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Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions company in the United States.

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NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS:
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Introduction

Many (though not all) healthcare policy analysts agree that the United States is in the midst of a widespread and growing physician shortage. The dearth of doctors has placed a growing premium on advanced practitioners, including nurse practitioners (NPs) and physician assistants (PAs) who can perform many of the duties performed by physicians.

NPs and PAs also fit the concept of team-based care, in which a variety of clinicians work in a coordinated manner, performing tasks appropriate to their training on behalf of patients.

Estimates suggest that primary care physicians taking sole responsibility for the care of their patients would need to spend 18 hours per day to provide a full range of diagnostic and preventive services, supporting the implementation of the team-based model of care (Transforming Primary Care: From Past Practice To the Practice of the Future." Health Affairs).

Additional factors driving the use of NPs and PAs include:

- *The focus on primary care.* The Association of American Medical Colleges (AAMC) projects a deficit of 91,000 physicians by 2025, including a deficit of 31,000 primary care physicians. Advanced practitioners are being used to make-up this deficit, particularly NPs, 87% of whom are in primary care.

- *Scope of practice.* State legislation has created an increasingly favorable environment for PAs and NPs to practice. Over 97% of NPs can prescribe medications while 20 states and the District of Columbia allow NPs to practice completely independently. PAs are also benefitting from a changing landscape, including reduced physician oversight and greater prescriptive authority.

- *Cost.* With median salaries of both PAs and NPs ranging at around $100,000, advanced practitioners are a relatively cost effective source for clinical care.

NPs and PAs by the Numbers

Below are some key highlights of the PA and NP marketplace:

Physician Assistants

There are over 104,000 PAs in the United States:

- About one-third work in primary care, about two-thirds work in specialties
- PAs can prescribe in all 50 states
- The number of PAs has increased 100% over the past decade
- PAs earn a median salary of $90,000, with annual compensation totaling $100,000
- 67% of PAs are women, 33% of PAs are men
- 19% of PAs are younger than 30, 56.8% are 30 to 49 years old, and 24.3% are 50 or older

Source: American Academy of Physician Assistants (AAPA)

Nurse Practitioners

There are over 190,000 NPs practicing in the United States:

- An estimated 15,000 NPs complete their training each year
- 97.2% of NPs prescribe medications, averaging 19 prescriptions per day
- NPs hold prescriptive privileges in all 50 states and Washington, D.C., and can prescribe controlled substances in 49 states
- 87.2% are focused on primary care
- Mean base salary for NPs is $91,310, and average full-time NP income is $98,760
- 70% of NPs see 3 or more patients per hour
- 96% of NPs are female
- The average age for NPs is 48 years old

Source: American Academy of Nurse Practitioners (AANP)

As advanced practitioners, both PAs and NPs provide a specialized skill set, with different levels of training, scope of practice, and expectations as to how they fit into staff-models.

Following is an examination of these considerations, including supply of PAs and NPs by state, scope of practice by state for each practitioner, and how these considerations fit into the team-based model of care.

Training and Utilization

NPs and PAs bring a unique skillset to the team-based model of care, each defined by the training that they receive and the way in which they are utilized

PA Training and Practice Areas

A Physician Assistant is a health care professional who is licensed to practice medicine under physician supervision. The PA's role is to conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on prevention, assist in surgery and write prescriptions.

A candidate is eligible for a PA training program after receiving a Bachelor's degree with appropriate prerequisite coursework in behavioral and basic sciences, along with "hands-on" healthcare experience prior to matriculation and appropriate GRE/MCAT scores. Candidates accepted into PA training programs

then complete a 26 month degree program as accredited through the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) to obtain a Master's degree in either Physician Assistant Studies (MPAS), Health Science (MHS) or Medical Science (MMS), along with completing more than 2,000 hours of clinical rotations during education.

Following this, graduates are eligible to complete the PANCE (Physician Assistant National Certifying Exam) administered by NCCPA (National Commission on Certification of Physician Assistants) to be certified as a PA. PAs then must obtain state licensure to practice. In order to maintain national certification, PAs must complete 100 hours of continuing medical education every 2 years and pass a recertification exam every 10 years.

According to the AAPA Annual Survey Report for 2013, the majority of PAs that practice clinically choose to do so in various specialty areas. The numbers below show PAs by specialty area and practice type:

Specialty Area	
General Surgery & Surgical Subspecialties	26.0%
Family Medicine	23.2%
General Internal Medicine & IM Subspecialties	14.8%
Emergency Medicine	10.6%
General Pediatrics & Pediatric Subspecialties	3.4%
OB/Gyn	2.0%
Occupational Medicine	1.5%
Other	18.4%

Source: 2013 AAPA Annual Survey Report

Practice Type	
Single Specialty Physician Group Practice	18.7%
Inpatient Unit of Hospital (not ICU/CCU)	10.6%
Solo Physician Practice Office	10.4%
Hospital Emergency Room	9.5%
Multi-Specialty Physician Group Practice	9.2%
Outpatient Unit of a Hospital	7.3%
Hospital Operating Room	6.0%
Other	28.3%

Source: 2013 AAPA Annual Survey Report

NP Training and Practice Areas

A Nurse Practitioner is an Advanced Practice Registered Nurse (APRN) who has completed graduate-level education (either a Master of Nursing or a Doctor of Nursing Practice degree). An NP treats physical and mental conditions through physical exams, comprehensive evaluation of medical history, and ordering and interpreting diagnostic tests.

Nurse Practitioner training involves completion of the education and clinical experience necessary to be a registered nurse (RN). This is followed by graduate-level NP program (either a Master's or Doctorate), and national board certification in their area of specialty. If a Registered Nurse is trained at the associate (two-year) degree level, he or she must complete a Bachelor of Science (BSN) degree before they can become an NP.

Some NPs are be able to work independently of physicians, while others sign a collaborative agreement with a supervising physician to practice. Scope of practice regulations, including clinical autonomy, prescribing level, responsibilities and medical treatments and other considerations afforded to an NP vary based on state regulations.

According to the AANP, the majority of NPs practice in Primary Care (87.2%). The table below shows NPs by practice area and average age:

Practice Area	***Percent of NPs***	***Average Age***
Acute Care	6.3%	46
Adult*	18.9%	50
Family*	48.9%	49
Gerontological*	3.0%	53
Neonatal	2.1%	49
Oncology	1.0%	48
Pediatric*	8.3%	49
Psych/Mental Health	3.2%	54
Women's Health*	8.1%	53

**Denotes Primary Care focus*
Source: AANP

Below is a breakdown of NPs by practice setting:

Practice Setting	
Ambulatory setting	56.7%
Private physician office/practice	31.6%
Hospital setting	31.6%
Hospital inpatient unit	13.4%
Hospital outpatient clinic	10.8%
Long-Term and Elder Care	4.7%
Public or Community Health	2.1%
Other Settings	5.0%

Source: National Sample Survey of Nurse Practitioners, Health Resources Services Administration (HRSA)

Physician supply per state also is a function of how many medical residents trained in a given state the state is able to retain. California is the most successful state in retaining its medical residents, while New Hampshire is the least successful.

PA Supply and Distribution

There are currently 104,337 PAs actively practicing throughout the country. A distribution by state can be seen below, with the top 5 most populous states of New York, California, Texas, Pennsylvania and Florida comprising 38.9% of the PA population. These 5 states compose 37.1% of the U.S. population, although a clear discrepancy is seen between the percentage of PAs versus the percentage of U.S. population in

California (9.4% compared to 12.2%) and Texas (6.6% compared to 8.5%).

	Number of PAs	*Percentage of PAs*	*Percentage of U.S. Population*
New York	10,866	10.4%	6.2%
California	9,836	9.4%	12.2%
Texas	6,898	6.6%	8.5%
Pennsylvania	6,678	6.4%	4.0%
Florida	6,332	6.1%	6.2%
North Carolina	4,969	4.8%	3.1%
Michigan	4,089	3.9%	3.1%
Georgia	3,305	3.2%	3.2%
Ohio	2,934	2.8%	3.6%
Maryland	2,784	2.7%	1.9%
Illinois	2,709	2.6%	4.0%
Colorado	2,591	2.5%	1.7%
Virginia	2,560	2.5%	2.6%
Washington	2,534	2.4%	2.2%
Massachusetts	2,428	2.3%	2.1%
New Jersey	2,292	2.2%	2.8%
Arizona	2,241	2.1%	2.1%
Wisconsin	2,034	1.9%	1.8%
Minnesota	1,811	1.7%	1.7%
Connecticut	1,774	1.7%	1.1%
Tennessee	1,561	1.5%	2.1%
Oklahoma	1,360	1.3%	1.2%
South Carolina	1,277	1.2%	1.5%
Oregon	1,237	1.2%	1.2%
Kentucky	1,212	1.2%	1.4%
Kansas	1,072	1.0%	0.9%
Indiana	1,055	1.0%	2.1%
Iowa	1,026	1.0%	1.0%
Nebraska	980	0.9%	0.6%
Utah	969	0.9%	0.9%
West Virginia	948	0.9%	0.6%
Missouri	917	0.9%	1.9%
Louisiana	862	0.8%	1.5%
Maine	763	0.7%	0.4%
Idaho	753	0.7%	0.5%
New Mexico	732	0.7%	0.7%
Alabama	718	0.7%	1.5%
Nevada	670	0.6%	0.9%
New Hampshire	629	0.6%	0.4%
South Dakota	515	0.5%	0.3%
Montana	511	0.5%	0.3%
Alaska	465	0.4%	0.2%
North Dakota	346	0.3%	0.2%
Vermont	304	0.3%	0.2%

Rhode Island	303	0.3%	0.3%
Arkansas	291	0.3%	0.9%
Delaware	290	0.3%	0.3%
Wyoming	235	0.2%	0.2%
Washington, D.C.	233	0.2%	0.2%
Hawaii	225	0.2%	0.4%
Mississippi	164	0.2%	0.9%
Puerto Rico	12	0.0%	1.1%
Total	104,337		

Source: American Medical Association Master File/MMS/U.S. Census Bureau

This distribution can also be quantified on a per capita level. Nationally, there are 33 PAs per 100,000 population, with ratios varying widely by state (see below):

State	***PAs per 100,000***
Alaska	63
South Dakota	60
Maine	57
New York	55
Pennsylvania	52
Nebraska	52
West Virginia	51
North Carolina	50
Montana	50
Connecticut	49
Vermont	49
Colorado	48
New Hampshire	47
North Dakota	47
Maryland	47
Idaho	46
Michigan	41
Wyoming	40
Kansas	37
Massachusetts	36
Washington	36
Washington, D.C.	35
Wisconsin	35
New Mexico	35
Oklahoma	35
Arizona	33
Minnesota	33
Iowa	33
Utah	33
Georgia	33
United States	33

Florida	32
Oregon	31
Delaware	31
Virginia	31
Rhode Island	29
Kentucky	27
South Carolina	26
New Jersey	26
Texas	26
California	25
Ohio	25
Tennessee	24
Nevada	24
Illinois	21
Louisiana	19
Indiana	16
Hawaii	16
Missouri	15
Alabama	15
Arkansas	10
Mississippi	5
Puerto Rico	0

Source: American Medical Association Master File/MMS

As these numbers indicate, the top 5 most populous states for PAs on a per capita basis are Alaska, South Dakota, Maine, New York and Pennsylvania. While some large states have a correspondingly large number of PAs, the ratio of PAs per population in these states is low. For example, Texas (26 PAs per 100,000 pop.), California (25 PAs per 100,000 pop.) and Florida (32 PAs per 100,000 pop.) fall below the national average of 33 PAs per 100,000 pop.

NP Supply and Distribution

There are currently 190,802 NPs in active patient care in the United States. The top 5 most populous states of California, Florida, New York, Texas and Pennsylvania include 33.9% of the NP workforce and 37.1% of the general population.

	Number of NPs	***Percentage of NPs***	***Percentage of U.S. Population***
California	17,167	9.0%	12.2%
Florida	15,338	8.0%	6.2%
New York	13,666	7.2%	6.2%
Texas	11,074	5.8%	8.5%
Pennsylvania	7,460	3.9%	4.0%
Massachusetts	7,221	3.8%	2.1%
Illinois	7,141	3.7%	4.0%
Tennessee	6,709	3.5%	2.1%

Ohio	6,636	3.5%	3.6%
New Jersey	5,650	3.0%	2.8%
Georgia	5,644	3.0%	3.2%
North Carolina	5,365	2.8%	3.1%
Virginia	5,027	2.6%	2.6%
Michigan	4,678	2.5%	3.1%
Arizona	4,204	2.2%	2.1%
Maryland	4,028	2.1%	1.9%
Missouri	3,865	2.0%	1.9%
Washington	3,819	2.0%	2.2%
Indiana	3,609	1.9%	2.1%
Kentucky	3,601	1.9%	1.4%
Connecticut	3,546	1.9%	1.1%
Colorado	3,455	1.8%	1.7%
Minnesota	3,212	1.7%	1.7%
Wisconsin	3,106	1.6%	1.8%
Alabama	2,790	1.5%	1.5%
South Carolina	2,564	1.3%	1.5%
Oregon	2,538	1.3%	1.2%
Louisiana	2,508	1.3%	1.5%
Mississippi	2,447	1.3%	0.9%
Kansas	2,246	1.2%	0.9%
Iowa	1,921	1.0%	1.0%
Arkansas	1,668	0.9%	0.9%
Utah	1,514	0.8%	0.9%
Oklahoma	1,429	0.7%	1.2%
New Mexico	1,351	0.7%	0.7%
New Hampshire	1,273	0.7%	0.4%
Maine	1,226	0.6%	0.4%
West Virginia	1,209	0.6%	0.6%
Nebraska	1,193	0.6%	0.6%
Nevada	959	0.5%	0.9%
Delaware	895	0.5%	0.3%
Idaho	851	0.4%	0.5%
Rhode Island	840	0.4%	0.3%
Alaska	632	0.3%	0.2%
Montana	627	0.3%	0.3%
North Dakota	595	0.3%	0.2%
Vermont	527	0.3%	0.2%
South Dakota	521	0.3%	0.3%
Washington, D.C.	479	0.3%	0.2%
Hawaii	412	0.2%	0.4%
Wyoming	311	0.2%	0.2%
Puerto Rico	23	0.0%	1.1%
Total	190,802		

Source: American Medical Association Master File/MMS/U.S. Census Bureau

As with PAs, per capita distribution of NPs varies widely by state.

State	***NPs per 100,000***
Massachusetts	107
Tennessee	102
Connecticut	99
New Hampshire	96
Delaware	96
Maine	92
Alaska	86
Vermont	84
Mississippi	82
Kentucky	82
North Dakota	80
Rhode Island	80
Kansas	77
Florida	77
Washington, D.C.	73
New York	69
Maryland	67
West Virginia	65
New Mexico	65
Colorado	65
Oregon	64
Missouri	64
Nebraska	63
New Jersey	63
Arizona	62
Iowa	62
Montana	61
South Dakota	61
Virginia	60
United States	60
Minnesota	59
Pennsylvania	58
Alabama	58
Ohio	57
Arkansas	56
Georgia	56
Illinois	55
Indiana	55
Washington	54
North Carolina	54
Wisconsin	54
Louisiana	54
Wyoming	53
South Carolina	53

Idaho	52
Utah	51
Michigan	47
California	44
Texas	41
Oklahoma	37
Nevada	34
Hawaii	29
Puerto Rico	1

Source: American Medical Association Master File/MMS

The national average for NPs per 100,000 residents is 60. Some large states such as Texas and California have a correspondingly large number of NPs, but trail the national per capita average.

Scope of Practice

When assessing the role of PAs and NPs in the team-based model of care, it is essential to understand the responsibilities of each advanced practitioner in regard to scope of practice. Considerations such as autonomy of practice, prescribing level, need for supervising physician oversight and collaboration all work to create a defining role for each practitioner, a role that can vary from state-to-state based on regulatory requirements.

Physician Assistant Scope of Practice

Establishing Scope of Practice

Although PAs are licensed to practice medicine under physician supervision, the degree to which PAs can establish this supervision varies based on location. While some states/regions allow a PA and supervising physician to establish a written agreement outlining a PA's scope of practice, others require scope of practice approval by the State Medical Board, or simply list the services PAs may provide.

States/regions in which PA and supervising physician may jointly establish written agreement outlining scope of practice include:

Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Washington, D.C., Delaware, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Wyoming

States in which scope of practice for individual PAs must be approved by State Medical Board include:

Alabama, Georgia, Kentucky, Mississippi, South Carolina, West Virginia

States in which law determines services PA can provide include:

Florida, Iowa, Maryland, New Jersey, Ohio, Oklahoma, Pennsylvania, Virginia, Washington, Wisconsin

Based on the outline above, 34 states plus Washington, D.C. allow for PAs and the supervising physician to establish a written agreement outlining PA scope of practice; 6 states require PA scope of practice to be approved by the State Medical Board; and in 10 states the law lists services PAs may provide.

Supervising Physician and Patient Record Oversight

Another important distinction with regard to physician supervision of PAs is the degree and manner in which the supervising physician must monitor the PA's completion of patient medical records and co-sign the records during a clinical visit. While some states/regions allow for monitoring and co-signature requirements to be determined at the practice level by the supervising physician, others pre-establish the monitoring of records by the supervising physician. These pre-established regulations may include an allotted period of time in which the supervising physician is allowed to review and co-sign medical records by the PA; variance in the number of records the physician is required to review based on established relationship with the PA or the PA's experience; or other factors.

States/regions in which physician co-signature requirements of patient records are determined at practice level by supervising physician include:

Alaska, Arizona, Arkansas, Connecticut, Washington, D.C., Delaware, Florida, Idaho, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Dakota, Texas, Vermont, Wisconsin, Wyoming

States in which physician oversight of patient records is pre-established. This oversight varies from state-to-state, but may include allotted period of time for physician to review all records by PA, variance in the number of records required for review based on PA's experience, or other stipulations include:

Alabama, California, Colorado, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia

As referenced above, 23 states plus Washington, D.C. allow for physician co-signature requirements of patient records to be determined at the practice level, while 27 states pre-establish conditions for the supervising physician to monitor PA patient records.

Prescriptive Authority

Physician Assistants are provided certain privileges when establishing prescriptive authority in a practice. Working hand-in-hand with the supervising physician, certain states/regions allow for the authority to be arranged at the practice level by the supervising physician. Other states establish restricted prescriptive authority, where prescribing level is limited for certain medications.

States/regions in which the prescriptive authority of the PA is arranged at practice by supervising physician include:

Alaska, Arizona, California, Colorado, Connecticut, Washington, D.C., Delaware, Idaho, Illinois, Indiana, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming

States in which prescriptive authority is restricted include:

- ***No prescription or administration of scheduled drugs*** – Kentucky
- ***Not authorized to prescribe Schedule II depressants*** – Iowa

- ***Not authorized to prescribe Schedule II medications*** – Alabama, Arkansas, Georgia, Louisiana, Maine, Missouri, West Virginia
- ***May not prescribe controlled substances, general anesthetics, or radiographic contrast materials*** – Florida
- ***Board defines scope with regards to prescriptive authority*** – Hawaii, Oklahoma

The supervising physician established the prescriptive authority of the PA in 38 states plus Washington, D.C. The other 12 states restrict PA prescriptive authority for the above medications specified.

Number of PAs Supervising Physician May Supervise

When establishing practice environment, the makeup of practices composed of PAs and supervising physicians can be influenced by the number of PAs each physician is allowed to supervise. While some states do not place a limit on the number of PAs a physician may supervise, others place limitations, including differing regulations based on practice type.

States in which there is no limit on the number of PAs a physician may supervise:

Alaska, Arkansas, Maine, Massachusetts, Montana, New Mexico, North Carolina, North Dakota, Rhode Island, Tennessee, Vermont

States in which physician may supervise no more than 2 PAs:

Hawaii, Indiana, Kansas˚, Kentucky, Louisiana˚, Mississippi, Nebraska*, Oklahoma˚, Pennsylvania, Wisconsin*

**Board may grant exceptions.*
˚Kansas: Limitation does not apply to medical care facility.
˚Louisiana: A physician acting as locum tenens supervisor may supervise more than 4 PA's at one time.
˚Oklahoma: Exceptions for limitation for medical director or supervising physician of a state institution.

States in which physician may supervise no more than 3 PAs:

Idaho, Missouri˚, Nevada*, West Virginia˚, Wyoming*

**Board may grant exceptions.*
˚Missouri: Limitation does not apply to hospital-employed PA's.
˚West Virginia: Physician may supervise up to 4 hospital-employed PA's.

States/regions in which physician may supervise no more than 4 PAs:

Alabama, Arizona, California, Colorado, Washington, D.C., Delaware, Florida, Georgia*, Maryland˚, Michigan, New Hampshire, New Jersey*, New York˚, Ohio˚, Oregon*, South Carolina*, South Dakota, Utah*

**Board may grant exceptions.*
˚Maryland: Limitation does not apply to hospitals, correctional facilities, detention centers, or public health facilities.
˚New York: Physician may not supervise more than 6 PA's in correctional facility.
˚Ohio: Limitation does not apply to hospital-employed PA's.

States in which physician may supervise no more than 5 PAs:

Illinois, Iowa, Minnesota*, Washington*

**Board may grant exceptions.*

States in which physician may supervise no more than 6 PAs:

Connecticut, Virginia

States in which physician may supervise no more than 7 PAs:

Texas

In 11 states, there is no established limit to the number of PAs a physician may supervise. In the other 39 states plus Washington, D.C., a limit on the number of PAs a physician may supervise is established.

Source: AAPA

Nurse Practitioner Scope of Practice

Based on prospects for autonomous practice and independent prescribing level, the AANP has defined 20 states and the District of Columbia in the United States where NPs enjoy Full Practice scope. Nurse Practitioners in these states/regions are allowed to evaluate patients independently, order diagnostic tests, manage treatments and prescribe medication under the authority of the State Board of Nursing. These states include:

Full Practice Scope:
Alaska, Arizona, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Iowa, Maine, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, Wyoming

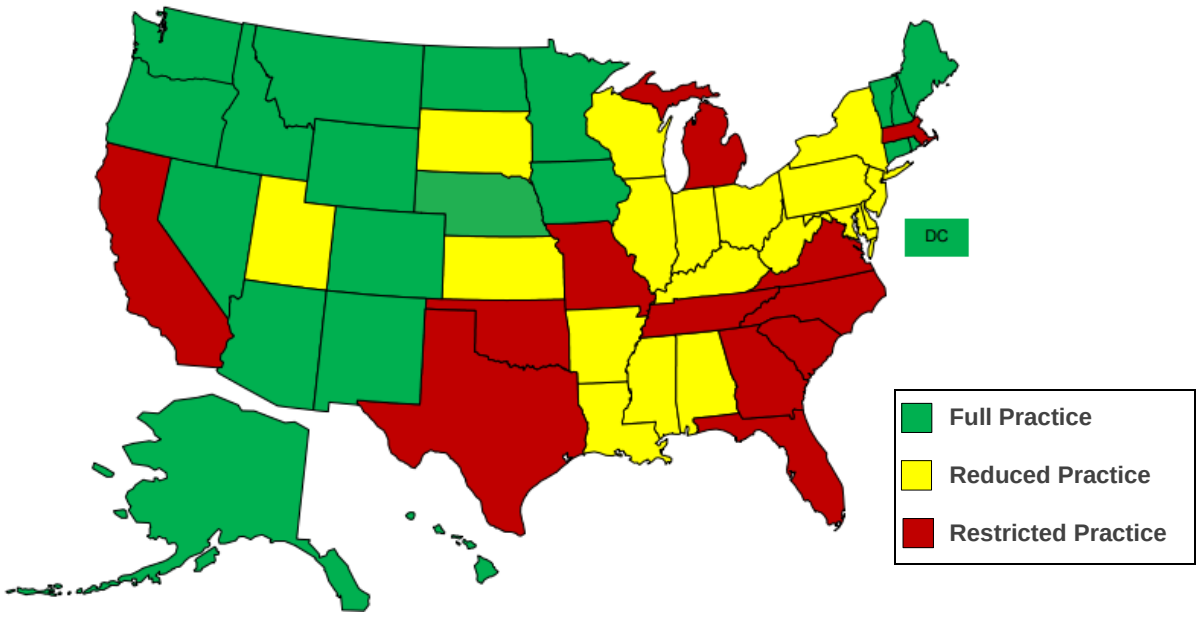
18 states are defined as having a Reduced Practice Scope limit in at least one aspect of practice, and require some form of collaborative agreement, including:

Reduced Practice Scope:
Alabama, Arkansas, Delaware, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, New York, Ohio, Pennsylvania, South Dakota, Utah, West Virginia, Wisconsin

12 states are defined as having a Restricted Practice Scope restrict NPs in at least one aspect of practice, and require supervision, delegation or team-management in order to provide care, including:

Restricted Practice Scope:
California, Florida, Georgia, Massachusetts, Michigan, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia

NP Scope of Practice Map



Source: AAPA

Practice Environment and Distribution of Practitioners

Scope of practice for advanced practitioners varies widely from state-to-state, creating unique practice environments for both PAs and NPs. But how do these differing regulations influence distribution of practitioners?

Physician Assistants

For PAs, there are many factors to consider when evaluating practice environment. Although PAs are required to be supervised by a physician in order to practice, the degree of this supervising relationship is wide-ranging. Based on the previous scope of practice elements discussed, the most open practice environment for a PA is one in which regulations are not pre-established and the role of the PA may be agreed upon with the supervising physician at the practice level, fitting these considerations:

- The PA and supervising physician may jointly establish written agreement outlining scope of practice
- Prescriptive authority of the PA is arranged at practice by supervising physician, without pre-established restrictions
- Physician co-signature requirements of PA patient records are determined at practice level by supervising physician
- There is no limit on the number of PAs a physician may supervise

The 6 states listed below match this definition of an open practice environment for a PA:

State	*PAs per 100,000*	*U.S. Rank (per capita)*
Alaska	63	1
North Carolina	50	8
Vermont	49	11
North Dakota	47	14
Massachusetts	36	20
Rhode Island	29	36

As the numbers indicate, 5 of the 6 states that are considered to have an open practice environment for PAs have greater than the national average of 33 PAs per 100,000 population, and rank in the top 20 in the U.S. for PA supply on a per capita level. This is an indication that an open practice environment may positively influences the supply of PAs in a given state.

Nurse Practitioners

Nurse Practitioners are afforded the potential for a greater degree of autonomy than PAs, as certain states allow for independent practice, prescribing, and other considerations. As previously defined by the AANP, scope of practice for NPs is divided into three categories: Full Practice Scope, Reduced Practice Scope, and Restricted Practice Scope. The 17 States/regions that enjoy Full Practice Scope are allowed to evaluate patients independently, order diagnostic tests, manage treatments and prescribe medication under the authority of the State Board of Nursing:

State	*NPs per 100,000*
New Hampshire	96
Maine	92
Alaska	86
Vermont	84

North Dakota	80
Rhode Island	80
Washington, D.C.	73
New Mexico	65
Colorado	65
Oregon	64
Arizona	62
Iowa	62
Montana	61
Washington	54
Wyoming	53
Idaho	52
Hawaii	29

As the numbers indicate, 13 of the 17 states/regions considered to have Full Practice Scope for NPs have greater than the national average of NPs per 100,000 residents (60). Compare this to states that fall under Restricted Practice Scope for NPs. These 12 states restrict NPs in at least one aspect of practice, and require supervision, delegation or team-management in order to provide care:

State	***NPs per 100,000***
Oklahoma	37
Texas	41
California	44
Michigan	47
South Carolina	53
North Carolina	54
Georgia	56
Virginia	60
Missouri	64
Florida	77
Tennessee	102
Massachusetts	107

For Restricted Practice Scope, 8 of the 12 states have less than or equal to the national average for NPs per 100,000 residents (60). This pattern indicates a correlation between an autonomous practice environment for NPs and NP distribution.

Emerging Role of NPs and PAs in an Evolving Healthcare System

In an era of physician shortages it will be necessary for physicians to redefine their roles. In order to accommodate patient demand, physicians will need to practice to the limits of their training, performing the most complex duties of which they are capable.

Specialists will focus their efforts on technologically advanced care for patients with complex medical conditions, using cutting edge diagnostic and surgical tools. Continuing medical advancements will require specialists to practice in ever narrower but deeper silos, driving the need for cooperation between specialists and primary care physicians who will oversee and coordinate care, in some cases through the medical home. The Accountable Care Organization (ACO) model also places increased emphasis on

coordination of care and on greater communication between specialists. This may improve quality, but it will absorb physician time, requiring doctors to delegate more duties to others.

Like specialists, primary care physicians will devote more time to treating complex cases and will manage patients with multiple chronic illnesses. Increasingly, they will manage the care of patients with complicated conditions through supervision of a growing number of non-physician clinicians, including NPs and PAs. The Affordable Care Act (ACA) acknowledged the growing importance of NPs and PAs by increasing Medicare reimbursement by 10% for those practicing primary care. A number of states continue to increase scope of practice of advanced practitioners to put them on closer footing with physicians. Massachusetts, for example, passed a law requiring insurers to recognize and reimburse NPs as primary care providers. Insurers in the state now list NPs with doctors as primary care choices.

It is clear that as health reform continues, many patients will be less likely to see a physician and more likely to see an NP or PA. This already is the case in many hospitals where NPs are performing tasks that medical residents can no longer perform because of limits on their work hours, as well as in rural and underserved areas. As noted above, NPs and PAs also will play a growing role in the emerging medical home and ACO models, and assisting in the expansion of Federally Qualified Community Health Centers (FQHCs), which received extensive funding through the stimulus package and through health reform.

With this in mind, it will be up to not only physicians, but also other clinicians in the medical team, to absorb an increasing amount of patient care duties.

As discussed previously, both NPs and PAs offer a specialized skillset, based on extensive educational and training backgrounds, to help augment the supply of skilled clinicians. Although the many PAs and NPs choose to practice in primary care, specialty areas will remain an enticing option for advanced practitioners. The majority of PAs already practice in specialty areas and therefore PAs cannot be expected to substitute for or alleviate the shortage of primary care physicians.

Based on specific state guidelines and scope of practice laws, the role of NPs and PAs can vary widely from state-to-state. Levels of autonomy, prescribing levels for practitioners, and the need for supervision and/or collaboration with a physician can create different team practice environments in each state.

Despite these challenges, analysts continue to note the quality of care NPs and PAs provide and the patient satisfaction scores they achieve remain high. While access to care will be a key issue in the era of reform, cost control will be at least as important. NPs and PAs are a relatively cost effective resource, as they can perform 80% to 90% of a physician's duties while frequently earning 50% or less than physicians. With this in mind, it will continue to be important to consider advanced practitioners as a realistic option to supplement physician services in the team-based model of care, particularly when taking into account growing physician shortages and overall healthcare costs.

Conclusion

As physician shortages persist and as delivery evolves toward the team-based model, Physician Assistants and Nurse Practitioners will become an increasingly important part of hospital, medical group, FQHC, and other healthcare facility staffing plans. Practice options provided to these advanced practitioners, defined by scope of practice regulations, varies from state-to-state, creating many different practice environments. Level of autonomy, prescribing authority, physician supervision and other concerns will be important to monitor as industry leaders continue to find the correct balance of clinicians in the team-based model of care.

For additional information on nurse practitioners and physician assistants, contact:

Corporate Office:
Merritt Hawkins
5001 Statesman Drive
Irving, Texas 75063
800-876-0500

Eastern Regional Office:
Merritt Hawkins
7000 Central Pkwy NE
Suite 850
Atlanta, Georgia 30328
800-306-1330

MERRITT HAWKINS
an AMN Healthcare company

www.merritthawkins.com **800-876-0500**