



8515 GEORGIA AVENUE, SUITE 400
SILVER SPRING, MARYLAND 20910-3492
301 628-5000 • FAX 301 628-5001
www.NursingWorld.org

KAREN A. DALEY, PhD, MPH, RN, FAAN
PRESIDENT

MARLA J. WESTON, PhD, RN
CHIEF EXECUTIVE OFFICER

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To: HRSA Negotiated Rulemaking Committee Designation of MUPs and HPSAs
Tess Kuenning, Chair, Workforce Subcommittee

From: ANA Staff, Nursing Practice & Policy

Re: An accurate assessment of primary care shortage areas and need requires the inclusion of NPs and CNMs on par with physicians.

In health policy, certain numbers get elevated to a special power and resilience. The origins of many enduring numbers are often unclear. Nonetheless, they can and do lead to persistent misinterpretations. ANA is concerned about the possible implications of holding that Nurse Practitioners might only be three quarters of a primary care provider.

Some observers suggest that physicians provide more care than an NP or CNM. Some tables provided by MGMA comparing physicians to NPs/CNMs suggest NPs/CNMs 'produce' approximately 75% of what the average physician 'produced'. Any such inferences are at best undocumented because there is no evidence that conditions under which those two sets of provider numbers were generated were either identical or well controlled. These measures fail to adjust for systems issues that limit the amount of time a NP or CNM can spend in direct patient care such as the need to obtain physician signoffs, organizational constraints, and differences in the quality of the visit experience as seen by the patient. Measures also do not account for standard operating procedures, provider preferences, patient preferences, case mix differences, or other factors that underlie productivity differences. Case mix differences are of particular importance. NPs and CNMs often provide care to patients with complex physical and psychosocial needs which demand more time per encounter to assure improved outcomes. Discounting the contributions of NPs and CNMs may create an unsubstantiated perception that physicians have skills, knowledge and abilities that enhanced their primary care services.

NPs/CNMs provide *the same* primary care services as physicians. The contributions of NPs/CNMs cannot be accounted for in a productivity measure that evaluates the number of visits rather than the outcomes of those visits and systems level contributions. NPs/CNMs could be the benchmark for providing primary care services with fewer visits producing better care which would be especially important in an era of needing to control health care costs. There is nothing in the data that accounts for time spent by NPs/CNMs in making systems level contributions that are not reimbursed or counted. Including NPs/CNMs in the methodology as a full time provider is essential to assure that their full range of contributions to primary care services are recognized.

Areas designated as MUPs and HPSAs are eligible for resources and support from the government that are believed to result in a more equitable distribution of health care resources. An accurate assessment of where MUPs and HPSAs exist is essential to fulfilling this goal. This accurate assessment requires that the methodology includes NPs and CNMs as providers, and includes them on par with physicians. Excluding NPs and CNMs would render their contributions to access to care invisible. Counting NPs and CNMs at some percentage will result in an inaccurate assessment of the primary care services being provided in MUPs and HPSAs.

Inclusion of NPs and CNMs in the methodology as full time providers may result in some areas currently designated as MUPs and HPSAs from losing their designation while others may gain a new designation. ANA is aware that for those that lose this designation, the change in status may create challenges in sustaining services. Nonetheless, this is an era in which health care resources need to be used prudently and distributed wisely. This requires that truly underserved or shortage areas receive the support they need.

If we can be of further assistance, or if you have any questions or comments, please feel free to contact Peter McMEnamin, PhD at Peter.McMenamin@ana.org or 301-628-5073, or Lisa Summers, CNM, DrPH at Lisa.Summers@ana.org or 301-628-5058.