

**To:** William Ebenstein, Ph.D., Co-chair, MRT Workforce Flexibility/Change of Scope of Practice Work Group  
George Gresham, Co-chair, MRT Workforce Flexibility/Change of Scope of Practice Work Group

**CC:** James Introne, Deputy Secretary for Health and the Director of Healthcare Redesign  
Jason Helgerson, New York State Medicaid Director and Medicaid Redesign Team Executive Director

**From:** The New York State Association of Nurse Anesthetists (NYSANA); The New York State Nurses Association (NYSNA); The New York Organization of Nurse Executives (NYONE); Northeast New York Chapter, National Association of Clinical Nurse Specialists; The Nurse Practitioner Association New York State (The NPA); Upstate New York Chapter, National Association of Clinical Nurse Specialists

**Date:** October 2011

**Re:** Workforce Flexibility and Change in Scope of Practice

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Dear Dr. Ebenstein and Mr. Gresham:

On behalf of the organizations identified above, we urge the Medicaid Redesign Team's Workforce Flexibility/Change in Scope of Practice Workgroup to take the necessary steps to enable registered nurses to practice to the full extent of their education and training. The continued lack of formal recognition of certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), barriers to practice imposed on nurse practitioners through required practice agreements with physicians and the impetus in New York to expand the services of unlicensed assistive personnel into the scope of practice of registered nurses, is negatively impacting not only the state's nursing population but also creating barriers to access to safe, quality care for New York's most vulnerable residents.

The Institute of Medicine (IOM), in collaboration with the Robert Wood Johnson Foundation (RWJF), issued an evidence-based report in October 2010 entitled *The Future of Nursing: Leading Change, Advancing Health*. This report was part of a multi-year initiative "to respond to the need to assess and transform the nursing profession."<sup>1</sup> One of the "key messages" of the Report is that "nurses should practice to the full extent of their education and training." Included among the recommendations for implementing the "key messages" of the Report, is the removal of scope of practice barriers for advanced practice registered nurses.

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<sup>1</sup> [www.iom.edu/nursing](http://www.iom.edu/nursing)

## Certified Registered Nurse Anesthetists

New York state remains the only state in the nation that does not fully recognize CRNAs. Certified registered nurse anesthetists are master's-prepared, advanced practice nurses who hold a nationally recognized certification after meeting the requirements of the National Board of Certification and Recertification of Nurse Anesthetists. They safely administer 32 million anesthetics to patients each year in the U.S. In 1986, the Federal government approved CRNAs as the first advanced nursing specialty to receive direct Medicare reimbursement. Since World War I, our nation's military has relied on CRNAs as the primary anesthesia provider to service men and women on the front lines.

New York's 1,200 nurse anesthetists provide care to patients of all ages and physical status, for all types of surgical procedures in all practice settings. Nurse anesthesia services are crucial to our underserved and vulnerable populations. In fact, CRNAs are the sole anesthesia providers in the vast majority of rural hospitals, offering these facilities surgical, obstetrical, trauma stabilization, interventional diagnostic and pain management services. Yet, with no approved mechanism for licensure and no recognition of established uniform standards, our regulators lack the authority to ensure competent providers. Our professionals are continuously challenged to defend their ability to practice, correct misinterpretation of their capabilities and effectively deliver care to the full extent of their abilities. More importantly, patients are increasingly denied access to high quality, affordable care as our talented workforce is recruited to neighboring states that afford proper legal and professional recognition of CRNA practice.

According to a 1999 report from the Institute of Medicine, anesthesia care is nearly 50 times safer than it was in the early 1980s. Numerous outcomes studies have demonstrated that patients experience the highest level of safety when anesthesia care is provided by CRNAs, in any practice model.<sup>2,3,4,5</sup> Most recently, a landmark study in *Health Affairs* (2010) shows that there is no difference in patient outcomes when anesthesia services are offered by CRNAs, physicians or CRNAs supervised by physicians.<sup>6</sup> Further, the cost-efficiency of CRNAs helps control escalating healthcare costs while maintaining quality and improving access to care. According to a study by the Lewin Group published in *Nursing Economics* (2010), anesthesia delivered by CRNAs is the most cost-

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<sup>2</sup> Needleman, J., Minnick, A.F. (2008). Anesthesia provider model, hospital resources, and maternal outcomes. *Health Services Research*. November 2008. DOI:10.1111/j.1475-6773.2008.00919x.

<sup>3</sup> Pine, M., Holt, K.D., Lou, Y.B. (2003). Surgical mortality and type of anesthesia provider. *AANA Journal*, 71, 109-116.

<sup>4</sup> Forrest, W.H. (1980). Outcome- The effect of the provider. In: Hirsh, R, Forrest, WH, et al., (eds). *Health Care Delivery in Anesthesia*. Philadelphia: George F. Stickley Company. Chapter 15, 137-142.

<sup>5</sup> Bechtoldt, Jr, A.A. (1981). Committee on anesthesia study. Anesthetic-related deaths: 1969-1976. *North Carolina Medical Journal*, 42, 253-259.

<sup>6</sup> Dulisse, B., Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs*, 29(8), 1469-1475.

effective method of providing anesthesia.<sup>7</sup> With healthcare costs increasing, our delivery system and related policies must support the utilization of CRNAs to the full extent of their education, training, and expertise.

Uniform standards for CRNAs are already well established and nationally recognized. Our regulators have reviewed and approved classification of our graduate programs in Nurse Anesthesia. They are well positioned to implement licensure and enforce professional competency. For more than twenty years, legislation has been introduced in various formats to codify this vital, advanced nursing practice in New York. Reform is long overdue.

### **Clinical Nurse Specialists**

Clinical nurse specialists (CNSs) are not recognized as advanced practice registered nurses in New York state. Clinical nurse specialists are prepared at the graduate level and are educated for advanced clinical practice in specialties within nursing; the role has existed for more than fifty years. Clinical nurse specialists play an essential role in providing high quality, evidence-based care. CNSs practice in a broad range of specialty areas and the role enhances the utilization of evidence-based practice and improves patient outcomes by providing direct care to complex patients; mentoring, educating and consulting with bedside nursing staff; providing leadership in nursing practice; conducting research and implementing management and systems improvements. Currently, 38 states recognize and provide title protection for the role of clinical nurse specialist.

Many healthcare facilities employ nurses as “clinical nurse specialists,” but protecting the title of clinical nurse specialist is necessary to maintain safe patient care and to ensure that only those who are properly educated and qualified are performing CNS services (see A.2992 (Lifton)/S.522 (Krueger)). The competencies for CNS practice have been nationally validated and recognized. With the increasing complexity of the healthcare environment, recognition of and title protection for CNSs is essential for the public’s health; it will enable the state to identify those registered nurses who have been properly educated to provide specialized care and will prohibit healthcare facilities from inappropriately utilizing unqualified persons in the role of clinical nurse specialist.

### **Nurse Practitioners**

Nurse practitioners (NPs) are registered nurses who have advanced educational and clinical preparation to serve as primary and specialty care providers with broad prescriptive privileges in New York state. They are authorized to diagnose illnesses and conditions within a specialty area of care; to prescribe a plan of care including diagnostic tests, medications, minor surgery, and diagnostic and corrective procedures and to make appropriate

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<sup>7</sup> Hogan, P.F., Seifert, R.F., Moore, C.S., Simonson, B.E. (2010). Cost effectiveness analysis of anesthesia providers. *Nursing Economics*, 28(3), 168.

collegial referrals to other providers. Nurse practitioners provide a wide range of preventive and acute healthcare services to people of all ages, in a variety of practice settings including hospitals, clinics, community health centers, nursing homes and hospices, private offices, as well as schools and colleges. In addition to their specialty certification to practice by the New York State Education Department, many NPs are certified by national accrediting organizations in one or more practice specialty.

Currently, New York state requires a written practice agreement and the establishment of practice protocols between a nurse practitioner and a physician. Nationally however, nurse practitioners practice without the required collaboration of a physician in nineteen states. Given the education, training and advanced certification of NPs, mandatory collaboration does not serve a legitimate clinical purpose. Instead, mandatory collaboration serves as a barrier to practice and may actually restrict access to healthcare services for individuals and families in underserved areas of our state (urban, suburban and rural). Nurse practitioners are educated and trained to collegially refer patients to other specialty healthcare providers as they deem appropriate. New York state should remove the current statutory requirement mandating that Nurse Practitioners (“NPs”) have a written practice agreement with a physician. (See A.5308 (Gottfried)/S.3289 (Young)).

There is an abundance of research examining clinical outcomes that show that patients benefit from the high quality, cost-effective health care delivered by nurse practitioners. The National Committee for Quality Assurance (NCQA), in its 2011 *Standards for Patient-Centered Medical Homes (PCMH)*, now includes nurse practitioner-led practices as providers who are eligible for NCQA Recognition as a Patient-Centered Medical Home. This eligibility is a testament to the quality of care that is provided by nurse practitioners who must not be precluded from leading either Medical and/or Health Homes in New York.

Additionally, it is important to clarify that an NP must be permitted to perform all healthcare functions – including signing, verifying or certifying forms or documents – pertaining to any healthcare service that is authorized within the nurse practitioner’s scope of practice. Frequently, while performing services within their lawful scope of practice, NPs are faced with patients who present documents that require signature by a medical professional. The NP may be lawfully authorized to perform the service (e.g. conduct a physical exam to qualify an individual as physically fit), and can lawfully execute the healthcare service, but due to arcane statutes and outdated forms, the NP may not be allowed to sign and execute the necessary form. Often times a statute may predate the NP scope law, and/or, specifically require a physician’s signature not taking into account that the healthcare service may have been performed by nurse practitioner, or other type of healthcare professional, practicing within their lawful scope. Enabling NPs to fully practice within their scope, and to perform appropriate and lawful healthcare functions and services, will immediately streamline healthcare delivery in all settings and prevent duplication of services, thereby creating efficiencies and cost savings.

This year New York took a step in the right direction by enacting Chapter 153, which clarifies that nurse practitioners are authorized to sign death certificates. However, moving forward the state should also: (1) Enact legislation that clarifies that when a healthcare service rests within the NP's authority, but the relevant statute uses the term physician, the nurse practitioner may nevertheless act lawfully within his/her scope (See S.3881 (Hannon)/A.2157 (Gottfried) and Chapter 30 of 2010, which provided a similar technical fix for physician assistants); and, (2) Refrain from enacting legislation that is not provider neutral and limits NPs and other healthcare professionals from performing services that are within their training and legal scope of practice (e.g. evaluate student athletes to identify mild traumatic brain injuries, enter into collaborative drug therapy management agreements, etc.).

### **Scope of Practice of Registered Nurses**

To ensure that New Yorkers are receiving the best quality care, it is essential that appropriate members of the healthcare workforce are providing the right care, in the right place.

*Medication Administration* – Administering medication is not simply the act of identifying the correct drugs and the correct patients. When administering medications, particularly to non self-directing patients, licensed professionals observe for side effects and whether or not the medications are providing the intended therapeutic response. Unlicensed assistive personnel are unable to function in this capacity. Licensed professionals are able to determine whether a patient's condition makes the administration of a medication contraindicated. Home health aides and medication aides do not possess the necessary qualifications to administer medications to non-self-directing or medically fragile patients, whether they are in the home or nursing home. As Maryanne Barra (2011) explains in her paper in the *Journal of Nursing Law*, "[A]lthough the MAT [medication assistant technician] is in direct contact with the patient, he or she lacks the clinical and educational background that the nurse possesses from years of education and practice to determine and report changes in the patients' status."<sup>8</sup> Of particular concern in the nursing home setting, where more of the patients are likely to be medically fragile and non-self-directing, is the absence of on-site, twenty-four hour registered nurses and/or prescribers (e.g. nurse practitioners) to assess and/or adjust medication regimens as needed, based on the patient's response or condition.

In a study published in the *Journal of the American Medical Directors Association*, Hughes, et al (2006) state that "[O]ur data indicate that the use of medication technicians to administer medications may not be an advisable strategy in the present climate of concern regarding the quality of nursing home care."<sup>9</sup> Their data reveal that the facilities that employed medication technicians had more deficiency citations for activities related to

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<sup>8</sup> Barra, M. (2011). Nurse delegation of medication pass in assisted living facilities: Not all medication assistant technicians are equal. *Journal of Nursing Law*, 14(1), 3-10.

<sup>9</sup> Hughes, C.M., Wright, R.M., & Lapane, K.L. (2006). Use of medication technicians in US nursing homes: Part of the problem or part of the solution? *Journal of the American Medical Directors Association*, 7: 294-304.

medication errors and pharmaceutical services, which include medication administration. The study authors conclude that “[T]he use of medication technicians may not be the solution to an increasingly important problem [poor quality medication management in nursing homes]... the quality of nursing home care may ultimately depend on how much it and the residents are valued by society” (p. 303).

*Home Care* – Care in the home should include registered nurses in a significant way in the initial assessment, care management, provision of complex care and in the ongoing quality assessments of all individuals receiving services. When considering models of care that would allow unlicensed assistive personnel to perform expanded services that are within the scope of practice of registered nurses, it is critically important that the patient, or their family member, be self-directing and capable of instructing and directing a home health aide or personal assistant. It is equally important that a registered nurse determines that the patient or family member is appropriate for a consumer-directed model of care and that they be involved in an ongoing and regular basis, in evaluating the quality of care provided.

### **Opportunities to Implement Federal Health Reform Initiatives**

There are opportunities in the Affordable Care Act (ACA) that can be leveraged in order to enhance the healthcare provided for New Yorkers. These opportunities include the establishment of health homes with nurse practitioners as team members and/or leaders and also accessing the Independence at Home program from the Affordable Care Act, which reimburses for nurse practitioner-directed, home-based primary care teams.

Another opportunity resulting from the Affordable Care Act is the expansion of transitional care services through programs of the Federal Coordinated Health Care Office – this office is intended to better integrate Medicare and Medicaid programs to improve care continuity, and to ensure safe and effective care transitions for dual eligible individuals (those who are eligible for both Medicaid and Medicare). Transitions of care are vulnerable periods that contribute to unnecessarily high rates of health service use and healthcare spending; transitions of care expose chronically ill people to lapses in quality and safety.<sup>10</sup> Transitions have also been associated with increased rates of potentially avoidable hospitalizations. The knowledge and skills of the registered nurse are ideally suited to the effective management of care transitions.

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<sup>10</sup> Naylor, M.D., Aiken, L.A., Kurtzman, E.T., Olds, D.M. & Hirschman K.B. (2011). The importance of transitional care in achieving health reform. *Health Affairs*, 30(4): 746–754.

If New York is to provide the resources necessary to transform our healthcare delivery system into one that ensures cost-effective, quality care that will also be agile enough to effectively implement federal healthcare reform, we will need to include advanced practice registered nurses in a meaningful way; we need to remove the barriers to their full practice and allow them to do the jobs for which they were educated. It is essential that nursing is a full partner in the solutions that emerge as a result of the Medicaid redesign process. If we are not, the state will have lost a critical opportunity to ensure that New York's health system provides affordable, quality care for New Yorkers.

We look forward to working with you and your team to help New York meet the challenges of redesigning our healthcare system and finally achieving meaningful reforms for the sake of our dedicated healthcare professionals and the patients we serve.

Sincerely,

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