

5-1-2011

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Abstract

The purpose of this project is to describe a conceptual Model for Primary Care in New York State (NYS). This model (Figure 1) places Nurse Practitioners (NPs) as first line primary care providers allowing physicians as specialists caring for the most difficult, complex cases. In the current model of primary care NPs are required to practice in statutory collaboration with a physician, are currently restricted from participating in many insurance panels, are reimbursed less for the same service performed by a physician, and are prevented from signing many health care orders and documents secondary to health care laws that were written prior to the establishment of NPs as care providers in the state. In the new model NPs will, continuing voluntary collaboration with physicians and other health care professionals, become full providers in the delivery of primary care. This paper will show how this new model will provide increased access to primary care services, while being patient centered, and cost-effective. With the passage of the Affordable Care Act (ACA) in 2010, millions of newly insured will be entering into the health care system. The ACA also brings recognition to the role of the NP as a qualified provider and suggesting funding for health promotion and disease prevention, along with recommending full participation of NPs as primary care providers. Collwill, Cultice, and Kruse (2008) state that there is a predicted overall shortage of primary care physicians nationwide with a 27% decline in family practice physicians. American Association of Medical Colleges (AAMC, 2009) and the American College of Physicians (ACP, 2009) states the demand for primary care services will outpace faster than any other specialty group. NPs will be needed to meet the nation's demand for primary care services and are well qualified to meet the demand and efficiently provide direct quality patient care services (ACP, 2009; National Center for Policy Analysis [NCPA], 2010; Sherwood, Brown, Fay, & Wardell, 1997). In NYS 2.6 million newly insured individuals will saturate an already overloaded primary health care system causing a delay in access to care. The new model provides for full participation of NPs who, across the continuum are autonomous, able to be reimbursed for the actual service they provide, without statutes and public health care regulations hindering their practice. In this model, physicians would become the second line of access to care as specialty providers. To do this, legislative changes are needed.

Document Type

Dissertation

Degree Name

Doctor of Nursing Practice

First Supervisor

Marilyn Dollinger

A Conceptual Model of Primary Care in New York State

By

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Submitted in partial fulfillment of the requirements for the degree

Doctor of Practice Nursing

Supervised by

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Date

May, 1, 2011

Abstract

The purpose of this project is to describe a conceptual Model for Primary Care in New York State (NYS). This model (Figure 1) places Nurse Practitioners (NPs) as first line primary care providers allowing physicians as specialists caring for the most difficult, complex cases. In the current model of primary care NPs are required to practice in statutory collaboration with a physician, are currently restricted from participating in many insurance panels, are reimbursed less for the same service performed by a physician, and are prevented from signing many health care orders and documents secondary to health care laws that were written prior to the establishment of NPs as care providers in the state. In the new model NPs will, continuing voluntary collaboration with physicians and other health care professionals, become full providers in the delivery of primary care. This paper will show how this new model will provide increased access to primary care services, while being patient centered, and cost-effective.

With the passage of the Affordable Care Act (ACA) in 2010, millions of newly insured will be entering into the health care system. The ACA also brings recognition to the role of the NP as a qualified provider and suggesting funding for health promotion and disease prevention, along with recommending full participation of NPs as primary care providers. Collwill, Cultice, and Kruse (2008) state that there is a predicted overall shortage of primary care physicians nationwide with a 27% decline in family practice physicians. American Association of Medical Colleges (AAMC, 2009) and the American College of Physicians (ACP, 2009) states the demand for primary care services will outpace faster than any other specialty group. NPs will be needed to meet the nation's

demand for primary care services and are well qualified to meet the demand and efficiently provide direct quality patient care services (ACP, 2009; National Center for Policy Analysis [NCPA], 2010; Sherwood, Brown, Fay, & Wardell, 1997).

In NYS 2.6 million newly insured individuals will saturate an already overloaded primary health care system causing a delay in access to care. The new model provides for full participation of NPs who, across the continuum are autonomous, able to be reimbursed for the actual service they provide, without statutes and public health care regulations hindering their practice. In this model, physicians would become the second line of access to care as specialty providers. To do this, legislative changes are needed.

A Conceptual Model of Primary Care in New York State

Since inception in 1965, NPs have helped fill provider gaps by increasing accessibility to cost-effective healthcare. At the center of our primary care system is the medical model that focuses on acute care (Figure 2). This model has been utilized to diagnose, and treat medical conditions. This model undervalues the importance of prevention. This model treats chronic illness as acute episodes and treats symptoms as they occur (Kane, Priester, & Totten, 2005). The Primary Care Development Corporation (PCDC, 2009) states the current health care model is “fragmented, reactive and episodic with a misaligned payment system” (p. 14). Health disparities, heavily utilized emergency rooms for primary care and avoidable hospitalizations are a direct result of this model of care. This accounts for a substantial amount of health care dollars spent.

Full utilization of autonomous NPs would allow for the “right care to be delivered at the right time at the right price” (The Nurse Practitioner Association [NPA], 2010, p. 1). NPs are qualified clinicians who, in addition to diagnosing and managing acute and chronic illnesses, emphasize health promotion and disease prevention (American Nurses Association [ANA], 1996). The proposed model focuses on primary preventative services. Primary prevention involves health care practitioners and individuals working at three levels to maintain and improve the health of communities. Primary prevention is the first level of care. It is hindering the occurrence of disease before it occurs. Secondary prevention is screening for a disease before it becomes symptomatic. Tertiary prevention concentrates on those who are already affected by disease by maintaining function and slowing progression of the disease (Nash, Reifsnyder, Fabius, & Pracilio, 2011). This model allots increased health care dollars to primary preventative services. By focusing

on prevention, the need for tertiary care will decrease. With the decreased need for tertiary care, health care spending would decrease substantially. By increasing primary preventative care services, the need for primary care practitioners also increases. There is already a need for increased numbers of primary care practitioners secondary to the primary care physician shortage, and the influx of newly insured will tax an already strained primary care system. Collwill et al. (2008) state that there is a predicted overall shortage of primary care physicians nationwide with a 27% decline in family practice physicians (AAMC, 2009), and the ACP (2009) state that the demand for primary care services will outpace faster than any other specialty group. O'Reilly (2010) states that nationally there will be a shortage of 160,000 physicians by 2025. ACP states that the shortage will only be 44,000 (Aston, 2010). According to O'Reilly (2010), the AAMC attributes the decreased physician shortage numbers to anticipated foreign medical students filling these positions. The AAMC (2010) reports one in three physicians is age 55 or over. In NYS 28% of active physicians is age 60 and "likely to retire within the next two decades" (AAMC, 2010, p.1). NPs will be needed to meet the demand for primary care services and are well qualified to meet the demand and efficiently provide direct quality patient care services (ACP, 2009; Sherwood, Brown, Fay, & Wardell, 1997).

Barbara Safriet the former Associate Dean for Academic Affairs at Yale Law School, a non-nursing professional who used a business model to analyze the state of America's health care system, noted in her seminal article *Health Care Dollars and Regulatory Sense* (1992), that the healthcare system requires a restructuring of the existing health care delivery system and increased utilization of all health care personnel.

At that time, Safriet argued that immediate legislative reform to diminish the restrictions that confine NPs was needed. States that limit NPs to a physician-dependent practice “impede the public’s access to safe and effective health care” (Safriet, 1992, p. 1). Safriet states that current health care system provides “too little care, too late, for too few people, at too high a cost” (1992, p. 1). Primary preventative care guides patients to make smarter health and lifestyle choices that ultimately reduce health care costs.

Across the nation, NPs practice under the rules and regulations of the individual state. From state to state, the regulations vary significantly from independent practice to physician supervision, with and without prescriptive authority. Supervisory regulations ultimately lead to decreased physician productivity and increased health care costs as physicians take time away from direct patient care to review NP charts and confer with insurance companies on behalf of NP’s patients. In some states NPs are governed by the state medical board. In NYS, NPs practice in statutory collaboration, without supervision, with a physician, and in accordance with written practice agreements and protocols. NPs may diagnose; treat; perform therapeutic and corrective measures; order tests; prescribe medications, devices and immunizing agents; and refer patients to other health care providers (Office of the Professions [OP], 2010; NPA, 2010).

In October 2010 the Institute of Medicine (IOM) released the “Future of Nursing: Leading Change Advancing Health”, a two-year review of what future role nursing will have in health care in the United States. There were four recommendations by the IOM with implications for nurse practitioners. Two of the recommendations were that nurses should practice to the fullest extent of their education and training without being limited by statutes and regulations, and that NPs should be full partners with physicians and other

health care professionals in designing health care in the United States. A key message in the IOM “Future of Nursing” report is that many States across the nation have not kept pace with the dynamics of health care and that NP scope of practice regulations need to be changed (2010). Along with the IOM, the ACA brings recognition to the role of the NP as a qualified provider. In addition to providing funding for health promotion and disease prevention, the ACA calls for full participation of NPs as primary care providers. The utilization of NPs who are trained in health promotion, disease prevention practices, educating the patient on self-care practices are among the broader set of skills that will provide optimal care. Sullivan-Marx (2008) found that up to 75% of primary care services could be provided by NPs and other non-physician providers maintaining quality outcomes along with being cost-effective.

Review of literature

By 2025, an overall shortage of primary care physicians upwards of 44,000 is predicted. Secondary to this shortage, there is expected to be a corresponding workload increase of 13% for primary care providers currently in practice (Collwill et al., 2008; Bendix, 2010). According to the American Academy of Family Practice (AAFP), the average number of primary care visits per year per patient is 3.19 (Murray, Davies, & Boushon, 2007) with an average of 20 patients seen per day. This anticipated increase will overload an already saturated primary care system causing increased delays in access to care and increased utilization of urgent care centers. By 2019, with the ACA’s newly insured individuals, the work load increase is expected to be substantially higher nationwide (Murray et al., 2007). The number of medical students choosing to train in primary care is declining at an alarming rate (ACP, 2009; Sherwood et al., 1997). New

physicians migrating toward specialty practice is largely due to the excessive amount of student loans. The average medical student loan in 2010 was \$157,000 with 26.1% reporting indebtedness prior to residency of greater than \$200,000 (American Association of Medical Colleges [AAMC], 2010; O'Reilly, 2010). The total amount of student loans for medical students is up 8% from last year. The average primary care salary in 2010 was \$186,000 whereas orthopedic surgery paid \$436,000 (MSNBC, 2011).

The Center for Health Workforce Studies (CHWS, 2010) states there are 82,828 licensed physicians in New York State. Only 78% of those are active patient care physicians and 91% are practicing in New York City and urban areas. Of the total number of active physicians, only 19,000 were in family practice, internal medicine or pediatrics. The others are in specialty practice (2010). The demand for primary care physicians will outpace supply faster than for any other specialty group (ACP, 2009; Bodenheimer, Grumbach, & Berenson, 2009; Sherwood et al., 1997).

The American College of Physicians states that the nation's primary care system is in danger of collapse (MSNBC, 2011). According to the Health Resources and Services Administration (HRSA) there are 6,204 health care provider shortage areas (HPSA) with 65 million living in them across the nation. To be considered a HPSA there is less than 1 provider to 3,500 population area (2010). There is already a marked shortage of primary care practitioners across the nation and with the migration of new physicians toward specialty practice, the nations' most vulnerable populations face decreased access to care with an increase in non-emergent visits to emergency rooms for care.

Of the 62 counties in New York State, HRSA (2010) identified 52 counties as completely or partially designated medically underserved areas. Medically underserved areas have difficulty recruiting and retaining physicians. Sherwood et al. (1997), and Taft and Nanna (2008) state that in some health care settings, such as rural underserved areas, NPs are occasionally the only health care provider. In these setting, the NP functions independently, with a collaborative off-site physician available when needed for consultation. This situation demonstrates that statutory collaboration has no clinical significance because there is no direct patient care or direct observation by the physician occurring. Safriet (1992) noted NPs were competent to practice autonomously in areas where there is high risk, low income populations, who experience higher morbidity and mortality rates, then “why can’t they provide it in other practice settings?” (p. 15). It would appear that the opposition to autonomous NP practice has more to do with physicians protecting their territory than with the health and well being of the public.

Although there are many barriers to practice, NPs play an essential role in the provision of primary care and are qualified to help meet the demand (ACP, 2009; Sherwood, et.al 1997). Obtaining equivalent reimbursement for NPs is a challenge and poses a significant barrier to NP practice. As early as 1992, Safriet recognized that NPs who cannot obtain direct reimbursement are hindered in their ability to provide quality, cost-effective care. NPs should be reimbursed for services provided and not provider status. The Physicians Payment Review Commission (PPRC) recommended a fee schedule for physician reimbursement in 1997 (Department of Health and Human Resources [HHS], 1998). The PPRC recommended that physicians and limited licensed practitioners (LLP) (other than NPs) should be paid the same because there was no evidence that their care was any different than that of a physician. But when the PPRC looked at evidence with regard to NP practice it relied mainly on the Office of

Technology Assessment U.S. Congress (OTA, 1986) reports that said that NP quality was equivalent to a physician but fell short of saying that the services rendered were the same, therefore unequal payment for the same service. At that time the PPRC conceded that the “current system is based on a series of political decisions” (Safriet, 1992, p. 22).

NPs in lower socioeconomic, Medicaid populations in rural and urban areas where physicians do not or will not practice are the first point of contact for primary care services in health care provider shortage areas. Many Medicaid and state funded health insurance programs utilize Managed Care Organizations (MCOs). A MCO is a form of health insurance that focuses on delivering care as cost-effectively as possible. MCO’s reduce unnecessary health care costs by reviewing the medical necessity of specific services, controlling hospital admissions and lengths of stay, selective credentialing of health care providers and rigorous management of high-cost chronic illness through health promotion and disease prevention practices.

Considering the well documented cost-effectiveness of NP’s, and high patient satisfaction indicators it would seem NPs and MCOs would be a perfect combination. But this is not the case. (Mason et al., 1999; Hansen-Turton, Ritter, & Torgan, 2008). A 2007 survey of MCOs across the nation revealed that only 50% credentialed NPs as primary care providers in States that require physician collaboration, and that 73% credentialed NPs in States that had no physician involvement (Hansen-Turton et al., 2008). This is a key barrier to nurse-managed health centers and ultimately a significant road block to access and cost-effective care.

With NPs as first-line primary care providers, a mandate is necessary so that all MCOs will empanel any willing provider and reimburse for a service, not a provider

class. There is no justifiable reason for NP primary care services to be reimbursed based on the class of the provider. NPs have proven time and again to have patient outcomes consistently comparable to physicians.

Currently in NYS, NPs are unable to sign death certificates, Do Not Resuscitate, or home health care orders and are unable to admit patients to long term care facilities. They are unable to be reimbursed for services provided through the Worker's Compensation or No-Fault insurance programs. Nationally, NPs are eligible to be empanelled as primary care providers within the insurance roles, but many insurance companies declare that only physicians may be listed as primary care providers (Hansen-Turton et al., 2008). These restrictions to NP practice decrease access to quality care services and increase health care costs.

The purpose of health care is to reduce the "burden of illness, injury and disability, and to improve the health and functioning of the people" (IOM, 2001, p. 3). Removal of regulatory barriers to NP practice would expand primary care services and better serve the health care needs of individuals living in New York State (Sherwood et al., 1997). NPs are qualified clinicians who assess, diagnose and manage acute and chronic illnesses with an emphasis on health promotion and disease prevention (New York State Education Department [NYSED], 2010; ANA, 1996). NPs are educated and trained in health promotion and disease prevention practices and have communication skills to educate the population on healthy lifestyles and self-management. This type of care guides patients to make smarter health and lifestyle choices that will ultimately reduce health care costs. Currently, more than three-quarters of NPs nationally are trained

in primary care, making them the largest group of non-physician primary care providers (ACP, 2009; Phillips, 2010; Sherwood et al., 1997).

There are more than 160,000 NPs nationally (Pearson, 2010; American College of Nurse Practitioners ACNP, n.d.) totaling 1/6 of the nation's health care workforce. Nationally, 85% of NPs are trained in primary care (2009). There are greater than 16,000 NPs, with approximately 12,000 practicing in primary care in NYS (OP, 2010). NYS NPs are regulated by the State Board of Nursing under the umbrella of the State Board of Regents. NPs are qualified by education and clinical experience to provide autonomous, independent direct patient care services (ACP, 2009; Phillips, 2007; Sherwood et al., 1997). As of 2009 NPs practice autonomously in 16 states and the District of Columbia and changes in NP legislation or scope or practice regulations are being considered in 31 other states (Pearson, 2010).

States that have autonomous NP practice have found that the removal of the formal physician collaboration has increased access to care (IOM, 2010). There have been several instances where a NP has had to close their practice while struggling to find a collaborating physician. Having autonomous practice provides readily available cost-effective care which ultimately has an impact on health care costs (NPA, 2010).

Federal legislation in 1965 provided funding for the development of primary care providers. A nurse educator and a physician developed a nurse practitioner program specializing in pediatrics. When this NP program began there was no requirement for specific education and no uniform model of practice and there were varying regulations across the United States. "In 1971, the Secretary of Health, Education and Welfare issued primary care intervention recommendations for which nurses and physicians could

share responsibility, thus implying support for nurses as primary care providers” (Sherwood et al., 1997, p. 4). Sherwood et al. (1997) state that in 1974, the ANA established guidelines for the education of NPs and in 1976 began a credentialing program that still exists today and in response to health care reform in the 1990’s, NPs were increasingly utilized to meet the demand for primary care services.

In 2008, 32 organizations recognized as Advance Practice Registered Nurse (APRN) stakeholders participated in a conference initiated to take an in-depth look at the issues related to APRN practice to include licensure, accreditation, certification and education (LACE). The National Council of State Boards of Nursing’s (NCSBN) adoption of the LACE model would create a standardized entry level advanced practice and certification that would be accepted as a competence assessment (2008). The LACE consensus model (NCSBN, 2008) created a national framework for APRN practice. The supposition of the model was that every state would agree to the document in its entirety and adopt the model into practice (NCSBN, 2008). The road map created by the LACE model is a guide to future regulatory direction. Most recently, Hawaii adopted the model for practice. This would eliminate barriers to NP practice from state to state as the national NCLEX exam has done for entry into Registered Nursing. The LACE model identifies APRNs as “licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body, as members of the health delivery system, practicing autonomously” (NCSBN, 2008). Safriet (1992) argued for this type of legislative reform to diminish the restrictions that confine NPs was needed.

Support for broader boundaries for nurse practitioners is recognized by the American Association of Retired Persons (AARP), the Macy Foundation, Veteran’s

Administration Health System, Kaiser Permanente, Geisinger Health System, NY State Education Department, and a multitude of national nursing organizations because these organizations recognize the safe, quality care NPs provide (Fairman, Rowe, Hassmiller, & Shalala, 2011). There are physician supporters such as Dr. Jeff Susman, Professor and Chair of the Department of Family Medicine, University of Cincinnati, a family practice physician and geriatrician who states “It’s time to collaborate-not compete- with NPs” (2010, p. 672).

The key stakeholders who oppose any such legislation are physicians. The national and state medical, osteopathic, pediatric, and family practice associations, along with their specialty organizations are in opposition. This opposition is reflected in the resolutions adopted by the American Medical Association in 1985 to oppose all legislation to independent, unsupervised, or any efforts by non-physicians to further their scope of practice in any way including reimbursement (Group & Roberts, 2001), illustrating the “turf” competition, and self-financial interest mentioned previously.

In a recent editorial, Dr. Terry Nye, an internal medicine primary care physician from Kingsport, Tennessee states that NPs are intended to be “extenders” providing assistance to the physician and also argues that NPs order more diagnostic tests to compensate for their lack of knowledge making them far from cost-effective (2010). Research by Barbara Safriet (1992) and OTA (1986) recognized that NPs continually demonstrated that they can provide cost-effective, high quality primary care. The OTA (1986) noted that cost per visit when the NP provided the initial service was 20% less than the physician cost.

According to the Primary Care Coalition (PCC, 2010) health care expenditures in NYS account for \$160 billion a year for hospital and emergency room use, and greater than \$100 billion is spent on hospitalizations, medications, treatments and long term care for chronic illness. Non emergent visits to the emergency room accounted for approximately 6.7 million visits. In 2008, \$160 billion was spent on home health care services which accounted for 16% of the gross state product. Health care spending in NYS has increased 6.2% per year since 1991. Half of all visits to private practitioner offices are related to chronic illness. That amounts to over 40 million visits in NYS alone. Nationally, over 70% of private health insurance spending is spent on chronic illness. Chronic illness accounts for over 80% of hospitalizations in the United States and is estimated to be 2 million in NYS (PCC, 2009). The PCC (2009) estimates that greater than \$10 billion per year could be saved in NYS by increasing accessibility to primary care services.

In 1992, Safriet noted, “Even greater productivity would be achieved if unnecessary legal and professional restrictions were removed” (p. 7). To moderate the current escalating trends regarding primary care practitioner shortages, high medical costs and the requirement to start providing preventive care to previously uninsured for populations who are being conveyed into the health care system by the ACA, NPs need to be liberated to practice as full participating primary care providers. As full participants, NPs would bring increased access to safe, quality, cost-effective health care.

Safriet (1992) did point out that the cost to the health care system would increase with expanding public utilization. However, she further stated that the “benefits of the

improved health status outweigh the potential marginal cost increase” (p.19). The PCC (2010) recommends that improvements in preventative primary care will reduce costs significantly. Florida state policy analysts reported that increasing NP autonomy could save millions in Medicaid, state-funded health plans, and also private health care costs. They reported that the utilization of non-physician providers could save as much as \$339 million a year (The Florida Legislature, 2010). Significant savings have already been observed in companies who utilized NPs. The nation’s leading sexual and reproductive health care centers saved \$3 million per year in 1981 by utilizing NPs who saw 3/5 of all patients (Manisoff, 1981). In Illinois utilizing three NPs in a cardiovascular surgery center from 1998 to 2001, decreased operative mortality steadily from 3 percent to 0.9 percent. These three NPs showed how NPs can be cost-effective. In 12 months costs per case declined more than 9 percent, resulting in direct savings of \$1 million per year (Manisoff, 1981). The University of Virginia Health System utilized a NP model in 1999 which decreased 2,000 inpatient days saving \$2.4 million the first year (Larkin, 2003). In 2007 Pennsylvania saved \$35.9 million through primary care management of chronic illness (PCC, 2010).

As the above examples show, NPs can provide cost-effective medical and nursing services including patient-centered health promotion and disease prevention. With the looming physician shortage, the need for increased utilization of NPs is necessary to increase access to health care services. Medically underserved areas have difficulty recruiting and retaining physicians (Sherwood et al., 1997). Taft and Nanna (2008) note that in some health care settings such as rural underserved areas, NPs are often the only health care provider. In these settings, the NP functions independently caring for patients

across the life span, voluntarily collaborating with other health care professionals. However, some primary care physicians, including Dr. Tom Ewald, a family practice physician from Ashland, Oregon believe that NPs are “over their heads” when seeing geriatric patients with their multitude of chronic illnesses and long medication lists (2010).

In several studies, patients with chronic illness who were treated by NPs had lower length of hospital stays, fewer hospital readmissions, lower mortality, and a higher patient compliance rates ultimately resulting in improved chronic illness outcomes (Dahle & Penque, 2000; Gross, Aho, Ashtyani, & Levine, 2004; Paez & Allen, 2006). This evidence illustrates that NPs can be cost-effective and can provide quality care, and have improved outcomes in chronic illness. NPs have again demonstrated that NP practice is safe, cost-effective, and has outcomes that are equal to that of a physician and in some cases outcomes are better. This demonstrated that statutory collaboration or supervision is unnecessary. Statements such as those of Dr. Ewald and the continuous opposition from the medical societies appear to have more to do with physicians protecting their territory than with the health and safety of the public.

NPs diagnose and prescribe safely without the need for such oversight. Clinical outcomes have been comparable with that of a physician, and sometimes even better quality with regards to communication and preventative care, and patient satisfaction is well-documented. (Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2005; Lemley & Marks, 2009; Lentz, Mundinger, Kane, Hopkins, & Lin, 2004; Mundinger et al., 2000; Sherwood et al., 1997). Seminal works by Safriet (1992) and OTA (1986) recognize NP quality of care. NPs have “demonstrated repeatedly that they can provide cost-effective,

high quality primary care” and that “their role in providing care has been severely limited by restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement” (Safriet, 1992, 1).

A quasi-experimental research study done by Lemley and Marks (2009) evaluated clinical outcomes in two rural family practice clinics. The study found statistically significant results with regards to wait time, provider listening, confidence and trust in the provider, information regarding condition, and being involved in decision making with NP care. A survey study conducted by Agosta (2009) examined patient satisfaction with NP care through factor analysis and found statistically significant factors in three areas supporting satisfaction with NP care in a primary health care setting. In a two year follow-up study done by Lenz et al. (2004) found no statistical difference between groups assigned to a physician or a NP in satisfaction, emergency room hospital services, disease status, or health status. The OTA (1986) also noted another quality indicator of the qualification paucity of successful malpractice suits.

According the 2010 Pearson report, the number of malpractice suits from 1990-2009 was 1:166 for NPs. For MDs and DOs that number was significantly higher at 1:4 during the same time period. The National Practitioner Data Bank (HRSA, 2011) national adverse action reports are listed in Table 1 and NYS adverse reports are listed in Table 2.

The statistics for NYS NPs is well under the national average at 1:470 with physicians at 1:7 which include MDs and DOs (U S Department of Health and Human Services [HRSA], 2011). These statistics have demonstrated a favorable NP safety record when compared with physician colleagues. A reasonable assumption may be made

that NPs have a noticeable and consistently lower ratio of reported malpractice events providing evidence to refute that NPs are unsafe providers.

A number of other barriers prevent NPs from being able to respond effectively to rapidly changing health care settings and an evolving health care system. Safriet (1992) stated three major barriers to NP practice. They included prescriptive authority, lack of reimbursement from third party payers, and lack of privileges related to hospital admissions. Lack of knowledge by the public of the NP role is another barrier. The role remains poorly understood by legislators, and other health professionals. These barriers need to be overcome to ensure that NPs are well-positioned to lead change and advance health. Only when NPs are full partners with physicians and other health care professionals will they be able to proceed with redesigning health care in the United States.

Conceptual Model of Primary Care in New York State

The Conceptual Model of Primary Care in NYS (Figure 1) incorporates the most recent IOM and ACA recommendations, in addition to those made by the PCC (2010), PCDC (2009), and the U.S. Department of Health and Human Services (HHS, 2009) Patient-Centered Medical Home constructs. The works of Safriet (1992) and the OTA (1986) also informed the development of the model. Along with the IOM, the ACA brings recognition to the role of the NP as a qualified provider and calls for full participation of NPs as primary care providers. In the current New York State model of primary care NPs are required to practice in statutory collaboration with a physician, restricted from participating in many insurance panels, and reimbursed less for the same

service performed by a physician. Regulations also prevent NPs from signing many health care orders and documents. It should be noted however, that many of the health care laws restricting NP practice were written prior to the establishment of NPs as care providers in the state. These restrictions ultimately lead to decreased physician productivity and increased health care costs as physicians take time away from direct patient care to review NP charts and confer with insurance companies on behalf of NP patients.

The proposed primary care model establishes NPs as the first line primary care practitioners who, across the continuum are autonomous, practicing to the full extent of their education and experience, able to be reimbursed for the actual services they provide, without statutes and public health care regulations hindering their practice. The model allows for NPs to be the first point of contact for quality, cost-effective primary care services. Access to primary care services lowers health care costs by decreasing inappropriate utilization of emergency rooms and avoidable hospitalizations by increasing health promotion and preventative practices.

In the new model, NPs will continue voluntary collaboration with physicians and other health care professionals while providing patient centered primary care services. Voluntary collaboration will also allow patient's better access to physician centered complex medical specialties, such as endocrinology, cardiology, and nephrology thus, allowing more patients increased access to quality, cost-effective health care. A study done by the University of Michigan Health System states that physician specialists spend greater than 650,000 work weeks collectively per year on routine follow-up care for patients with common chronic conditions such as asthma, diabetes, and low back pain

(Miller et al., 2010) . It would be more cost-effective to delegate such care to NP centered primary preventative care. Primary prevention involves health care practitioners and individuals working at three levels to maintain and improve the health of communities. Primary prevention is the first level of care and hinders the occurrence of disease before it occurs. Secondary prevention is screening for a disease before it becomes symptomatic. Tertiary prevention concentrates on those patients who are already affected by disease by maintaining function and slowing progression of the disease (Nash et al., 2011).

Stern (1991) states that delayed access to primary care results in patients utilizing emergency rooms as their means of primary care. When patients are admitted through the emergency room they utilize far more resources than patients who are admitted from primary care (Stern, 1991). Improving access to primary care services and using health promotion and prevention will improve delivery and therefore decrease cost (Safriet, 1992).

Objective 1: Remove statutory collaboration

New York mandates a statutory collaborative agreement between a NP and a physician. Hamric, Spross, & Hanson (2005) define collaboration as a dynamic, interpersonal method in which two or more individuals make a commitment to each other to interact authentically and constructively to solve problems and to learn from each other to attain identifiable objectives, purposes, or outcomes. The individuals distinguish and express the mutual values that make this commitment possible (Hamric et al., 2005). By its nature, health care is a collaborative process, between and within disciplines to reach the common goal of best patient outcomes. Hamric et al. (2005) state collaboration

implies that the participants are independent team members, who combine their knowledge and skills to promote a common goal.

By definition, the term statutory simply is a law enacted by a government entity. In 1988, legislation authorizing title and scope of practice for NPs in NYS was adopted (New York Legislature, 1988). The original legislation used the word “independent” but the opposition wanted “supervision”. In a political concession by NPs the word “collaboration” was substituted as this would relate to a less restrictive practice than supervision. Statutory collaboration serves as a barrier to NP practice. As there is no direct patient care within collaborative practice agreements in NYS, statutory collaboration serves no clinical purpose. Arguments such as public safety, liability, and quality are the mainstay of debate on any practice regulations involving non-physician providers from physicians. But over the past 40 years these arguments have repeatedly been repudiated in the research literature. The ideals of “turf”, competition, and self-financial interest on the part of the physician opposition have become quiet undercurrents.

Statutory collaboration restricts access to NP centered primary health care in underserved areas of the state and for those of lower socioeconomic status as there are few primary care physicians to collaborate within Health Provider Shortage Areas (HPSA). A HPSA is an area where there is less than one provider in a population of 3,500. Mueller (2009) states it is difficult to recruit and retain physicians in rural, sparsely populated areas and NPs are essential personnel. A majority of NYS counties are recognized as HPSAs. Modernizing and simplifying NYS law for NPs who already

diagnose illness and physical conditions, perform therapeutic and corrective measures and prescribe medications, devices, and immunizing agents autonomously is an important part of the solution to the primary care shortage in NYS.

The conceptual model of primary care establishes NPs as first line primary care practitioners who, across the continuum are autonomous, practicing to the fullest extent of their education and experience, able to be reimbursed for the actual service they provide, without statutes and public health care regulations hindering their practice. The model allows for NPs, to be the first point of contact for quality, cost-effective primary care services. Access to primary care services lowers health care costs by decreasing inappropriate utilization of emergency rooms and avoidable hospitalizations by increasing health promotion and preventative practices.

In the new model, NPs will continue voluntary collaboration with physicians and other health care professionals while providing patient centered primary care services. NPs are educated to practice with a high degree of autonomy and statutory collaboration impedes utilizing them to the fullest extent to help offset the primary care practitioner shortage. With the looming shortage, NPs will not solve the problem, but full utilization would help to reduce the burden on the state.

Current bills in the NYS legislature A5308 and S3289 establish the Nurse Practitioners' Modernization Act allowing the practice of registered professional nursing by a certified nurse practitioner to include diagnoses and performance without statutory collaboration. The bills were referred to the Committee on Higher Education in the New

York State Assembly and in the Senate and are awaiting Committee discussion (New York State Assembly, 2010; New York State Senate, 2010).

The proposed legislation has encountered opposition from the medical, osteopathic, pediatric, and family practice associations, along with specialty medical organizations. This opposition reflects the resolutions adopted by the American Medical Association (AMA) to oppose all legislation to independent, unsupervised, or any efforts by non-physicians to further their scope or practice in any way including reimbursement. Approximately 45 years ago, the AMA made an attempt to restrict the Chiropractic profession. Just over 20 years ago, the AMA was found guilty of engaging in a “conspiracy” to eliminate the profession (Devitt, 2006). No one profession should have the power to define the scope of practice of another. It would appear that the Medical Society is again attempting to limit another profession’s growth. Whether this continued opposition to non-physician advancement is territorial, financial or that they just consider another profession’s growth as being competitive remains hidden under the guise of public health and safety.

In 2009, the AMA compiled the “AMA Scope of a Practice Data Series” and their findings were distributed to “serve as a resource to the State medical societies and policymakers” (2009, p.4). The AMA states that the intention of these modules is to “provide the background information necessary to challenge the state and national advocacy campaigns” of LLPs (2009, p.4). They go on to say that it is the “AMA’s position that patient safety should always be the foremost concern” (2009, p. 6). The report also addresses a 2006 study that found that rural NPs were writing more prescriptions than physicians, PAs, or NPs in urban areas and questioning if the NP role

is “safe, effective, and responsible” (2009, p.6). Based on the statistically significant higher malpractice rates of physicians than NP’s from the National Practitioner Data Bank (HRSA, 2011), the AMA might consider reevaluating their educational curriculum regarding safe practices.

The AMA further states that they encourage “training programs for physicians who will practice primary care include appropriate educational experiences to introduce physicians to the required knowledge and skills, as well as to the types of services and modes of practice that characterize primary care” (2009, p57). The AMA (2009) admits that “blurred boundaries” (p.9) is the term physicians and government regulators often use to identify the difference between NP and physician capabilities and authority. Again, the AMA has shown no just cause for their continued attempt to hinder advancing the profession of NPs and allowing them to become full participants.

NPs know the “boundaries of their competence, they know when to consult with and refer to other health care providers, and they know that they have both an ethical and a legal duty to do so” (Safriet, 1992, p. 13). Permitting NPs full participation without statutory collaboration in a timely manner is essential to the health of the nation. Bodenheimer, Chen, and Bennett (2009) suggest that even with greater use of NPs and Physician Assistants (PAs) that it would only reduce the demand for primary care providers by 25%. As a physicians’ additional training has not been shown to result in a measurable difference from that of nurse practitioners in the quality of basic primary care services (Fairman et al, 2011) and NPs can be trained in less time than that of a physician, greater access to care can be obtained through increasing the number of NPs in primary practice.

Objective 2: Remove barriers to access and reimbursement

Obtaining equivalent reimbursement for NPs is a challenge. As early as 1992, Safriet recognized that NPs who cannot obtain direct reimbursement have their ability to provide quality, cost-effective care. NPs should be reimbursed for services provided and not provider status. The PPRC recommended a fee schedule for physician reimbursement in 1997, but when they looked at evidence with regard to NP practice it relied mainly on the OTA reports that said that NP quality was equivalent to a physician but fell short of saying that the services rendered were the same, therefore unequal payment for the same service. At that time the PPRC conceded that the “current system is based on a series of political decisions” (Safriet, 1992, p 22).

Medicare requires a NP to have a collaborative agreement with a physician in order to bill for services. Although this is a statutory requirement, it is a purely professional collaboration. The Balanced Budget Act of 1997 provided reimbursement of nurse practitioners for Medicare and Medicaid Services with a provision requiring physician collaboration. The regulation requires written documentation of collaboration and the process by which patients are referred to the physician. The collaborating physician does not have any authority over NP practice (ACNP, n.d.). An amendment to the Social Security Act to change the current method of reimbursement is necessary. Along with this, an amendment to change the fee schedule to reflect payment for a service rather than the type of practitioner. There is no justifiable reason for NP services to be reimbursed based on the class of the provider. NPs have been proven time and again to have patient outcomes consistently comparable to physicians for similar services.

There has been opposition to this stating that reimbursing NPs at 100% of the physician fee schedule will lead to higher costs. The OTA noted that cost per visit when the NP provided the initial service was 20% less than the physician cost (1986). “Even greater productivity would be achieved if unnecessary legal and professional restrictions were removed” (Safriet, 1992, p. 7). Safriet (1992) supposed that the cost to the system would increase with expanding utilization, supposing that the “benefits of the improved health status outweigh the potential marginal cost increase” (p.19). Universal payment for services rendered not type of provider will initially increase costs. The cost savings will be recognized with decreased expenditures on avoidable hospital admissions, non-emergent emergency room usage, and the decrease in tertiary care of chronic illness.

The PCC (2010) reports NYS primary health care estimates that NYS spends \$160 billion a year on hospital and emergency room use. The PCC estimates that \$10 billion per year could be saved by increasing accessibility to primary care. The PCC estimates that greater than \$100 billion is spent on hospitalizations, medications, treatments and long term care for chronic illness. Non emergent visits to the emergency room accounted for approximately 6.7 million visits. In 2008, \$160 billion was spent on home health care services which accounted for 16% of the gross state product. Health care spending in NYS has increased 6.2% per year since 1991. Half of all visits to private practitioner offices are related to chronic illness. That amounts to over 40 million visits in NYS alone. Chronic illness accounts for over 80% of hospitalizations in the United States and estimated to be 2 million in NYS. Nationally, over 70% of private health insurance spending is spent on chronic illness (2010). Initial primary care expenditures, with universal reimbursement by service rendered will increase health care costs. The

utilization of cost-effective care is realized with health promotion and disease prevention services that ultimately decrease costs over time.

The PCC (2010) recommends that improvements in primary care will reduce costs significantly. Boeing had a 56% reducing in missed work days and saved approximately 20% saving nearly \$200 million by investing in wellness programs. IBM eliminated co-pays for primary care services for its employees to ultimately reduce spending related to chronic illness. In 2007 Pennsylvania saved \$35.9 million through primary care management of chronic illness (PCC, 2010). Reducing hospitalizations and increasing health promotion, chronic illness prevention is a goal of Healthy People 2020 (U.S. Department of Health and Human Services, 2010).

Additional barriers to practice in NYS include NP restrictions from participation in the Worker's Compensation and No-Fault programs. NPs are not credentialed in most private or managed care organization (MCO) networks, and are not fully compensated for services provided. Considering the documented cost-effectiveness of NP's, and high patient satisfaction indicators it would seem NPs and MCOs would be a perfect combination. But this is not the case. (Mason et al.,1999; Hansen-Turton, Ritter, & Torgan, 2008).

Another reason that MCO's do not empanel NPs is that the MCOs were not mandated by law to credential NP's. The Employee Retirement income Security Act (ERISA) of 1974 enacted any willing provider laws (APW). APW laws require that MCOs credential any licensed provider who is willing to provide services within the regulations set by the individual state (Hansen-Turton et al., 2008) although another law, the any willing class of provider (AWCP) law, states that they cannot refuse to credential

by provider type. The MCOs have challenged these rulings in court stating that they keep cost down by negotiating lower cost arrangements with an exclusive network of providers. The courts have agreed with the MCOs leaving who they credential to each individual MCO (Hansen-Turton et al., 2008). With NPs as first-line primary care providers, a mandate is necessary so that all MCOs will empanel any willing provider and reimburse for a service, not a provider class. Legislative changes to the public health laws of NY replacing the word “physician” with the word “practitioner” are needed prior to mandating any willing provider empanelment.

NYS does not have AWP laws (New York State Insurance Department, 2011). Legislation has been proposed to change the public health law to state that no MCO can discriminate against AWP who can meet the terms of the contract (Pearson, 2010). In NYS although Aetna, Blue Cross Blue Shield, GHI/Emblem Health, MVP MCO plans allow NPs to be credentialed as primary care providers within their networks, most of the MCOs in NYS are not credentialing NPs.

In NYS, Atlantis Health Plan specifies a PCP is a “participating physician, general practitioner, family practitioner, internist, or pediatrician”(Atlantis Health Plan, 2008, p. 5). The Capitol District Physician Health Plan (CDPHP, 2008) has a form entitled Practitioner Credentialing Application. This is extremely misleading. Part of the enrollment form is a Physician Qualification Overview which states that “physicians” must hold a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) license (p. 4). CDPHP also credentials what they term “Adjunct Practitioners” (p. 4) to include audiology, diabetes educator, pharmacist, chiropractic, dental, to name a few, but do not include NPs or PAs. Cigna Healthcare (2011) does not credential NPs. When searching

their provider network, the choices are Physician, Dentist, Pharmacy, Hospital, Behavioral or Vision. NPs are not credentialed as a PCP with United Healthcare which offers credentialing to those who are licensed independent practitioners (LIP). LIP is defined as “any health care professional who is permitted by law to practice independently within the scope of the individual’s license or certification, and includes but is not limited to physicians, dentist, chiropractors, doctors of osteopathy, doctors of podiatric medicine, psychiatrists, psychologists, social workers, and certified nurse midwives” (United Healthcare, 2009, p. 6).

If the new model of primary care is to be completely functional, the laws allowing for NP credentialing need to be revised. A mandate that NPs be credentialed by all private insurers and MCOs as primary care providers is needed. NPs with legal authority to practice independent of statutory collaboration would lead the way to MCO credentialing.

A report by the PCDC (2009) states that key issues to the current primary care reimbursement system were a) different payers reimburse providers differently for the same service, b) the reimbursement may be different for the same service depending where the service was rendered, and c) MCO’s use different methods of payment and rates. NPs allowed to have their own panel of patients increases the number of primary care providers. With the number of uninsured becoming insured by the passage of the ACA, an increase of paneled primary care providers is necessary as most of those who will be obtaining health insurance will be with Medicaid MCOs. A shift in focus from who is paid to what to pay for (PCDC, 2009) is a necessity requiring legislative action.

NPs have been recognized by the government as primary care providers for Medicaid and Medicare since 1965, but it was not until the Omnibus Reconciliation Act of 1997 authorized payments to NPs in rural clinics that they were directly reimbursed for their services (Sullivan-Marx, 2008), although there was no stipulation as to the reimbursement rate. NPs are reimbursed at only 80-85% for the same services provided by their physician colleagues (Center for Medicare and Medicaid Services [CMS], 2010). With NPs as first-line primary care providers, a mandate is necessary so that all MCOs will empanel any willing provider and reimburse for a service, not a provider class. Legislative changes to the public health laws of NY replacing the word “physician” with the word “practitioner” are needed prior to mandating any willing provider empanelment.

There has been opposition from physicians, insurance companies, and hospital groups to these reimbursement issues. The AMA adoption of the “oppose any legislation” documents explains the physician opposition. The OTA (1986) found that the third party payers contend that directly paying additional providers will increase the costs to third party payers, beneficiaries, and in turn the public and hospitals argue that decreased hospitalizations will decrease their revenue.

Objective 3: Update Public Health Care Laws

NYS public health laws were written before the NP profession was established in the state. Article 41 Title 4 and Article 29-CCC of the Public Health Laws of New York (NYSED, Updated June 2010) require rewording. The language utilized to update these laws must be chosen to reflect primary care provider or health care provider to acknowledge the diversity of providers. This change is part of the movement forward toward a healthier New York.

The IOM report states that access to care is denied patients, the cost of care is dramatically increased and much time spent unnecessarily with physician supervision/ collaboration with duplication of services. Millions of dollars are spent lobbying the legislature by those continuing to restrict practice (2010). “Turf” wars are expensive and consume a large amount of time not only for the regulatory party, but for the professions, and the legislators. Organized medicine’s persistent opposition to the expansion of another profession’s practice results in legislative time being wasted on a turf war.

Article 41 Title 4 and Article 29-CCC (New York State Public Health Law, n.d.) require rewording to include NPs as persons able to issue death certificates and DNR orders. The Valid Signature Bill, A2157 was introduced in the January 2011 session of the New York State Assembly to amend the education law, thereby authorizing NPs to perform functions in conjunction with clinical services within their scope of practice. Bill A.1603 is a Mental Health bill authorizing nurse practitioners to admit patients to Inpatient Mental Health Units on voluntary or involuntary bases was introduced in the January 2011 session. Both of these bills also were referred to the Committee on Higher Education. Neither bill has yet to be introduced to the Senate (New York State Assembly, 2010; New York State Senate, 2010). The language utilized to update these laws must be chosen to reflect primary care provider or health care provider to acknowledge the diversity of providers. This change is part of the movement toward a healthier New York.

Kingdon’s Multiple Streams Model and Advocacy in nursing

Spenceley, Ruetter, & Allan state that large gaps exist in nursing knowledge about how to advocate at the policy level (2008). Nursing leaders agree that more NPs should be involved in expanding policies (Keepnews, 2005, Pimomo, 2007, Taft & Nanna,

2008). According to Fawcett and Russell (2001), the mission of many nursing professional organizations is to facilitate health policy development or revision. Changing policy can be very difficult. Valid, reliable, and convincing data are necessary as a foundation for change (Wylie, 2005).

In Kingdon's agenda setting model the main focus is on the flow and timing of policy action more than on its elemental steps. Furthermore, this model helps to organize and analyze the parts of the policy making process and how to move toward action. It also aids in the understanding the intricacies of policy-making. In Kingdon's model attention is paid to three streams: the *problem* stream, the *policy* stream, and the *political* stream. These streams each move independently through the policy system. It also attempts to explain why some topics become prominent in the policy agenda and are translated into tangible policies, while other topics do not attain that distinction. This model accounts for alternate processes that influence policy that often do not appear to follow a linear or rationale sequence. It is the amalgamation of these streams that allows for a particular issue to be turned into a policy (Kingdon, 2011). Kingdon's framework organizes and analyzes the parts of the policy process to guide advocacy efforts.

When a problem has been identified, research and evidence is gathered to support that a problem exists and needs legislative action. The idea that a current situation is wrong and that something should be done to modify and/or improve it is therefore a requirement for turning an issue into a policy. Furthermore, it is essential to be able to exhibit that the problem can actually be attributed to causes within human control and accordingly that action can be taken to change the situation (Kingdon, 2011). This evidential support provides the succinct statement designed to persuasively educate

legislators about the issues and to convince them that the issue is important and worthy of their attention and advocacy (Kingdon, 2011). There are three things that can bring problems to the attention of legislative officials. These are specific indicators of a problem, a sentinel event, or feedback such as from a government agency. Problems such as the looming primary physician shortage, the report from the IOM on the nursing's future, and the passage of the ACA insuring an additional 32 million Americans nationally have provided the flow for setting the primary care agenda.

The problem with health care delivery in NYS is multifaceted. The lack of primary care providers in NYS became evident with the newly released HPSA report. The inability of NPs to practice to the full extent of their education in relation to the outdated public health laws and not being able to obtain necessary treatments without physician intervention are significant problems in NYS. Health care expenditures are skyrocketing within NYS. Increased costs occur when time needs to be taken out of the physician's day and there is duplication of services when the physician has to see the patient for the same diagnosis as the NP. This accounts for decreased productivity and loss of income for the physician, along with decreased access to care for patients. This indicates unnecessary cost and a significant barrier to practice.

The problem for NYS NPs practicing without full autonomous practice is quite evident. With the multitude of evidence provided showing quality care as evidenced by patient satisfaction and low malpractice rates. NPs in NYS practice with statutory collaboration which does not prevent NPs from having a private practice. The concession a decade ago to the use of "collaboration" to gain the right to practice now needs to be repealed. With the practice environment in which NPs practice today, collaboration has

no evident clinical significance. NYS public health laws are in need of updating. These laws were written at a time when physicians were the only providers. Updating the public health laws allowing NPs to execute any order within their scope of practice, in any health care setting, that a current statute allows a physician to do (New York State Assembly, 2011). This does not change the scope of NP practice in NYS. NYS NPs already diagnose, treat, and prescribe medications safely. In order to update these laws it is not necessary to open the scope of practice document which has worried the nursing community. NPs have always had the education to provide the services related to the public health law, just not the legal authority.

The second stream in Kingdon's model is policy. This stream is where one will articulate the possible solutions that might be proposed and determine what the best solution is. This stream involves the creation of policy alternatives and proposals (Kingdon, 2011). With the problems identified above the solution for NYS is identified within the conceptual model. NPs with full autonomous practice as the first line providers are the solution to the primary care shortage. This model allows for greater access to cost-effective, quality care for the citizens of NYS. With health promotion strategies decreasing the incidence of disease, NY will become a healthier state with a cost effective approach to health care delivery. With NPs practicing autonomously, physicians are released to provide care to their panel of patients. This model allows for NPs to provide basic primary care services with patient education regarding health promotion and disease prevention and places physicians in specialty care roles, caring for the most critical patients who need physician expertise.

The third stream is politics. The politics stream includes factors related to current public mood, legislative ideology of the majority, and events that capture the public's attention. Although independent of the other two streams, this stream is affected by administrative and legislative turnover such as a sudden influx of new members of Congress or a change in leadership (Kingdon, 2011). This change can lead a given topic and policy to be included or excluded from the agenda (Travis & Zahariadis, 2002). The dynamics created by a political event may change the agenda entirely. In the political stream, accord is usually obtained as a result of bartering rather than influence. Consequently, more consideration is given to evaluating the costs and benefits of a policy proposal than its logical importance and relevance (Kingdon, 2011).

The election of President Obama and the passage of the ACA (2010) along with the IOM (2010) message that nurses are to practice to the fullest extent of their education have changed the mood of the nation to one of "pro" NP. The election for the new legislative term in NYS with a changeover of power and the election of a new Governor have changed the political mood in NYS. The NYS NPA has begun to establish coalitions with legislative members and have embarked on an overtly active campaign to promote the problem and their solution to that problem.

Kingdon's model (1995) underlines the existence of three distinct, parallel processes in policy-making. It is the union of these streams that allows for a particular issue to be turned into a policy (Kingdon, 2011). Problem identification, the creation of proposed policies and political events each has its own dynamics and pace. The three streams are separate and independent and each has its own dynamics and pace. No one stream is vital to the overall policy process, but it is when the streams meet and coincide

then an issue is transformed into an actual policy. All 3 streams are vital to understanding how a problem can be moved onto the policy agenda. By understanding the factors in the three streams one can advocate more effectively for and target specific issues. There is no chronological sequence among the streams. Streams act and react according to their own purpose until a window of opportunity is opened and two or more streams coincide and become a policy (Kingdon, 2011). The three streams operate in a constant 'flow' with no clear beginnings or ends. For a change in policy to occur, a window of opportunity occurs (Mannheimer, Lehto, & Östlin, 2007).

The policy window is an opportunity for problems to be brought to the attention of key legislators. It is often an event in the political stream that will open a policy window by capturing the attention of legislators and the public for a short but important period of time. The strength of Kingdon's framework is that a policy is analyzed in relation to the underlying problems. It appreciates that the policy process is dynamic and non-linear, and that it involves a vast number of performers and influences. It also explains how a given issue becomes a policy—or not (Mannheimer et al., 2007).

The window has been opened for NP legislation. The problem has been identified by the primary care provider shortage and by the increased work load anticipated with the ACA's newly insured individuals. The recommendations of the IOM have given solutions to the problems, and the NYS NPA is active in promoting NP legislation toward the state's political agenda. The LACE (2008) document has given a global framework for licensure, accreditation, certification, and education. This framework gives a conceptual model of NP practice in the United States. The model was given more credibility as it was a consensus of the most influential nursing communities. One State

having already adopted the consensus model as the framework for NP practice opens the door for adaptation of one of the IOM (2010) key recommendations. With 16 States and the District of Columbia already having autonomous, independent practice, and legislation in 31 one other States to advance them closer to autonomous practice, now would be the time for all States to consider adopting the consensus model. By adopting this model into practice, it would eliminate many of the arguments made by the AMA hindering practice. Now is the time to utilize the “open window” to promote the NP agenda.

At this time, the NPA has placed a call to action. They have commenced an enormous grassroots campaign across the state calling it an “all hands on deck” approach (NPA, 2011, p. 1). The NYS NPA has followed in the footsteps of the NYS Nurse Midwives (2010) who were recently able to remove statutory collaboration. Organized constituent advocacy teams are being assembled to meet with legislators in their local district offices. This meeting will be followed up with a visit at the legislator’s office in the Capital. Key legislators have been identified. Those on the Committee for Higher Education have been targeted as those of special interest (NPA, 2011). The teams are being assembled with NPs, physician colleagues, community members, and family members, all of whom are registered voters within the local area of these legislators. The state and national organized medical associations continue to obstruct any legislation proposed by NPs.

This grassroots effort includes NPs, physician colleagues, and other stakeholders. In Kingdon’s model (1995), identifying key stakeholders relative to the issue is extremely important. Consumers affected by the legislation, both positively and negatively, need to

be identified. Identifying supporters and those who oppose the legislation is vital. The cost, quality and access associated with all lobbying efforts must be considered.

Summary & Conclusion

NPs have spearheaded the path to full patient care. Their ability to weave through the legislative process is one of the many skills used in a long (and continuing) journey (Edmunds, 2003). One cannot rush legislation; homework and legwork must be completed first. Funding, time and detailed planning are essential to the legislative process. “And be prepared for the long haul,” as many pieces of legislation take many years to pass (Edmunds, 2003).

Legislation battles require an experienced lobbyist who will work with the NP leaders. This grassroots effort includes NPs, physician colleagues, and other stakeholders. In Kingdon’s model (1995), identifying key stakeholders relative to the issue is extremely important. Consumers affected by the legislation, both positively and negatively, need to be identified. Identifying supporters and those who oppose the legislation is vital. The cost, quality and access associated with all lobbying efforts must be considered.

Organized constituent advocacy teams are being assembled to meet with legislators in their local district offices. This meeting will be followed up with a visit at the legislator’s office in the Capital. Key legislators have been identified. Those on the Committee for Higher Education have been targeted as those of special interest (NPA, 2011). The teams are being assembled with NPs, physician colleagues, community members, and family members, all of whom are registered voters within the local area of these legislators. The state and national organized medical associations continue to obstruct any legislation proposed by NPs.

Developing connections is a must for grassroots lobbying. Grassroots lobbying begins with telephone and email trees to allow quick access to members of all associations urging them to contact their local representatives regarding the NP agenda. Association often creates grassroots legislative handbooks. A handbook contains the information regarding the key legislative members, sample letters of support, letters of support from major groups, the bill itself, talking points, names of legislative committee members and their contact numbers, and the research documents showing the evidence base for proposed legislation (Nurse Practitioner Association of Maryland[NPAM], 2001; Stachowiak, 2009).

The efficacy of the implementation of this model will be able to be evaluated over time by measuring patient outcomes, the anticipated decrease in healthcare expenditures, and an anticipated decrease in morbidity and mortality. All of which are the overall goals of Health People 2010 and continues into Healthy People 2020 (HHS, 2010). The outcomes in NYS will be able to be measured by the health departments in their five year community assessments, by the NPDB malpractice data, hospitalization records, and quality indicators such as satisfaction surveys.

Donna Shalala, head of the committee on the future of nursing had this to say about nursing's future. "This report is really about the future of health care in our country. It points out that nurses are going to have a critical role in that future especially in producing safe, quality care and coverage for all patients in our health care system" (IOM, 2010). Broad spectrum change is necessary to solve many of these issues (Safriet, 1992). Efforts to incorporate this proposed primary care model that includes NP as full participants is a crucial element in reaching the goals of health care in NYS. NPs as first

line of access especially in the rural and lower socioeconomic areas have proven over the past few decades to be competent and safe practitioners.

As the largest group of non-physician providers in the nation, NPs are well positioned to lead the way in revolutionizing health care in the nation. Since 1965, NPs have transformed the profession from “extender” to one of provider. They have managed to overcome obstacles in the legislative process and have honed our skills in our unrelenting journey. Accepting NPs as partners and colleagues with a wealth of knowledge from nursing theories and frameworks that complement the medical model is the future of health care delivery in the United States.

Fairman, et al. (2011) state this is a crucial point in time to support a standardized scope of practice for NPs. The chasm amid supply and demand, the expansion of health care to millions of Americans dictates change in our primary care delivery system. “A growing shortage of primary care providers seems to ensure that nurses will ultimately be required to practice to their fullest capacity” (Fairman, et al., 2011, p. 1). Fighting the expansion of nurse practitioners' scope of practice is no longer a defensible strategy. The challenge will be for all health care professionals to embrace these changes and come together to improve U.S. health care” (Fairman, et al., 2011).

The time for NPs to have full autonomous practice in NYS is quite evident. NPs in NYS practice with statutory collaboration. The concession a decade ago to the use of “collaboration” to gain the right to practice now needs to be repealed. In NYS NPs can own and operate an independent practice as long as a written collaboration agreement is on file with the State Board of Nursing. In the environment which NY NPs practice today, collaboration has no evident clinical significance. Public health laws which date

back to the turn of the 19th century are greatly in need of updating. These laws were written at a time when physicians were the only providers. Updating the wording from “physician” to “practitioner” does not change the scope of NP practice in NYS and it is not necessary to open the scope of practice document. NPs have always had the education to provide the services related to the public health law, just not the legal authority.

There is currently a shortage of primary care providers within the state and restrictive covenants reduce access to the states neediest individuals. In the current model of practice in NYS, physicians are the “captain of the ship”. NP’s must have a collaborative practice agreement in place in order to be able to practice. With the current model, acute episodic treatment of chronic disease and urgent care of illness is the norm and there is non-emergent use of the emergency rooms and avoidable hospital admissions.

The proposed model of care placed NPs as the front line provider increasing access to primary care services with quality health promotion and disease prevention strategies while being cost-effective. “NPs incorporate nursing philosophy, theory, knowledge, skills, and paradigms, blending these with knowledge from other related disciplines, including, but not limited to medicine. In doing so, NPs synthesize a unique, potentially superior hybrid model of practice” (Elwell, 2007). Transforming primary care in NYS from the medical model where pharmaceutical and diagnostic treatment are the norm to a model of health promotion and disease prevention which is patient-centered that includes self-care management education with an increased level of health and a decreased level of chronic illness can be achieved.

Hansen-Turton, Ritter, and Valdez (2009) concluded that policy makers' have a current interest in putting an end to the health care crisis which offers an immense opportunity for nurses to reform health care. "To seize this opportunity, nurses must learn to speak with a unified voice and build strong relationships with a broad range of bipartisan policy makers, funders, civic leaders, business leaders, and legislative advocates" (Hansen-Turton, et al., 2009, p.1). When NYS hears the voices of the nursing profession is when the health care system will be redefined. When Benjamin Franklin signed the Declaration of Independence he stated "We must all hang together or, most assuredly, we shall all hang separately." As a profession now is the time more than ever for nurses to "all hang together" and speak with one voice.

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Figure 1
Conceptual Model for Primary Care in
New York State

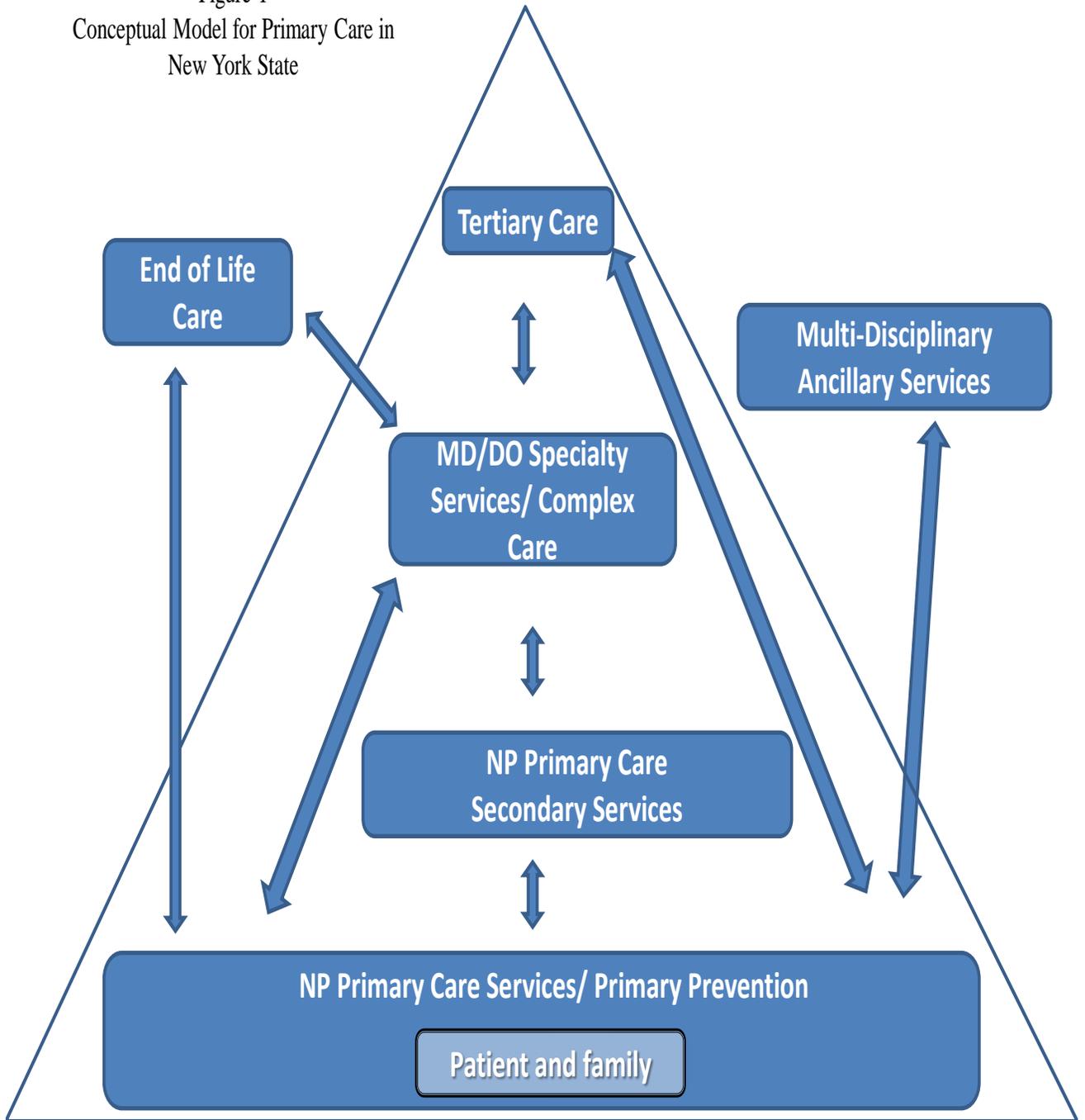


Figure 2 Current Model of Practice

Traditional Healthcare Continuum

Primary Care:

- First Aid/Assistance
- First contact with health care professional
- Occurs in a office, nursing home, etc.

Secondary Care:

- Hospital Aid/Assistance
- Referred through general practitioner
- Occurs at a hospital, clinic, emergency room, etc.

Tertiary Care:

- Special Aid/Assistance
- The most specialized level of care
- Occurs at specialized centers regionally or nationally

<http://www.clillinois.edu/healthlibrary/pdf/continuum.pdf>

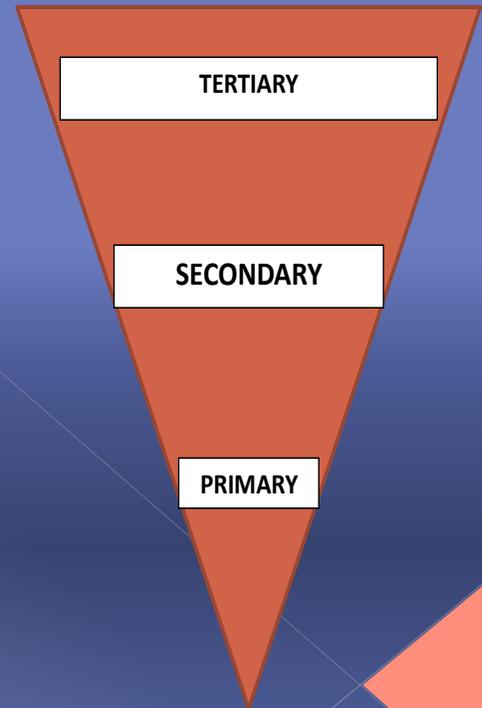


Table 1 National Data

Practitioner Type	Adverse Action Reports	Convictions
Nurse Practitioner	1,236	18
Physician Assistant	2,301	34
Doctor of Osteopathy	5,468	66
Medical Doctor	51,246	432
Pharmacist	17,193	No data

Table 2 New York State Data

Practitioner Type	Adverse Action Reports	Convictions
Nurse Practitioner	34	0
Physician Assistant	173	0
Doctor of Osteopathy	226	0
Medical Doctor	4,474	66