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Response to the APRN Sunrise PERD Application

The West Virginia State Medical Association (WVSMA), the West Virginia Academy of Family Physicians (WVAFP), and the WV Chapter of the American College of Physicians (ACP) strongly oppose the APRN request for increased scope of practice because doing so could compromise the health and safety of West Virginians. Current WV Code, which requires collaborative agreements between licensed physicians and APRNs, is a necessary protection for the public since APRN education programs are not standardized and provide far less clinical training compared to medical school programs. Further, the APRNs' request to prescribe all controlled substances without any reasonable limitations could have the disastrous effect of aggravating West Virginia's prescription drug abuse problem, already the worst in the nation. In addition, the request to allow APRNs to have "global signature" authority raises red flags since the scope of this policy change would be far-reaching.

Although a small minority of states have removed the statutory protections of collaborative agreement requirements, there is no data to show that this has led to increased access to care in those states. Thirty-four other states, including all of our surrounding states, require collaborative agreements. Collaborative agreements provide important safeguards for public health and safety, especially in regard to rules that call for reasonable limits on APRNs' prescriptive authority for potentially dangerous controlled substances. The WV law on APRN scope of practice has been recently updated and already allows APRNs to prescribe many medications and to practice independently in any locations they choose. Removing the collaborative agreement requirement would not affect APRNs' ability to practice in rural areas, it would only remove a practical method of oversight that enhances patient safety. The APRNs have cited a number of research studies that purport to show that APRNs offer the same quality of care as physicians, but these studies are riddled with methodological problems and other shortcomings, and many show that APRNs have skills that are different than

those of physicians (although complementary). Further, APRNs can be reimbursed at levels up to 100% of doctors' fees for the same services, and studies show that APRNs tend to order more tests and use more services than do physicians, so they do not achieve cost savings. The WVSMA and the WVAFP believe that a team approach, incorporating the strengths of the professions of medicine and nursing, leads to the best quality of medical care, and research supports this theory.

The APRNs' request for "global signature" authority also causes the medical community grave concern. The APRNs are requesting carte blanche permission to sign any documents currently required by law to be signed by physicians. This is a patient safety issue. The Legislature has made careful decisions in many sections of the WV Code to require physicians' judgment for such important documents as medical orders, forensic medical determinations, competency declarations, disability evaluations, end-of-life documents, death certificates, and more. No documentation of medical need was provided in the APRN "Sunrise Application." Any statutory change to allow "global signature" authority for APRNs should not be approved until a special legislative interim study can be conducted to assess any medical need and potential effects on public safety.

The following report outlines ten reasons for opposing APRN scope of practice expansion, with substantiation for the ten reasons on the following pages.

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Reasons to Oppose APRN Scope of Practice Expansion

1. West Virginia has the highest rate of death by overdose of prescription drugs, and granting APRNs prescriptive authority for Schedule II controlled substances could exacerbate this problem.
2. While WV APRNs are requesting the unfettered right to autonomously prescribe all classes of controlled substances, all of our surrounding states (KY, MD, OH, PA, VA) require collaborative agreements with physicians, as well as imposing other limitations on APRNs' prescriptive authority.
3. Physicians' training is substantially different than that of APRNs. It is far more rigorous, lengthy, and standardized. In contrast, APRN programs vary widely and can be completed in as little as 18 months through online courses. APRN training is not equivalent to medical school, but it does provide complementary skills, which are best utilized through collaborative arrangements between APRNs and physicians.
4. Nurses have authored a glut of research studies on quality of care of APRNs, but most of the studies suffer from a variety of shortcomings and limitations. Many studies indicate that APRNs have different strengths than physicians, suggesting that the best model for care is a collaborative team approach.
5. Increasing APRNs' scope of practice is unlikely to increase access to primary care in rural areas. APRNs are much more likely to practice in urban settings in West Virginia, even though collaborative agreements do not limit them from rural areas. Further, increased scope of practice has *not* led to increased access to care in other states.
6. Not only are APRNs unlikely to provide cost savings, they can increase costs of care. They can bill Medicaid for their services at 100% of the physician rates and Medicare at 85% (100% if "incident to" physician services). Further, research studies show that nurse practitioners are less productive, and tend to order more exams and utilize more resources compared to physicians, leading to increased costs of care when working independently.
7. Research shows that patients have a clear preference for physician-led health-care services, and the WV Legislature has already addressed this issue.
8. Current WV Code specifies recently updated, reasonable rules for collaborative agreements between physicians and APRNs that provide important protections for health care consumers in the state.
9. Proposed changes to the law are broad and potentially could have far-reaching unintended consequences.
10. Research shows that the best and most cost-effective medical care occurs when physicians and nurses work together to provide a team approach, balancing the strengths of each profession. Virginia has recently enacted a new law, drafted by nurse and physician groups working in conjunction, which stipulates requirements for patient care teams. Virginia's new law calls for collaboration, just as current West Virginia law already requires.

1. *West Virginia has the highest rate of death by overdose of prescription drugs, and granting APRNs prescriptive authority for Schedule II controlled substances could exacerbate this problem.*

West Virginia has a serious prescription drug abuse problem. Expanding APRNs' prescriptive authority and removing the statutory requirement for collaborative agreements, which provides an important level of oversight, could make the problem much worse.

A report just released by the Trust for America's Health states that West Virginia has the highest drug overdose mortality rate in the country, with 28.9 deaths per 100,000 people, a 605% increase since 1999. One of the authors' key recommendations is, "Ensure responsible prescribing practices, including increasing education of healthcare providers and prescribers."[1] Physicians have far more extensive education than do APRNs, and expanding prescriptive authority for dangerous substances to a less educated group is a step in the wrong direction.

According to the CDC, some of the people most vulnerable to prescription drug overdose are those who obtain multiple prescriptions from multiple providers ("doctor shopping"). Other high-risk groups include low-income people and those living in rural areas. Increasing the number of less-trained providers increases the potential risk of prescription drug abuse, particularly in a state such as West Virginia.[2] Further, an FDA advisory panel in January recommended reclassifying hydrocodone as a Schedule II drug, with the understanding that, in most states, the reclassification would effectively limit prescriptive authority for the drug to physicians, in an effort to help control the drug diversion problem.[3]

A recent WV Supreme Court of Appeals case demonstrates the potential problem with relying on the WV Board of Examiners for Registered Professional Nurses (RN Board) for oversight, and thus the need to maintain the current system of collaborative agreements. In *State ex rel. Fillinger v. Rhodes* (2013), the Court chastised the RN Board for failing to conduct disciplinary hearings for a nurse accused twice of unlawfully obtaining prescription narcotics for personal use and distribution. The nurse had been fired for that reason from CAMC in 2008 and Logan Regional Medical Center in 2009. Both medical centers filed complaints with the RN Board, but it never conducted a hearing on either complaint. Since the RN Board denied the nurse due process, the Court had to dismiss the case, and the nurse's license was not suspended. Justice Benjamin called the RN Board's failure to act "excessively vexatious conduct," and Justice Loughry called it "unconscionable."[4]

The exorbitant rate of death by overdose in West Virginia should lead to more protective laws to limit the overuse of prescription medications in an effort to curtail the problem. The APRNs' proposal to increase their prescriptive authority to include Schedule II drugs would make our laws less protective. The proposed law would allow less educated providers to prescribe potentially dangerous controlled drugs, increasing the opportunity for abuse. Further, removing the collaborative agreement rule would leave oversight of nurses' prescribing practices to the RN Board, which has been shown to be unreliable and ineffective for this purpose.

2. *While WV APRNs are requesting the unfettered right to autonomously prescribe all classes of controlled substances, all of our surrounding states (KY, MD, OH, PA, VA) require collaborative agreements with physicians and impose other limitations on APRNs' prescriptive authority.*

Kentucky:
KRS 314.042 requires that an APRN must enter into a collaborative agreement with a physician, defining the scope of prescriptive authority for nonscheduled legend drugs, and a separate collaborative agreement with a physician for controlled substances, before prescribing such substances, and also obtain DEA registration.

KRS 314.011 provides additional limitations on APRNs' prescriptive authority, including that they can only prescribe Schedule II substances in a 72-hour supply, without refill; Schedule III for 30 days without refill, and Schedule IV and V substances to the original prescription plus refills not to exceed a 6-month supply.

Maryland:
Ch. 77 8-302 (b) states that a certified nurse practitioner (CNP) may not practice in the state without an attestation that a collaborative agreement is in place with a licensed physician, and an agreement to consult with that physician and other health care providers as needed.

Ch. 77 8-508 (a)(1) lists requirements and limits for CNPs' prescriptive authority.

Ohio:
OAC 4723-8-04 requires that, prior to engaging in practice, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner must enter into a "standard care arrangement" with a collaborating physician.

ORC 3719.06 (A) (2) states that a CNS, CNM, or CNP who is authorized to prescribe drugs, may only prescribe Schedule II controlled substances for patients with terminal conditions, for a 24-hour supply, and if the collaborating physician initially prescribed the substance.

Pennsylvania:
§ 21.283 provides that a certified registered nurse practitioner (CRNP), acting in a collaborative agreement with a physician, may prescribe and dispense drugs, after obtaining prescriptive authority approval by successfully completing 45 hours of coursework in advanced pharmacology, as well as meeting other specific conditions.

§ 21.284b. provides requirements for CRNPs who prescribe controlled substances.

Virginia:
Chapter 213 (HB 346), passed in March 2012, which was drafted by a coalition of physicians and nurses in the state, requires that nurse practitioners may only practice as part of a "patient care team," and the law stipulates various requirements for collaborative practice agreements.

3. *Physicians' training is substantially different than that of APRNs. It is far more rigorous, lengthy, and standardized. In contrast, APRN programs vary widely and can be completed in as little as 18 months through online courses. APRN training is not equivalent to medical school, but it does provide complementary skills, which are best utilized through collaborative arrangements between APRNs and physicians.*

Quality of care in medicine depends in large part on the practitioner's education and training. In West Virginia, the education requirement for an APRN is a graduate degree in nursing plus license and certification from the state RN Board.[5] The graduate degree must be from an accredited school and include a "supervised clinical component,"[6] although the rule does not provide specific minimum requirements for this component. A bachelor's degree is not even necessary to enroll in a master's of nursing program: most programs also accept an associate's degree or nursing diploma. The master's degree can be obtained from an online program. Currently over 70 online programs exist nationwide, in addition to countless traditional programs, and they can be completed in as little as 18 months of full-time study.[7] There is no standardization among programs, although the APRN consensus model calls for 500 hours of clinical practice.[8]

Physicians, in contrast, have to complete a four-year college degree, four years of medical school (no on-line programs available), and a three- to five-year residency, as well as optional fellowships for additional years. Further, medical schools and residency programs are highly competitive. In addition, licensure requires passing multiple medical board exams. So, while APRNs have as little as 1.5 years post-graduate work, physicians have at least seven, five of which comprise clinical training. Even with the minimum three-year residency, primary care physicians spend about 34,000 hours on education, and specialists spend nearly 50,000 hours.[9] The American Academy of Family Physicians estimates that family physicians spend 20,700 to 21,700 hours on education compared to 2,800-5,350 for NPs.[10] That means family practice physicians accrue four to eight times as many hours of education as do NPs, and other specialists may accrue up to 18 times as many!

Family practice physicians undertake at least 15,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training.[11] In comparison, APRN programs vary, but, if they are in line with the APRN consensus model, they require 500 of clinical experience.[12] That means that family practice physicians have 30 times as much clinical training as do APRNs.

The fact is, physicians have substantially greater medical education and far more hours of clinical training compared to nurse practitioners, and more education and training equates to more knowledgeable diagnoses and treatment. Nurses' training is not equivalent to that of physicians, but it is complementary, and ideally the two professions should work together collaboratively.

4. *Nurses have authored a glut of research studies on quality of care of APRNs, but most of the studies suffer from a variety of shortcomings and limitations. Many studies indicate that APRNs have different strengths than physicians, suggesting that the best model for care is a collaborative team approach.*

Research studies on the quality of care provided by APRNs suffer from various limitations. For example, one large study focused on patients with pre-existing, common diagnoses with well-established treatment protocols.[13] Another study that appeared large because of the patient population actually involved only a single, possibly anomalous nurse practitioner (NP) with 15 years of critical care nursing experience compared with physicians in training rotating through the unit for a week or two at a time.[14] The data in one study that was touted as demonstrating cost savings associated with APRN care indicated that NPs missed a known diagnosis in 40% of patients![15]

In their PERD Application, APRNs list a plethora of research studies purporting to show that APRNs provide care that is equivalent to that of physicians. Many of the studies have methodological limitations, however, and, as the authors of a meta-analysis sponsored by the American Nurses Association stated, "There was a lack of methodological rigour and logical formulation in many of the included studies."[16]

In some studies cited by the APRNs, the findings cannot be extrapolated because of the specificity of the setting or other parameters. For example, one of the studies compared senior house officers (SHOs) and NPs in an emergency room in Glasgow, Scotland;[17] another study was from Bristol, England.[18] In the United Kingdom, SHOs are doctors in training, and the qualifications for NPs are more rigorous compared to the U.S. training programs: A levels are required for applicants, and the post-graduate training has a 3-year duration, as well as additional clinical training, so those studies are not relevant to care in the United States. Further, some of the studies cited evaluated care in nursing homes;[19] and three of the studies dated all the way back to the 1970s,[20] predating today's advanced medical technology, and long before any online NP training programs existed, and therefore not germane. Another important limitation of the studies is that they generally compare patient populations with simple, chronic conditions; in the case of nurse midwives, the studies typically include low-risk patients with uncomplicated pregnancies.

Some of the studies actually show that APRNs have a different skill set which would be complementary to physicians in a collaborative team approach. For example, several studies reported that NPs tend to have better communication and interviewing skills compared to physicians.[21] One of the most compelling studies listed by the APRNs was a study of 1,207 general medicine patients randomized to receive either traditional care or care by a multidisciplinary team of physicians and NPs. The researchers found that the multidisciplinary teams were more cost effective, achieving a net cost savings of $978 per patient.[22]

The research studies on quality of care by NPs help to demonstrate that physicians and APRNs have different skill sets which can best be utilized by encouraging collaboration on multidisciplinary teams.

5. *Increasing APRNs' scope of practice is unlikely to increase access to primary care in rural areas. APRNs are much more likely to practice in urban settings in West Virginia, even though collaborative agreements do not limit them from rural areas. Further, increased scope of practice has not led to increased access in other states.*

One of the main arguments that NPs offer for increasing their scope of practice is that doing so will improve access to care, particularly for people in rural areas. Unfortunately, evidence does not support this theory. Most NPs practice in urban areas; only about half practice primary care; and states that have laws granting them greater autonomy are not significantly different than those without such laws.

Nationally, there are 152,000 APRNs, 106,000 of which are NPs, and they are much more likely to practice in urban areas. Their density in urban areas is 3.6 NPs per 10,000 population compared to only 2.8 per 10,000 in rural areas. In West Virginia, the comparative density is even worse, with 3.7 NPs per 10,000 in urban areas compared to only 2.6 in rural,[23] even though West Virginia's proportion of population living in rural areas is significantly higher than that of the nation, with 44% of West Virginians living in rural areas compared to only 17.7% nationwide.[24] While all counties in West Virginia have at least one actively practicing primary care physician, at least seven counties have no practicing APRNs.[25]

Further, nearly half of NPs do not practice in primary care settings. Although the American Academy of Nurse Practitioners reports that 89% of NPs are trained in primary care and 75% practice in primary care settings,[26] data from the National Provider Identifier File, a database tracking all clinicians who file insurance claims, shows that only 52% of NPs actually practice in primary care settings.[27]

Changing state laws to provide more autonomy for NPs has not helped the problem: the handful of states that allow NPs to practice independently have not experienced increased access to care in underserved areas. No significant difference exists in the relative practice densities of NPs in states with more statutory autonomy for NPs.[28]

The fact is, nothing is preventing WV APRNs from practicing in rural areas now because they are allowed to practice independently in any location they choose. Collaborative agreement requirements in West Virginia do not stipulate any limitations on practice locations. There is no reason why APRNs cannot practice in underserved rural areas under the current law, and there is no reason to believe that changing current law would motivate them to change their practice locations. Changing the law is highly unlikely to make any difference in access to care.

6. *Not only are APRNs unlikely to provide cost savings, they can increase costs of care. They can bill Medicaid for their services at 100% of the physician rates and Medicare at 85% (100% if "incident to" physician services). Further, research studies show that nurse practitioners are less productive, and tend to order more exams and utilize more resources compared to physicians, leading to increased costs of care when working independently.*

APRNs claim that increasing their autonomy will provide health care cost savings, but facts and research data do not support this claim. The fact is, they can bill at the same rate as physicians, and research studies have shown that they utilize more resources, compared to physicians, leading to increased costs.

APRNs can bill at 100% of the physician rates for services. In West Virginia, the Department of Health and Human Resources allows primary care physicians and APRNs to bill for reimbursement at the same rate.[29] Medicare provides reimbursement to APRNs at 100% of the physician rate if the service is "incident to" physician services and otherwise at 85% of the physician rate.[30] This slight savings may be short-lived, however, since the American Nurses Association is currently lobbying for pay parity.[31]

Research studies have shown that APRNs can be associated with higher costs of care because of their lower productivity, relative to physicians, and their tendencies to order more tests and utilize more resources. A study cited by the APRNs in their application reported that APRNs are only 60% as productive physicians.[32] In a literature review from the Cochrane Collaboration, researchers screened over 4,000 articles and reviewed 25 articles comparing doctors and nurses providing similar primary health care services. The researchers reported that the studies showed that, when the nurses provided first contact care to patients, they tended to use more resources and have lower productivity compared to doctors. They reported that salary differentials varied between nurses and doctors, but even when nurses salaries were lower than doctors' no cost savings was achieved because of the decreased productivity and increased use of tests and other services.[33]

In another study on resource utilization, researchers collected data on number of radiologic and laboratory tests for patients assigned to either a NPs or an attending or resident physician at a Veterans Administration medical center. They found resource utilization was higher in 14 of 17 measures for NPs compared to residents (doctors in training) and 10 of 17 measures for NPs compared to attendings (fully trained physicians). None of the utilization measures was lower for the NPs compared to either physician group. The researchers concluded that NPs utilize more resources than do physicians in a primary care setting.[34]

Although APRNs claim that increasing their autonomy will result in lower health care costs, the reports they cite are generally speculative. Research demonstrating that actual cost savings can be achieved typically involve settings in which APRNs and physicians are working together in health care teams, as discussed below (#10).

7. *Research shows that patients have a clear preference for physician-led health-care services, and the WV Legislature has already addressed this issue.*

The WV Legislature in 2009 enacted legislation to address the issue of physician-led health care services through patient-centered medical homes in §16-29H-9. In pertinent part, the statute provides: "(b) The patient-centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology."

Research studies affirm that the majority of patients prefer that their clinicians are physicians. A recent study showed that the vast majority of people older than 65 years prefer seeing a physician for health care services rather than a nurse practitioner (77% vs. 6%). This groups makes up about a third of the patients in primary health care visits. For those aged 35-64 years, the ratio is about 55% to 20%.[35]

Another study found that, even though the majority of retail healthcare consumers under 65 consider affordability their primary concern, they would not visit a nurse practitioner rather than a physician in order to save costs. Retail consumers are defined as those under 65 who have individual insurance, insurance through a small group employer or are uninsured. Of this group, 72% consider affordability their most important healthcare concern, over quality of care and accessibility, yet 59% would not go to a nurse practitioner for routine visits to save costs.[36]

Other research shows that patients have a strong preference for physician-led health care:

- 86% of patients believe they benefit from a physician-led primary care team;
- 80% prefer a physician to have primary responsibility for their health care;
- 78% do not think nurse practitioners should be able to run their own practices without physician involvement;
- 79% do not think NPs should practice independently of physicians without direct supervision;
- 92% believe that only physicians should be allowed to diagnose heart conditions;
- 83% believe only physicians should prescribe complex medications;
- 78% think only physicians should diagnose and treat chronic diseases;
- 75% say they would prefer to be seen by a physician instead of a mid-level provider even if it took longer for them to get an appointment;
- 98% say physicians and nurses need to work in a coordinated matter to ensure patients get the care they need.[37]

Patients have voiced a strong preference for physician-led health care teams, and the Legislature has found that such teams provide the best way to meet patients' needs.

8. *Current WV Code specifies recently updated, reasonable rules for collaborative agreements between physicians and APRNs that provide important protections for health care consumers in the state.*

West Virginia's current statutes for APRNs have been recently updated and are less restrictive in regard to APRN prescriptive authority than those in most other states, including all of our contiguous states.

Over the past four years, the WV Legislature has expanded APRNs' prescriptive authority, and in this past session, introduced a statutory definition of the term APRN. In 2009 the WV RN Board collaborated with the WVSMA and the WV Board of Medicine to develop new rules significantly rewriting and expanding the existing prescriptive authority rules for nurse midwives and nurse practitioners (SB 664, codified as §30-7-15a and §30-7-15b), and in 2012 a definition of APRN was added to the statute, replacing previous language referring to advanced nurse practitioners (SB 572, adding §30-7-1a). In 2012 other changes were also made to the APRN rule: §30-7-15b and §30-7-15c were amended to add a grandfather clause, and allow the WV RN Board to set an application fee and providing rule-making authority.

The current rules, §30-7-15 and §30-15-7, permit APRNs and nurse midwives to prescribe medications, including those listed under Schedule IV and V, without limitation, pursuant to a collaborative agreement with a physician. They are also permitted to prescribe Schedule III medications in a 72-hour supply without refill.

West Virginia statutes provide fewer restrictions on APRN practice compared to laws in most other states. West Virginia is one of only 22 states that allow APRNs to diagnose and treat patients without physician involvement. While West Virginia does require that APRNs have collaborative agreements to prescribe medications, it is one of 38 states that have such a requirement.[38]

Collaborative agreements provide an important level of patient protection because they require a physician to provide a periodic review and evaluation of the APRN's prescriptive practices to ensure patient safety and to help protect the public from unsafe prescribing practices. Also, having a collaborating physician means that the APRN has a readily available contact who can share information and expertise.

The WV Board of Medicine has promulgated a set of guidelines for collaborative agreements that helps ensure patient safety. The guidelines provide common-sense rules, such as providing that the collaborating physician should be in the same specialty as the APRN, and the agreement should not include medications that the physician does not prescribe in his or her own practice, or those with which the physician is not familiar and knowledgeable.[39]

West Virginia's statutes regarding APRNs provide reasonable protections for health care consumers in the state, and they are already more permissive for APRNs than those in a significant majority of other states.

9. *Proposed changes to the law are broad and potentially could have far-reaching unintended consequences.*

The APRNs' proposed changes to existing WV statutes include removing the limitations on NPs' and nurse midwives' prescriptive authority for Schedule II and III controlled substances, removing the requirement for collaborative agreements with physicians, and permitting APRNs the authority to sign, or otherwise affirm, any documents that WV law or regulations currently require to be authorized by a physician. These changes could have unintended negative consequences.

Removing current limitations on APRNs' and nurse midwives' prescriptive authority for Schedule II and III controlled substances could exacerbate the drug diversion problem in West Virginia. Removing the current reasonable limitations would allow mid-level providers, who have considerably less training than physicians, to prescribe substances recognized for their potential for abuse. Further, this would increase opportunities for patients who are vulnerable to abusing controlled substances to shop for multiple providers.

Another significant risk of allowing APRNs and nurse midwives to prescribe controlled substances without collaborative agreements is that this would remove an important level of oversight. Collaborative agreements require that physicians periodically evaluate prescriptive practices with the APRN or nurse midwife, which helps prevent misuse and protects public safety. Not only would periodic reviews be eliminated, but egregious abuse might go unpunished, as demonstrated in the recent WV Supreme Court of Appeals case, *State ex rel. Fillinger v. Rhodes* (2013). The case revealed that the WV RN Board failed to take action against a nurse who was fired from two different hospitals following accusations that she had unlawfully obtained narcotics for personal use and distribution.[40]

Removing the collaborative agreement requirement also eliminates the partnership with a physician, which can be very beneficial if the APRN has questions or concerns regarding patient care. This can be particularly important regarding de novo diagnoses, as one study showed that NPs working independently missed a known diagnosis in 40% of patients.[41]

The proposed addition to the law allowing global signatures could result in significant issues. The extent of the consequences of this change cannot be estimated since the number of documents to which it refers is unclear. Some of the documents include disability determinations, forced psychiatric admissions, competency declarations, etc., which could lead to increased costs (as from accelerating the number of disability claims) and other issues. This proposed change merits careful consideration to investigate all of the potential ramifications.

Finally, changing laws to define APRNs as equivalent to physicians could have the unintended consequence of aggravating the current shortages of primary care physicians and registered nurses. It could discourage medical students from entering primary care residency programs since such residencies would be considered equivalent to training that is significantly shorter and less rigorous, and it could discourage nurses from traditional nursing positions.

10. *Research shows that the best and most cost-effective medical care occurs when physicians and nurses work together to provide a team approach, balancing the strengths of each profession. Virginia has recently enacted a new law, drafted by nurse and physician groups working in conjunction, which stipulates requirements for patient care teams. The new law calls for collaboration, just as current West Virginia law already requires.*

Studies show that a multi-disciplinary team approach provides cost effective and high-quality health care because such an approach takes advantage of the relative strengths of each profession. For example, data from Kaiser Permanente Georgia shows that health care teams with high levels of collaboration and teamwork performed 40-90% better when caring for patients with chronic diseases such hypertension, diabetes, and asthma.[42] A large study of inpatients at the UCLA Medical Center shows that multidisciplinary teams of physicians and NPs achieved significant cost savings.[43] Researchers at a Veterans Administration hospital found that patients treated by multidisciplinary teams had significantly lower average lengths of stay with no difference in mortality or readmissions.[44] These studies and many others demonstrate that multidisciplinary teams provide the most effective model for health care delivery.

The Virginia State Legislature, recognizing the benefits of the team approach, in 2012 unanimously passed landmark legislation requiring APRNs to practice as part of physician-led patient care teams.[45] The legislation was the culmination of 18 months of combined effort by the Medical Society of Virginia and the Virginia Council of Nurse Practitioners, and their cooperation and focus on patient safety and quality of care ensured easy passage of the bill.[46] As well as requiring that APRNs practice only as part of teams, the new law also requires that APRNs are jointly licensed by the Virginia Boards of Nursing and Medicine.[47] The Virginia legislation provides a model for other states to enhance patient-centered care, a key recommendation of the Institute of Medicine (IOM) report, *The Future of Nursing*.

The IOM report, which is often touted by nurses but, like some earlier IOM reports, is the subject of criticism by many physicians, does include some recommendations and comments that are unassailable. One of the key messages of the report is that health care should focus on the unique needs of patients, not on the convenience of health care professionals.[48] The report also notes that APRNs are trained to focus on promoting health as opposed to curing illness; valuing public health, as opposed to emphasizing technology and interventions.[49] Further, the IOM acknowledges that APRN education is not standardized, with "multiple educational pathways leading to licensure… which state legislators are sometimes confused about (or susceptible to mischaracterizations of)."[50] For example, a 2-year nursing degree is sufficient in many cases for entrance in a master's program for APRN certification, and, while there is an APRN Consensus Model for education and accreditation, the model only provides recommendations, not mandates. Considering those issues, the best way to provide patient-centered care is to recognize the differences between APRN and physician training, and promote collaborative, multidisciplinary teams that balance the relative strengths of each profession.

[1] *Prescription drug abuse: Strategies to stop the epidemic*. October 2013. Trust for America's Health. http://healthyamericans.org/reports/drugabuse2013/.

[2] *CDC Policy Impact: Prescription Painkiller overdoses*. http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

[3] *Summary Minutes of the Drug Safety and Risk Management Advisory Committee Meeting January 24-25, 2013*. http://www.fda.gov/downloads/advisorycommittees/committeesmeetingmaterials/drugs/drugsafetyandriskmanagementadvisorycommittee/ucm344674.pdf. *See also* http://www.nytimes.com/ 2013/01/26/ health/fda-vote-on-restricting-hydrocodone-products-vicodin.

[4] *State ex rel. Fillinger v. Rhodes*, 230 W. Va. 530, 741 S.E.2d 118, 126-27 (2013).

[5] WV 19CSR7 §19-7-3.1.a.1 (2012).

[6] WV 19CSR7 §19-7-5.1.e.2.d (2012).

[7] *Online nurse practitioner programs*. http://www.bestnursingdegree.com/programs/online-nurse-practitioner/

[8] *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*. APRN Joint Dialogue Group Report, July 7, 2008.

[9] Brown, B. *The Deceptive Income of Physicians*. http://benbrownmd.wordpress.com/2010/06/20/informedconsent. *See also*, Brown, B., *Informed Consent: The U.S. Medical Education System Explained*. 2011.

[10] *Medical/professional school and residency/post-graduate hours for completion*. American Academy of Family Physicians, Primary Health Care Professionals: A Comparison, http://aafp.org/online.en/home/media/kits/fp-np.html.

[11] *Clinical training hours during a family physician's education.* American Academy of Family Physicians, Primary Health Care Professionals: A Comparison, http://aafp.org/online.en/home/media/kits/fp-np.html

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