

AMERICAN ACADEMY OF NURSE PRACTITIONERS

Incorporated 1985

Administration: PO Box 12846 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: admin@aanp.org · Web Site: www.aanp.org
Office of Health Policy: PO Box 40130 · Washington, DC 20016 · 202-966-6414 · Fax: 202-966-2856 · E-mail: dcoffice@aanp.org
Journal (JAANP): PO Box 12965 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: journal@aanp.org

January 20, 2011

Good morning. I am Dr. Mary Jo Goolsby, the Director of Research & Education for the American Academy of Nurse Practitioners (AANP) and have been an adult NP for almost 30 years. As the largest membership organization for NPs of all specialties, the American Academy of Nurse Practitioners represents the interests of the 140,000 NPs currently recognized to practice in the U.S., 89% of which are prepared in primary care. We appreciate the opportunity to provide comment to the committee as it considers its work and the ability to have observed the discussions that have occurred this week.

Seventy-five percent of practicing NPs provide primary care on a full or part-time basis, as primary care is where the interests of most NPs lie. These NPs fully meet the definition of primary care providers, in that they serve as the initial entry into the healthcare system for many patients, including those with undifferentiated problems, and assess, diagnose, and treat a range of acute and chronic conditions, in addition to providing health promotion and health maintenance and coordinating care over time. Yesterday, during the Committee's discussion, it was suggested that NPs are increasingly moving into sub-specialty care and a figure close to 50% was mentioned. In reality, there is not necessarily a larger percentage of NPs practicing in areas other than primary care. The population is growing, so that even a static percentage would represent an increasing number. For instance, in 2010, over 9200 NPs were completed their academic programs and we anticipate that the number of new NPs entering the field in 2011 will be closer to 10,000. The continuing growth of the NP population is a reflection of the need for high quality healthcare and the recognition by healthcare consumers and others in the value that NPs bring to the patients and communities they serve.

AANP definitely supports the Committee including NPs and other primary care providers such as physician assistants and CNMs in the designation formula, in order to accurately portray the resources available. We also request that NPs be included at a rate commensurate with their scope of practice and the contributions they make. Yesterday, it was mentioned that individuals have come expect more time with their NP than with other primary care providers so that NPs should be discounted in the formula, to account for their seeing fewer patients. In fact, the time that NPs take with their patients is well-spent and results in better outcomes and fewer unplanned follow-up visits. For this reason, NPs who spend more time in individual patient encounters should still be able to see the same number of patients over time as other providers.

NPs are the primary care discipline most likely to practice in rural shortage areas and are often a community's only provider, as mentioned yesterday. In fact, 18% of all NPs practice in rural communities. This rate is higher in states with greater rural expanses and is highest yet in states where the regulations do not present barriers, but allow NPs to practice to their full scope of practice. For instance, in rural states such as Maine and Montana with positive practice environments, approximately 40% of NPs practice in rural areas. There are a few states that require a physician to be on-site with an NP, at least for a small number of hours every week or month. In those states, NPs experience significant obstacles in serving rural communities. They find it difficult to recruit physicians to meet the requirements and if the physician later withdraws from the arrangement, the NP's practice must close until another physician can be recruited. Texas is an example of this situation with only 13% of Texas NPs practicing in rural areas, in spite of the fact that most counties in the state are either fully or partially underserved. The good news is that the regulatory environment is improving over time with the recognition that NPs provide high quality, cost-effective care, so that we anticipate that NPs will continue to experience fewer barriers in their efforts to serve communities in need. While I am focusing my comments on rural areas, NPs do serve the full spectrum of communities where there is need.

In addition to supporting the inclusion of the categories of NPs the committee agreed upon yesterday, we encourage the Committee to include gerontological NPs (GNPs) in the formulas. While one of the Committee

members suggested that the majority of GNPs practice in institutions, in reality, the majority practice in non-institutional settings. Although GNPs make up only approximately three percent of the NP population, they are a critical resource in providing primary care services to older adults. We also encourage inclusion of women's health NPs (WHNPs), a category not identified yesterday, but previously mentioned in comments by Susan Wysocki of the NPWH. WHNPs make up a sizeable portion (over 9%) of the NP population and are prepared to address a wide range of a woman's primary care needs across the lifespan, including health maintenance and health promotion.

Finally, the American Academy of Nurse Practitioners offers to assist the Committee and HRSA in locating NPs, identifying where and how they practice. The American Academy of Nurse Practitioners maintains the only comprehensive and de-duplicated database of NPs. This database includes details on NP practice site addresses and types of settings for a majority of records, and default addresses on all NPs. This dataset is used to geocode locations of NPs, with the recognition that default addresses are, on average, within an 18-mile radius of an individual NP's practice setting. Although the National NP Database is not "perfect", it has been maintained and improved over the history of our organization and we welcome the ability to work with HRSA to understand and address their needs for NP data. In the past several months, we have significantly enhanced our IT department and database team, to ensure that the database continues to have the support staff and technology required for its maintenance over time. We are currently in the midst of a National NP Practice Site Survey, which is repeated at intervals. These projects are "census surveys" and surveys are sent to all NPs in the database, to verify information such as their area of clinical practice, practice site address, and type of setting. It is from those respondents that we have the greatest degree of detail, so that these surveys are critical. However, if needed as part of the Committee's work, we would be able to assist in reaching out to NPs to provide information helpful to those efforts.

In closing, we thank the Committee for the opportunity to address you this morning and to be an observer during the discussions which I have found very informative and interesting. On behalf of the American Academy of Nurse Practitioners, I want to offer to provide any assistance in your efforts to better understand the role of NPs in serving the needs of underserved communities. Thank you for your attention.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Mary Jo Goolsby". The signature is fluid and cursive, with the first name "Mary" and last name "Goolsby" clearly distinguishable.

Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
Director of Research & Education