

AMERICAN ACADEMY OF NURSE PRACTITIONERS

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I appreciate the opportunity to provide comments related to the Committee's deliberations. As we have observed the deliberations, members of the committee have articulated their purpose as improving the health of communities and to ensure that those who are most in need receive resources. On behalf of the American Academy of Nurse Practitioners, or AANP, and the 140,000 NPs we represent, the purpose of my comments is to advocate again for inclusion of primary care NPs in the formula being considered, as to do otherwise risk maldistribution of resources. For example, I ask the committee to imagine four rural communities, generally in all ways similar with the exception of the presence of primary care providers. One has one physician primary care provider, the second has two NP primary care providers, the third has both a physician and an NP primary care provider, and the fourth has no primary care providers. In this case, there is only one community among the four with absolutely no primary care providers. The community with only one physician is likely in the second greatest need. The current formula does not depict real need when NPs are excluded. AANP's vision is that all patients have access to high quality care by their provider of choice. This discussion is critical to our organization and the discipline it represents.

I want to reiterate some of the basic statistics about the NP discipline. Of the population of 140,000, 89% of NPs are prepared in a primary care role. This percent is continuing to increase slightly, as the trend continues to be for NPs to complete family NP programs. Moreover, the population of NPs in primary care is going to continue to exponentially grow at least over the next several years. In the past five years, according to both the American Association of Colleges of Nursing and the National Organization of NP Faculties, enrollment in NP programs has increased 60% from approximately 22,000 to over 35,000. Over this same period of time, graduation from programs increased almost 50%, from over 6,000 to over 9,000. Because the increased graduation rate slightly lags the increase in enrollments, we see healthy and continued growth in the discipline.

As mentioned before, NPs are the discipline of licensed independent providers who are most likely to practice in areas of need. Similar to the population of U.S. citizens, 18% of NPs practice in communities of less than 25,000 residents. The percentage of NPs practicing in rural areas is higher in states in which there are more rural communities and the regulatory environment supports their ability to serve rural communities. For example, in Vermont, 56% of NPs practice in rural areas. In South Dakota and Montana, 50% and 40%, respectively practice in rural communities. This is important to the committee's work, as variation based on a state's "rurality" and regulatory environment will account for NP distribution across communities and this variation must be taken into account in impact testing, to avoid over or under estimating NP practice.

There was mention yesterday regarding the rates of ambulatory care sensitive hospitalizations as an indication of need. I would like to refer the committee members to a body of evidence that supports our discipline as highly qualified to fill this type of need. A paper commissioned by the Commonwealth Fund discusses ambulatory care sensitive outcomes and how to improve them, including increased access and better patient education. Evidence supports that NP care is associated with decreased ED visits and hospitalizations for patients through the counseling provided their patients as a start part of their primary care visits. A number of studies support that NP care is at least equivalent to that of our physician colleagues for chronic and acute conditions.

Finally, as you deliberate the formulae and impact testing, we encourage you to consider the critical contributions made not only by adult, family, and pediatric NPs, but also those of women's health and gerontological NPs. Their models of care are not synonymous with those of obstetrician/gynecologists and gerontologists. The women's health NP is prepared to care for the whole woman across the lifespan, starting with adolescence. The

gerontological NP is prepared to care for the whole older adult, regardless of setting and complexity. We hope that all categories of primary care NPs will be considered in your impact testing, to determine the contributions.

In closing, we recognize that distribution of need may be affected if new formulae include NPs, who have not previously been accounted for in determining need. However, to do otherwise precludes the ability to distribute limited resources in the most fair and equal manner.

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.

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Director of Research & Education