frequently cited meta-analyses have shown that NPs and physicians in primary care provide comparable care with respect to assessment and diagnostic accuracy and achieve similar patient outcomes (26,27). However, an analysis of 25 studies comparing nurses to doctors providing similar primary care services cautions:

The findings suggest that appropriately trained nurses can produce as high-quality care as primary care doctors and achieve as good health outcomes for patients. However, this conclusion should be viewed with caution given that only one study was powered to assess equivalence of care, many studies had methodological limitations, and patient follow-up was generally 12 months or less.

While doctor-nurse substitution has the potential to reduce doctors' workload and direct healthcare costs, achieving such reductions depends on the particular context of care. Doctors' workload may remain unchanged either because nurses are deployed to meet previously unmet patient need or because nurses generate demand for care where previously there was none. Savings in cost depend on the magnitude of the salary differential between doctors and nurses, and may be offset by the lower productivity of nurses compared to doctors (28).

Nurse practice acts govern the types of services that NPs can provide and

vary among states. NPs typically can conduct medical histories and physicals, diagnose and treat health problems, order laboratory tests and x-rays, prescribe medications, administer immunizations, provide patient education and prevention services, and perform case management and care coordination (29). Their presence can reduce the impact of physician shortages on health care access and may allow physicians to tend to more serious illnesses, such as managing patients with complex chronic illnesses. Care by NPs has been associated with improved patient satisfaction and quality of care related to patient education, communication, and documentation, which typically involve more face-to-face time with each patient (30,31).

NPs are critical to improving access to health care in underserved communities. Most state laws do not include physical proximity requirements for supervising and collaborating physicians, allowing NPs to provide much-needed primary care in rural and other underserved communities. The success of health care delivery will require collaborative teams of physicians and nonphysicians to provide quality care for individuals and populations with both common and complex health care needs using evidence-based guidelines and effective models of collaboration.

All members of a multidisciplinary health care team must be adequately prepared to respond within their scope of practice to the diverse, often complex, needs of patients. Accordingly, educational programs for health care professionals, including advanced practice nurses (APRNs), should have established standards of training. As indicated in Position 1, the education and training of NPs is not the same as or equivalent to that of physicians. The relatively new degree of Doctor of Nursing Practice expands on the Master's level of NPs training and prepares APRNs to practice at the highest clinical level within their scope of practice.

An NP who is a prominent nurse educator and leader explains:

NPs who are either adult or family nurse practitioners are nationally certified by either the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP). The DNP is an academic degree, not a role. As with other academic degrees, there are no exams that test the depth and breadth of the *entire* degree program. The national certifications (e.g., ANCC and AANP) test the "population focus" (e.g., adult, family) of the NP *role* in which the NP has been prepared. Presently, the majority of students enrolled in DNP programs are post-Master's degree students. Those students are already certified and practicing NPs who do not need any further certification testing to practice. There are DNP programs that anticipate that nurses with a BS in nursing will enroll and graduate with a DNP degree. Those students will also sit for the existing certification exams in order to gain entry to practice (32).

The Essentials of Doctoral Education for Advanced Nursing Practice, developed by the American Association of Colleges of Nursing, includes eight competency areas, seven of which are not related to enhancing clinical skills, but are more focused on systems-based practice and policy. The DNP Essentials are:

- I. Scientific Underpinnings for Practice
- II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
- III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
- V. Health Care Policy for Advocacy in Health Care
- VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes
- VII. Clinical Prevention and Population Health for Improving the Nation's Health
- VIII. Advanced Nursing Practice (33)

DNP programs also require completion of a Master's degree program for the RN degree and a minimum of 1,000 postbaccalaureate clinical hours. Training of physicians involves 4 years of premedical college education, 4 years of medical school that includes 2 years of clinical rotations, 3 years or more of clinical residency training with up to 80-hour workweeks, additional fellowship subspecialty training, and continuing medical education. The ACP supports advanced training for NPs but holds strongly that the NP or DNP degree does not prepare NPs to perform in the same capacity as physicians.

ACP believes that patients rely on a health care provider's professional designation as an indication of the level of training, skills, and knowledge of those providing their care. The use of the prefix "Dr." or "Doctor" by NPs who have completed the DNP degree could lead to confusion and misconceptions by patients. Accordingly, the College has recommended that information be available to patients to help them to distinguish among the different health care professionals involved in their care.

**Position 2: Collaboration is defined as ongoing interdisciplinary communication regarding the care of individuals and populations of patients in order to promote quality and cost-effective care. Recognizing the importance of coordinated care to improving health outcomes, we offer the following principles on collaboration between physicians and nurse practitioners:**

- A. Effective interdisciplinary collaboration is critical to ensuring that all patients receive the highest possible quality of care.
- B. Members of a health care team should understand their complementary roles in the delivery of care as defined through their respective professional practice acts.
- C. Collaboration among physicians and nurse practitioners can occur during both face-to-face encounters and electronically through the use of technology, including telephone, e-mail, telehealth, and electronic health records.



- D. Effective collaboration among nurse practitioners and physicians requires appropriate sharing of information and mutual acknowledgment of and respect for each professional's knowledge, skills, and contributions to the provision of care.**
- E. Payment systems should provide sufficient reimbursement for the coordination of care and collaboration between nurse practitioners and physicians.**

Collaboration has been defined as a joint communication and decision-making process with the goal of satisfying the health care needs of a target population. Components of a collaborative practice model include a shared commitment to achieving positive patient outcomes, a mutual understanding of team member's roles, an agreement to practice within an individual's scope of practice, and a mechanism for communication (34).

The Institute of Medicine (IOM) declared that to improve the quality of patient care, enhanced infrastructures are needed to ensure effective and timely communication among clinicians and between patients and clinicians (35). Because state laws allow many NPs to practice in remote sites, health information technology is critical to improving both the quality and coordination of care. Through computer networks and the use of information technology, medical linkages and long-distance learning and consultation opportunities can be established that will enable physicians and nonphysician clinicians to communicate easily concerning patient diagnosis and treatment. Such technology should ensure the availability of clinical information at the point of care for all providers and patients. ACP supports the use of electronic health records (EHRs) as one critical element of the infrastructure needed to facilitate communication between physicians and nonphysician clinicians. The availability of such communications systems will enhance opportunities for primary care services to be delivered through a collaborative team involving physicians, NPs, and PAs.

Enhanced communication systems among clinicians in a team are important, given the increasing complexity of medical care. Just as patients benefit when primary care physicians and subspecialty consultants communicate easily and effectively, so they benefit when NPs, especially those in states allowing independent practice, can communicate easily and effectively with physician consultants. Research has found that independent NPs are practicing within their scope of practice, serving younger patients, serving patients with selected illnesses and injuries, performing basic primary care procedures, and referring patients to primary care physicians and subspecialists when the patient requires care outside the NP's scope of practice (36,37). Accordingly, NPs fill a gap when patients have illnesses that are not very complex. In states where NPs are permitted to practice independently, processes must be implemented to assure that the appropriate medical personnel are involved when needed.

This becomes most important with the expansion of retail health clinics, which are primarily staffed by NPs. The convenience and affordability of retail health clinics appeal to both insured and uninsured individuals. In 2006, the College adopted principles for retail health clinics, which encourage the development of referral systems to physician practices or to other entities appropriate to the patient's symptoms beyond the store-based clinic's scope of practice (38). There should also be linkages to assure that the patient's primary care physician is notified of any treatment or prescriptions and to assure the availability of continuity of care. ACP supports the use of EHRs to facilitate communication among the episodic providers of care at the store-based clinics, primary care providers, subspecialists, and other members of the collaborative health care team. In addition, independent NPs should establish formal connections with physician practices in the community to provide continuity of care and to encourage the patients they treat to establish a primary care relationship.

**Position 3: Licensing and certification examinations for nurse practitioners should be developed by the nursing discipline and based on standardized training involved in graduating from advanced practice nursing programs as well as scope of practice statutes and regulations. Certification examinations should be carefully constructed so as to avoid any appearance of equivalency of training/certification with physicians. ACP therefore opposes use of test questions (past or present) developed by the National Board of Medical Examiners (NBME) for Step 3 of the U.S. Medical Licensing Exam in the certifying examination of Doctors of Nursing Practice (DNPs).**

The ACP regards advanced practice nursing as a distinctive and complementary profession. ACP opposes any policies or regulations that have the consequence of replacing or substituting NPs for physicians. The unique training and skill set taught in NP programs merits its own licensing and certification process. Examinations should be developed by the discipline of nursing and not drawn from another discipline's examination or certification mechanism.

The NBME has a contractual arrangement with the Council for the Advancement of Comprehensive Care (CACC), a leadership group in the Doctor of Nursing Practice (DNP) community, as well as with other non-physician professional organizations to provide testing services.

A white paper by the NBME explains the DNP examination process as follows:

The DNP Certification Examination utilized the test blueprint developed for USMLE Step 3 as a basis for its design; however, a CACC-appointed expert committee made final decisions regarding the actual test design to be used, and the resulting design has different dimensions than the Step 3 examination. The exam will utilize test items previously used in the USMLE Step 3 examination; no items in current use in USMLE will appear in the CACC exam. The CACC-appointed expert committee will establish its separate pass/fail standard, informed by information about the pass/fail standard for USMLE Step 3. The exam will be shorter than USMLE Step 3, will contain a different mix of multiple-choice questions, and will initially not use the computer-based patient management simulations that are part of USMLE Step 3, although this test format will be added in the future. CACC will define eligibility requirements for taking its examination; these requirements will differ substantially from USMLE Step 3 requirements, for example, no formal clinical skills assessment or test of fundamental science knowledge will be prerequisites.

The exam is only one element of a three-part process for DNP certification. Candidates must also possess an active license as an advanced practice nurse and must successfully complete the educational requirements of the DNP program to qualify for the DNP certification examination of the American Board of Comprehensive Care. Although the certification examination for DNPs is not the same as licensing or certifying exams for physicians and separate entities are responsible for the design of the exam and for certification of DNPs, the use of USMLE test questions could give the misleading impression that the exams are the same or imply that DNPs successfully completing the certification exam have met the same standards and have the same credentials as physicians.

<sup>1</sup>National Board of Medical Examiners. NBME Development of a Certifying Examination for Doctors of Nursing Practice (White Paper). Accessed on 4 March 2009 at <http://www.nbme.org/about/news.html>.

**Position 4:** In the patient-centered medical home (PCMH) model, care for patients is best served by a multidisciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and consistent with the following:

- A. Demonstration projects testing the effectiveness of NP-led PCMH practices should meet the same eligibility requirements as those for physician-led practices.**
- B. NP-led PCMH practices should be subject to the same recognition standards to participate in the demonstration project as physician-led practices.**
- C. NP-led PCMH practices should be subject to the same standards of evaluation as physician-led PCMH practices.**
- D. Patients who are selecting a PCMH as their source of regular care should be informed in advance if it is a physician-led or nurse practitioner-led practice and the credentials of the persons providing care within each practice.**
- E. All clinicians within the PCMH are operating within existing state practice acts.**
- F. Payments and evaluation metrics for both physician-led and nurse-practitioner-led PCMH practices must take into account differences in the case mix of patients seen in the practice.**

The patient-centered medical home (PCMH) model is based upon providing patients with comprehensive primary care in a team-based environment. Within the PCMH, a physician leads a team of individuals who collectively take responsibility for the ongoing care of patients. A "team" may consist of different individuals who are members of the PCMH practice or individuals who provide service to complement the PCMH practice through established agreements and relationships. Ideally, each member of a clinical team should practice to the highest level of their license, knowledge, skills, and abilities--and no lower. In addition, health care professionals should not be expected to, nor endeavor to, practice beyond their license, scope of practice, or ability. While the PCMH is a physician-guided model of practice, NPs can play a vital role as key members of the team working collaboratively with physicians and other health care professionals. The many roles NPs play within the PCMH depend on the clinical setting, patient population, clinical competency and experience, and the professional relationship between the NP and the physician(s).

PCMH demonstration projects present a unique opportunity to examine not only best practices for collaboration between health care professionals, but also the performance and effectiveness of NPs as members of the multidisciplinary health care team. Payments and evaluation metrics for both physician- and nurse practitioner-led PCMH practices must account for differences in case mix, including differences in health status, socioeconomic status, cultural background, and other patient factors that may contribute to differences in cost and quality outcomes.

Although at this point the nursing and medical practices remain separate, the distinctions among the types of care being provided by primary care physicians and NPs appear to be fading. There is some evidence to suggest that NP-



led practices can provide services within their scope, serve younger patients with selected illnesses and injuries, perform basic primary care procedures, and refer patients to primary care physicians and subspecialists when the patient requires care outside the NP's scope of practice (39,40,41). Nurse-managed health centers (NMHCs) also illustrate a paradigm of nurse-led practice that merits further examination. NMHCs are mostly independent nonprofit organizations or academically based clinics affiliated with schools of nursing. NMHCs provide primary health care, health promotion, and disease prevention services to people in rural and urban areas with limited access to health care and record over 2.5 million annual patient encounters. More than 250 NMHCs operate throughout the U.S. and serve an estimated 250,000 patients (42). The centers are managed by advanced practice nurses, and care is provided by NPs, collaborating physicians, clinical nurse specialists, RNs, health educators, community outreach workers, and health care students. As safety net providers, NMHCs supply cost-effective care that reduces expensive emergency room use and hospitalization among patients (43).

**Position 5: ACP advocates for research to identify and disseminate effective models of collaboration, referral, and co-management of patients between and among nurse practitioners and physicians.**

Collaboration between NPs and physicians is essential to ensuring that patients have timely access to appropriate health care. To improve the coordination and quality of health care, physicians and NPs must be prepared to work effectively within varying health care systems, teams, and practice models. By nature, multidisciplinary health care teams are a diverse group with a wide variety of educational backgrounds, specializations, and skills. In addition, training, regulations, and culture establish and reinforce professional hierarchies that can impede effective collaboration between providers of care. The future of health care delivery will require multidisciplinary teams of health professionals who are prepared to meet the diverse and complex needs of the population. Accordingly, research is needed on effective models of multidisciplinary teams--especially those in which members have varying levels of autonomy and in which health information technology is used to facilitate collaboration.

**Position 6: Opportunities for professional multidisciplinary training and team development should be incorporated into the education and training of all health professionals.**

Multidisciplinary teams of physicians, NPs, and other health professionals are vital to improving the coordination and quality of care. Currently, the complexity of rules across disciplines and settings makes it a challenge to form effective multidisciplinary teams. For the most part, there are few opportunities for joint preparation between medical and NP students. According to the IOM, "people should be trained in the kinds of teams in which they will provide care, starting with initial professional training and continuing through graduate training and ongoing professional development" (44). However, the IOM recognizes that "multidisciplinary training is difficult to implement because of professional boundaries, the traditional hierarchical structure of health care, clinical specialization, faculty experience, and educational isolation" (45).

National health care workforce policies should ensure health care providers are adequately trained to work collaboratively within teams. Efforts should focus on providing multidisciplinary training to both future and practicing clinicians. ACP supports policies and funding to *explore the effectiveness of multidisciplinary training, which could include studies of:*

Incorporating joint coursework and clinical experience opportunities into educational curricula for medical and NP students.

Employing faculty from both schools of nursing and schools of medicine to teach NP and medical students.

Offering joint continuing education programs for physicians and NPs through both in-person and distance learning.

**Position 7: Workforce policies should ensure adequate supplies of primary care physicians and nurse practitioners to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more nurse practitioners does not eliminate the need nor substitute for increasing the numbers of general internists and family physicians trained to provide primary care.**

Any workforce policies should recognize the continued and essential need for patients to have access to a personal physician who accepts responsibility for their entire health, working in collaboration with nonphysician clinicians involved in caring for the patient.

NPs and primary care physicians are confronted with similar workforce issues of predicted clinician shortages, increased proportion of clinicians practicing in subspecialties, and decreased enrollment in educational programs. The well-documented nursing shortage, which could reach as high as 500,000 by 2025, translates into fewer RNs to enter advanced training programs and fewer qualified nurse educators to teach the number of nurses needed to ameliorate the nursing shortage (46). In 2007, the Association of American Colleges of Nursing (AACN) found that U.S. nursing schools turned away 3,048 qualified applicants from Master's programs and 313 qualified applicants from Doctoral programs (47). The primary reason for not accepting all qualified students was a shortage of faculty. Higher compensation in clinical and private-sector settings is luring current and potential nurse educators away from teaching. In addition, as the average age of nursing faculty members continues to climb, 75% percent of the current faculty population is expected to retire by 2019. The National League for Nursing estimates that 15% of all nursing Master's graduates would have to enter teaching just to maintain current faculty levels. They conclude, "Since this is very unlikely, the gap between unfilled positions and the candidate pool will widen significantly" (48).

Given the increasing role that NPs are playing in the provision of primary care, the scarcity of nurses is particularly concerning due to predicted shortages in the numbers of primary care physicians and limits on resident work hours. Recent studies have shown that the number of primary care physicians is declining at an alarming rate. For example, only 2% of fourth-year medical students plan to practice in general internal medicine, compared with 9% in 1990, according to a September 2008 survey published in the *Journal of the American Medical Association* (49).

The future of primary care will depend on adequate supplies of physicians trained to provide primary care as well as NPs and other nonphysician clinicians. A recent study suggests that, similar to medical students and residents, NPs and PAs choose settings other than primary care. It estimates that fewer than half of NP/PAs are in office-based primary care. Many NPs work in emergency rooms, hospital clinics, intensive care units, and inpatient services. Forty-two percent of patient visits to NP/PAs in office-based practices are in offices

of specialists. It concludes, "Limited numbers of NP/PAs, lucrative alternative practice opportunities, and uncertain numbers of future graduates will likely limit their availability in primary care" (50).

A study by the Association of American Medical Colleges found that even with projected growth of 2% per year between 2006 and 2025 in the number of NPs and PAs, an increase of 46%, an additional 150,000 NPs and PAs beyond this level would be required to reduce demand for primary care physicians by 25%. It predicts an overall shortage of 124,400 physicians by 2025, and warns that the demand for primary care physicians will outpace supply faster for primary care than for any other specialty group (51)\*.

## Conclusion

The future of health care delivery will require multidisciplinary teams of health care professionals that collaborate to provide patient-centered care. The key to high performance in multidisciplinary teams is an understanding of the distinctive roles, skills, and values of all team members. Just as the ACP celebrates the special attributes and capabilities of advanced practice nurses, it recognizes the unique role that a personal physician plays in patient care. Advanced practice nursing should not substitute for nor replace primary care medical practice as provided by general internists, family physicians, and other physicians. Physicians and NPs not only share a commitment to providing high-quality care, but also face similar challenges regarding reimbursement and workforce outlook. Recognizing and building on the common ground between the two professions is vital to improving collaboration to meet the complex health care needs of the population.

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\*The U.S. is facing a shortage of over 40,000 primary care physicians for adults, which are principally made up of the specialties of internal medicine and family medicine. Pediatricians, which provide primary care to both children and adolescents, are also an essential part of the primary care physician workforce in the U.S, although the evidence is less clear on whether the U.S. will be facing a shortage of pediatricians. ACP believes strongly that assuring a sufficient supply and mix of the primary care physician specialties that take care of children, adolescents, and adults—internists, family physicians and pediatricians—must be a goal of national workforce policies. Workforce policies should also ensure sufficient supplies of nurses, PAs, and other health professionals that provide primary care in collaboration with primary care physicians.

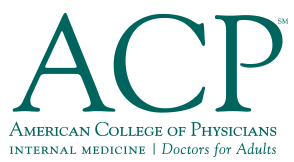
## References

1. **Phillips RL, Harper DC, Wakefield M, Green LA and Fryer GE.** Can Nurse Practitioners and Physicians Beat Parochialism into Plowshares? *Health Affairs* 2002;21(5):133-141.
2. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
3. **Cooper RA.** New Directions for Nurse Practitioners and Physician Assistants in the Era of Physician Shortages. *Academic Med.* 2007;82(9):827-828
4. **Cawley JF.** Physician Assistants and Title VII Support. *Academic Medicine.* 83(11):1049-1056, November 2008.
5. **Reynolds PP.** A Legislative History of Federal Assistance for Health Professions Training in Primary Care Medicine and Dentistry in the United States, 1963-2008. *Academic Medicine.* 83(11):1004-1014, November 2008.
6. **Phillips RL, Harper DC, Wakefield M, Green LA and Fryer GE.** Can Nurse Practitioners and Physicians Beat Parochialism into Plowshares? *Health Affairs* 2002;21(5):133-141.
7. **Steinwald AB.** Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services. Testimony to Committee on Health, Education, Labor, and Pensions, U.S. Senate, 12 Feb. 2008. U.S. Government Accountability Office, Washington, DC (GAO-08-472T), 2008. Accessed on 21 Nov. 2008 at [www.gao.gov/new.items/d08472t.pdf](http://www.gao.gov/new.items/d08472t.pdf).
8. **American Academy of Nurse Practitioners.** Frequently Asked Questions. Accessed on August 8, 2008 at [www.aanp.org/NR/rdonlyres/5C81057B-9C87-4C88-AD6D-6F78BDC55207/0/FAQsWhatisanNP31408.pdf](http://www.aanp.org/NR/rdonlyres/5C81057B-9C87-4C88-AD6D-6F78BDC55207/0/FAQsWhatisanNP31408.pdf).
9. **Wilson IB, Landon BE, Hirschorn LR, McInnes K, Ding L, Marsen PV, Cleary PD.** Quality of HIV Care Provided by Nurse Practitioners, Physician Assistants, and Physicians. *Ann Intern Med.* 2005; 143: 729-36.
10. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
11. **Roblin DW, Howard DH, Becker ER, Adams EK, Roberts MH.** Use of Midlevel Practitioners to Achieve Labor Cost Savings in the Primary Care Practice of an MCO. *HSR: Health Services Research.* 2004; 39(3): 607-25.
12. **Grumbach K, Hart LG, Mertz E, Coffman J, Palazzo L.** Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Non-physician Clinicians in California and Washington. *Annals of Family Medicine.* 2003; 1 (2): 97-104.
13. **American Academy of Nurse Practitioners.** Scope of Practice for Nurse Practitioners (Rev. 2007).
14. **Hooker RS, Berlin LE.** Trends in the Supply of Physician Assistants and Nurse Practitioners in the United States. *Health Affairs.* 2002; 21(5): 174-81.
15. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
16. **Cooper RA; Henderson T; Dietrich CL.** Roles of Non-Physician Clinicians as Autonomous Providers of Patient Care. *JAMA,* September 2, 1998; 28-(9):795-802.
17. **Division of Nursing, Bureau of Health Professions, US Department of Health and Human Services.** Accessed on Oct. 6, 2008 at [www.nonpf.com/finalaug2002.pdf](http://www.nonpf.com/finalaug2002.pdf).
18. **Essentials of Doctoral Education for Advanced Nursing Practice.** Washington, D.C.: American Association of Colleges of Nursing. 2006.
19. **American Academy of Nurse Practitioners.** Discussion Paper: Doctoral of Nursing Practice. Rev. 2007. Accessed on August 7, 2007 at [www.aanp.org/NR/rdonlyres/eohypbva5ab2yefiszl3nttmi3czv2lojklfechu5w3lecyuy6gmnn6ykpzv6xhjmropsmeo2wou3ebo6qhdsafgf/DoctorofNursingPractice\\_DNP\\_DiscussionPaper.pdf](http://www.aanp.org/NR/rdonlyres/eohypbva5ab2yefiszl3nttmi3czv2lojklfechu5w3lecyuy6gmnn6ykpzv6xhjmropsmeo2wou3ebo6qhdsafgf/DoctorofNursingPractice_DNP_DiscussionPaper.pdf).

20. **National Organization of Nurse Practitioner Practice.** White Paper: Eligibility for NP Certification for Nurse Practitioner Students In Doctor of Nursing Practice Programs; August 2008.
21. **Klein T.** Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution. *Advanced Practice Nursing Journal*; June 2005.
22. **Phillips SJ.** Ninetieth Annual Legislative Update. *The Nurse Practitioner.* 2007; 32(1).
23. **American Academy of Physician Assistants.** Third Party Reimbursement for Physician Assistants. Accessed Aug. 6, 2007.
24. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
25. **Sox HC Jr.** Quality of patient Care by Nurse Practitioners and Physician's Assistants: A Ten-Year Perspective. *Annals of Internal Medicine,* 1979; 91: 459-468.
26. **Mundinger MO, Kane RL, Lenz ER, Totten AM, Tsai WY et al.** Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians. *JAMA.* 2000; 283 (1): 59-68.
27. **Horrocks S, Anderson E, Salisbury C.** Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors. *British Medical Journal.* 2002; 324, 819-23.
28. **Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B.** Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews* 2005, Issue 2. Art. No.: CD001271. DOI: 10.1002/14651858.CD001271.pub2
29. **Buppert C.** *Nurse Practitioner's Business Practice and Legal Guide (Third Edition):* Jones and Bartlett, 2008.
30. **Horrocks S, Anderson E, Salisbury C.** Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors. *British Medical Journal.* 2002; 324, 819-23.
31. **Brown S, Grimes D.** A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care. *Nursing Research.* 1995; 44: 331-39.
32. **Dumas MA.** Personal communication by e-mail, July 21, 2008.
33. **American Association of Colleges of Nursing.** The Essentials of Doctoral Education for Advanced Nursing Practice. Accessed on September 16, 2008 at [www.aacn.nche.edu/DNP/pdf/Essentials.pdf](http://www.aacn.nche.edu/DNP/pdf/Essentials.pdf).
34. **Arcangelo V, Fitzgerald M, Caroll D, Plumb J.** Collaborative Care Between Nurse Practitioners and Primary Care Physicians. *Primary Care: Clinics in Office Practice.* 1996; 23 (1):103-13.
35. **Crossing the Quality Chasm: A New Healthy System for the 21st Century.** Academy of Sciences, Institute of Medicine. Washington, DC, 2001.
36. **Druss BJ, Marcus SC, Olfson M, Tanielian T, Pincus HA.** Trends in Care by Non-physician Clinicians in the United States. *NEJM.* 2003; 348(2): 130-37.
37. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
38. **American College of Physicians.** Principles on Retail Health Clinics, January 2007. Accessed on November 20, 2008 at [www.acponline.org/advocacy/where\\_we\\_stand/other\\_issues/prhc.htm](http://www.acponline.org/advocacy/where_we_stand/other_issues/prhc.htm).
39. **Druss BJ, Marcus SC, Olfson M, Tanielian T, Pincus HA.** Trends in Care by Non-physician Clinicians in the United States. *NEJM.* 2003; 348(2): 130-37.
40. **Hooker RS, McCaig LF.** Use of Physician Assistants and Nurse Practitioners in Primary Care 1995-1999. *Health Affairs.* 2001; 20(4): 231-38.
41. **Mundinger MO, Kane RL, Lenz ER, Totten AM, Tsai WY et al.** Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians. *JAMA.* 2000; 283 (1): 59-68.
42. **National Nursing Centers Consortium (NNCC).** The Nurse-Managed Health Clinic Investment Act of 2007 (S.112). Accessed on August 25, 2008 at [nncc.us/policy/NMHCAct.pdf](http://nncc.us/policy/NMHCAct.pdf).



43. **National Nursing Centers Consortium (NNCC).** 2007 NNCC Managed Care Credentialing and Reimbursement Study 2007. Philadelphia: National Nursing Centers Consortium.
44. **Crossing the Quality Chasm: A New Healthy System for the 21st Century.** Academy of Sciences, Institute of Medicine. Washington, DC, 2001.
45. **Crossing the Quality Chasm: A New Healthy System for the 21st Century.** Academy of Sciences, Institute of Medicine. Washington, DC, 2001.
46. **Buerhaus PI, Staiger DO, Auberbach DI.** The Future of the Nursing Workforce in the United States: Data, Trends and Implication (March 2008).
47. **Association of American Colleges of Nursing.** Nursing Faculty Shortage—March 2008. Accessed on September 16, 2008 at [www.aacn.nche.edu/media/pdf/FacultyShortageFS.pdf](http://www.aacn.nche.edu/media/pdf/FacultyShortageFS.pdf).
48. **National League of Nursing.** Nurse Faculty Shortage Fact Sheet—August 2005. Accessed on September 15, 2008 at [www.nln.org/governmentaffairs/pdf/NurseFacultyShortage.pdf](http://www.nln.org/governmentaffairs/pdf/NurseFacultyShortage.pdf).
49. **Hauer KE, Durning SJ, Kernan WN.** Factors Associated With Medical Students' Career Choices Regarding Internal Medicine. *JAMA*. 2008; 300(10): 1154-1164.
50. **Colwill JM, Cultice JM, and Kruse RL.** Will generalist physician supply meet demands of an increasing and aging population? 29 April 2008, Health Affairs Web Exclusive (w232-w241).
51. **Dill MJ and Salsberg ES.** Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections Through 2025. Nov. 2008. Accessed on 12-10-08 at [https://services.aamc.org/Publications/showfile.cfm?file=version122.pdf&prd\\_id=244&prv\\_id=299&pdf\\_id=122](https://services.aamc.org/Publications/showfile.cfm?file=version122.pdf&prd_id=244&prv_id=299&pdf_id=122).



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