

How to Enhance Advocacy with Research

Daniel Pace, CHCP
Chief Strategy Officer
Vice President, Education and Research
American Academy of Physician Associates

Disclosures

Daniel Pace: No relevant disclosures

Learning Objectives

By the end of this session, you should be able to ...

- Recognize the importance of research to support your advocacy efforts
- Evaluate opportunities for you to get involved with research
- Relate existing AAPA research supports to your organizational needs
- Explain the basic tenets of critically appraising research studies
- Formulate approaches for integrating research into your advocacy efforts

The importance of research to support your advocacy efforts



Importance of Research

With research PAs can...


 Improve clinically

 Gain trust

 Build credibility

 Expand opportunities

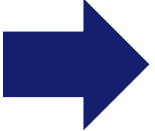
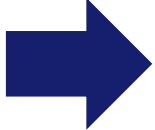
 Develop solutions

 Be leaders

 Provide the greatest impact in your advocacy!

Research Strengthens the Profession

Research...

-  Demonstrates the value of the profession
-  Serves as the basis for advocacy

PAs need to represent themselves

Types of Research

Primary

New data are collected.

Secondary

Data was already collected.

Qualitative

Data are words; Used to understand concepts.

Quantitative

Data are numbers and graphs; Used to test hypotheses.

Descriptive

Subject is not manipulated; Used to describe topics.

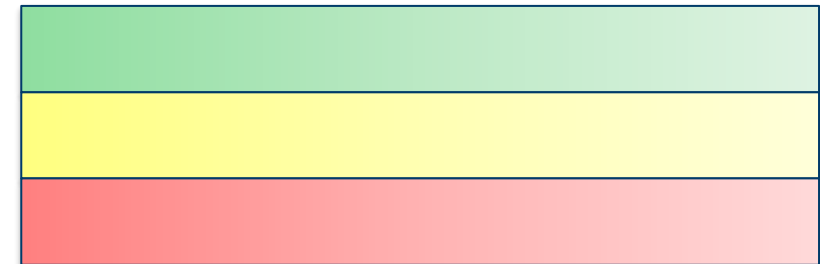
Experimental

Subject is manipulated; Used to determine cause and effect.

Pause for Discussion

Think about what you are currently working on regarding advocacy.

What are a few ways research can enhance the work that you are doing?



Opportunities for you to get involved with research

Get Involved with Research

Learn

Read

Pursue additional education

Engage

Identify opportunities for QI

Find employers who value research

Participate in research

Collaborate

Find a mentor or be a mentor

Join an established team

Disseminate

Present work at conferences

Write your results

AAPA Opportunities to Get Involved with Research

Learn

Take CME. [Free Research CME](#) is available in Learning Central

Read *JAAPA*

Engage

Participate in AAPA surveys

[Join PA Observations](#)

Become a [reviewer for JAAPA](#)

ePosters as inspiration

Seek funding from AAPA

Collaborate

Find a mentor through AAPA [Mentor Match](#)

Talk about research on AAPA [Huddle PA Research Discussion Group](#)

Disseminate

[Submit to JAAPA](#)

Present at AAPA Conferences

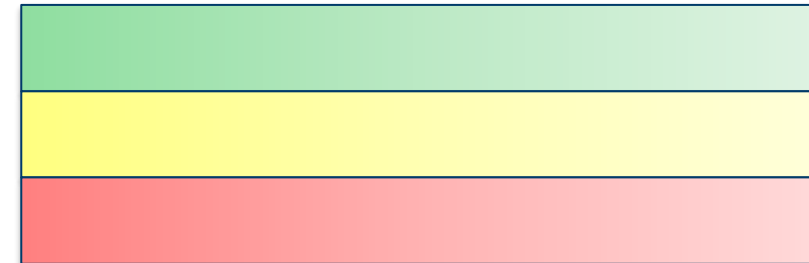
Write for News Central

Pause for Discussion

Are you currently engaged in research in any capacity?

If **yes**, how?

If **no**, how can you start to get engaged?



Existing AAPA research supports

**“The goal is to turn data into information,
and information into insight.”**

*~ Carly Fiorina
(former CEO of Hewlett Packard)*

AAPA Research Supports

Learn

Research bibliographies

National PA Research Agenda

Data requests

Collaborate

Survey support

Research collaborations

Networking events

Engage

AAPA-PAEA Research Fellowship

Fielding research surveys

Open data sets

Small Research Grants

Disseminate

ePosters and Research in Action at
AAPA '23

JAAPA

Dates to Know

Small Research Grants

September 1 to November 27, 2022

\$68k available

AAPA 2023 Research Submission

December 1, 2022 to January 9, 2023

Research in Action (CME) and ePoster presentations

AAPA-PAEA Research Fellowship

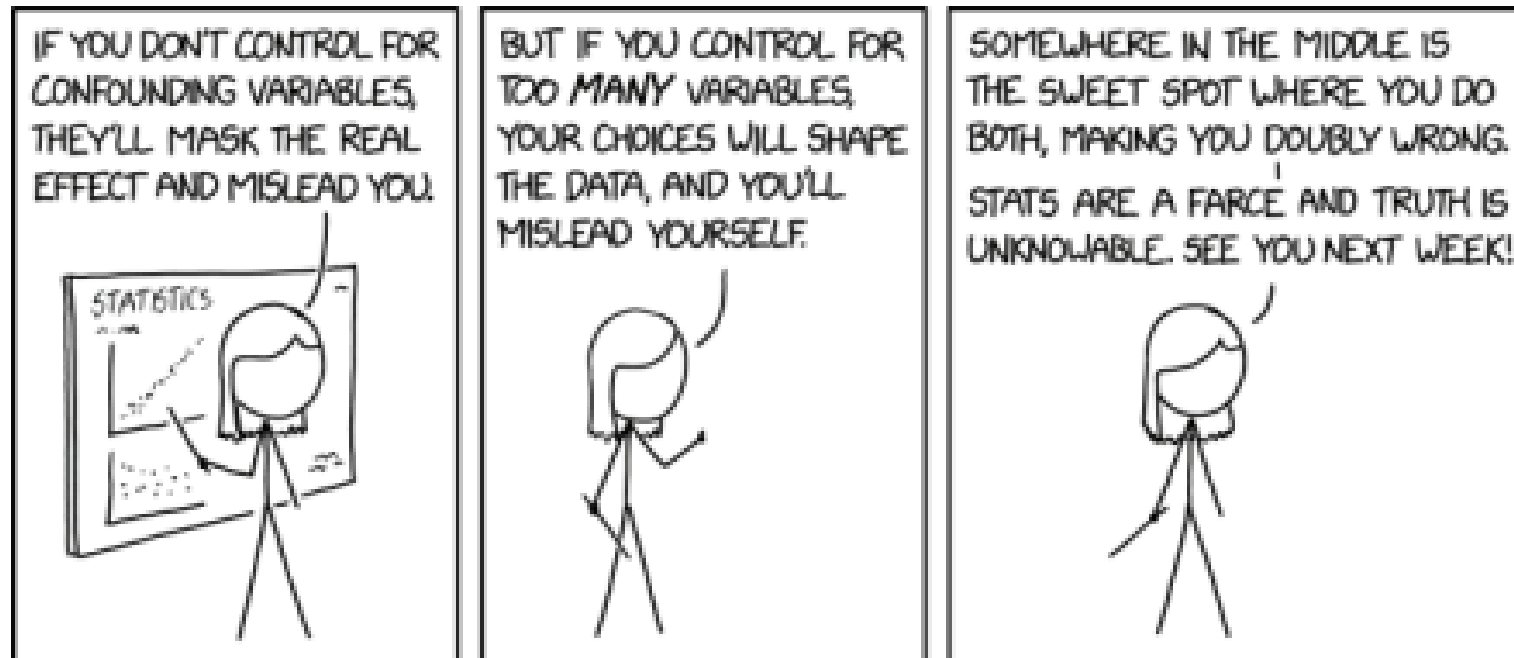
May 2023 to June 2023

20% time buyout, and educational and networking sessions

“If you have a question, let us know and we will figure out how we can help you. If we cannot, we will get you moving to the right place!”

Basic tenets of critically appraising research studies

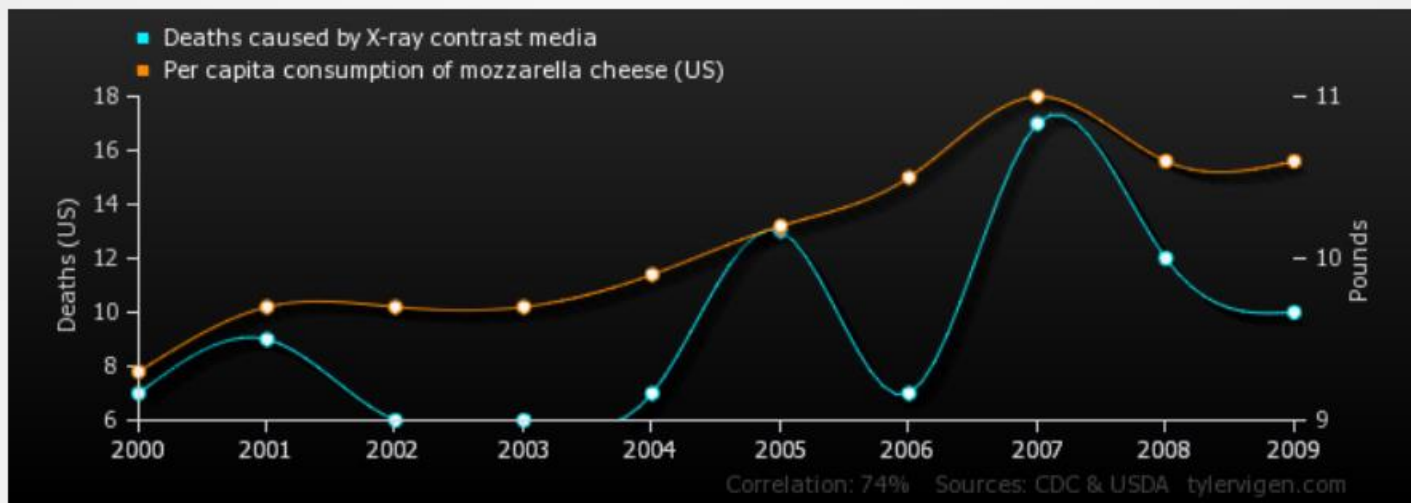
Lies, Damned Lies & Statistics?



1

“There are three kinds of mendacity: lies, damned lies, and statistics.”

Deaths caused by X-ray contrast media correlates with Per capita consumption of mozzarella cheese (US)



Upload this image to imgur

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Deaths caused by X-ray contrast media Deaths (US) (CDC)	7	9	6	6	7	13	7	17	12	10
Per capita consumption of mozzarella cheese (US) Pounds (USDA)	9.3	9.7	9.7	9.7	9.9	10.2	10.5	11	10.6	10.6

Correlation: 0.742652

Source: http://tylervigen.com/view_correlation?id=4493

Things to Consider When Reading Research

Background

- Clear research question
- Clear reason for the work

Methods

- Appropriate for research question
- Appropriate design
- Generalizable & replicable
- Minimizes bias

Results and Conclusions

- Methods support results
- Results are clear
- Data supports conclusions
- Conclusions answer research question

Overall

- Passes a “gut check”
- Comes from a legitimate source
- Unbiased
- Ask questions

Don't believe everything you read!

Example of Review: Hattiesburg Clinic

Comparisons.

Average of PCV-13 & PSSV-23 for 65+ y/0	Average of breast cancer screen	Average of colon cancer screen	Average of Cervical Cancer screen	Average of HTN pts BP <140/90	Average of ASCVD pts LDL <100	Average of diabetes pts A1c < 8
Mississippi Frontline – Targeting Value-based Care with Physician-led Care Teams						
				9.92		76.37
Bryan N. Batson, MD; Samuel N. Crosby, MD; and John M. Fitzpatrick, MD						



Batson, B., Crosby, S., Fitzpatrick, J. Mississippi Frontline – Targeting Value-based Care with Physician-led Teams. *Journal of the Mississippi State Medical Association*. 2022;63:19-21.

Conclusions (!?)

Patients have the best quality of care and cost outcomes when co-managed by physicians and APPs.

Data for “co-managed” patients NOT provided in case study

APPs should not have panels of their own nor see new consults when working as a specialist.

No evidence differences were the result of APP’s having their own panel

Visit attribution suspect; Twice as many physicians saw 13 to 16 times as many patients during the same time period (Tables 2 & 4)

APPs did not provide patients with an equivalent value-based experience.

No APP group breakdown provided – only 10 PAs out of 150 total

Some differences not clinically meaningful

Numerous reasons to question the data

Example of Review: Hattiesburg Clinic

Background

- No clear research question
- Descriptive in nature: “We will review four sets of data that brought us to these disappointing and unexpected conclusions (Quality, Cost, Utilization, and Patient Experience).”

Results and Conclusions

- No summary data: providers, patient characteristics
- Results not always clear
- Most of the results/data do not support conclusions

Methods

- Case study: Single clinic in Mississippi
- Methods are appropriate for the type of research
- Limited generalizability/replicability
- Unclear data points (ie., provider attribution, inclusion in APP) & no rationale for selection of outcomes measures

Overall

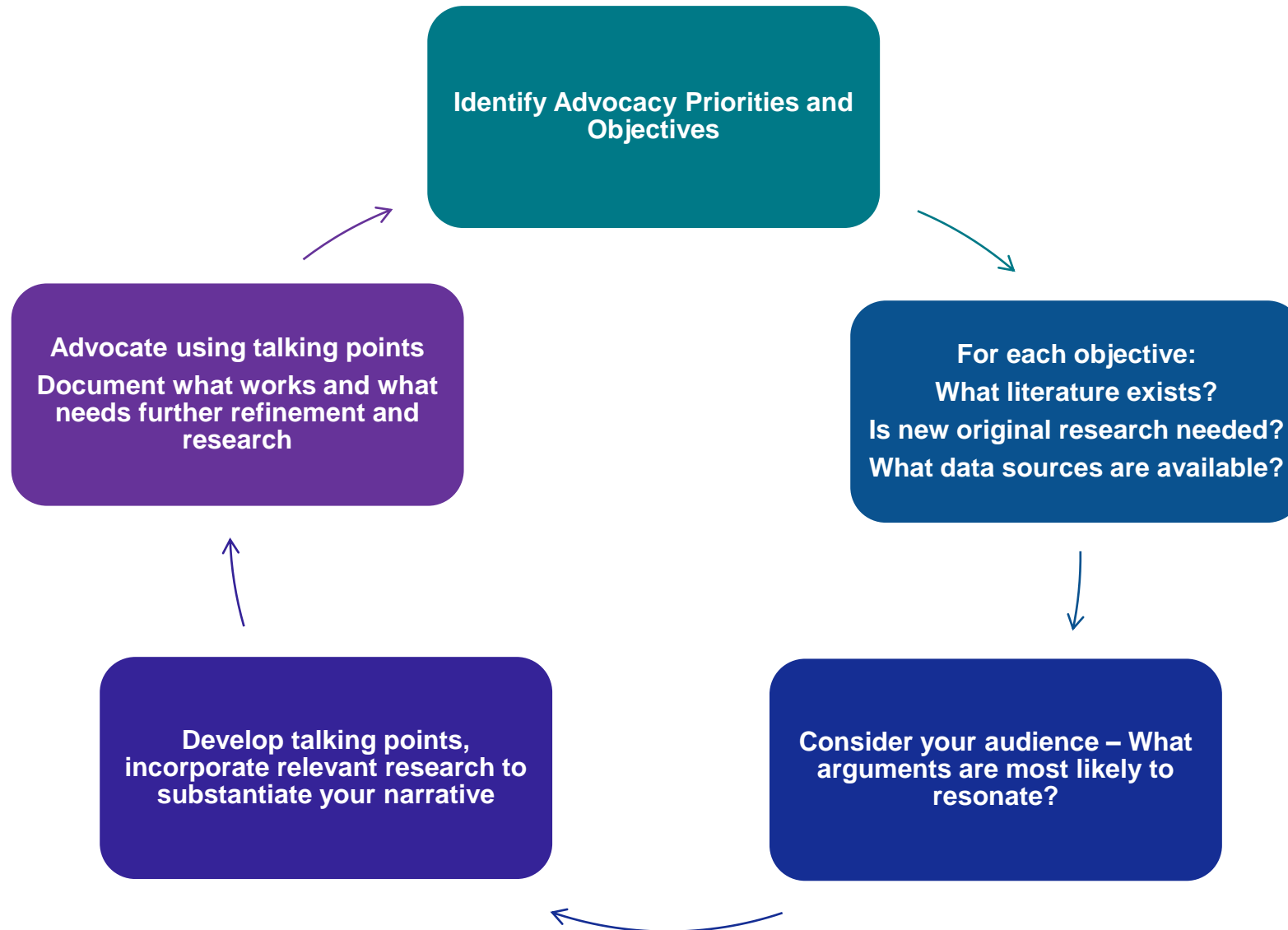
- Shows bias
- NY CO asked authors: How many PAs are included? Just 10 out of 150!
- Statistical significance versus clinical significance

Batson, B., Crosby, S., Fitzpatrick, J. Mississippi Frontline – Targeting Value-based Care with Physician-led Teams. *Journal of the Mississippi State Medical Association*. 2022;63:19-21.

“In Summary, if not for the addition of over 100 NPs and PAs to Hattiesburg Clinic over the last 15 years, our organization could not have provided services to thousands of patients who might have otherwise gone without care.”

An approach for integrating research into your advocacy efforts

An approach for integrating research into advocacy



Building your case...an example

Premise – Greater access to care leads to better patient outcomes

Premise – PAs increase access to care for patients in rural and underserved areas

Premise – Restrictive laws and regulations constrain PAs ability to increase access to care

Conclusion (talking point)

- **Rural and underserved communities stand to benefit from improved laws and regulations governing PA practice**

What Makes Physician Assistant (PA) Training Programs Successful at Training Rural PAs?

KEY FINDINGS

- A survey of United States physician assistant (PA) training programs showed that 57.1% of the responding programs considered training rural PAs to be an important program goal.
- Of those rurally oriented programs, just over half actively recruited rural students. Fewer than half used rural background as an admission criterion or required clinical training in a rural location.
- PA training programs that are successful at training PAs who choose rural practice are likely to combine a rural mission, targeted recruitment of rural students, and specific rural clinical training experiences.

INTRODUCTION/BACKGROUND

When the physician assistant (PA) profession first developed in the United States in the late 1960s and early 1970s, it was strongly promoted as an important part of the solution to an impending shortage of primary care providers in rural areas.^{1,2} PA participation in the rural health care workforce was initially quite high; about 27% of all PAs worked in communities of less than 10,000 population in the early 1980s. Federal policy played a key role in establishing and sustaining roles for PAs in rural health care with the creation of the National Health Service Corps and the passage of the Rural Health Clinics Act of 1977.² More recently, while the number of PAs practicing in rural areas has grown along with the profession (there are now over 100,000 certified PAs in the U.S.),³ the proportion practicing in rural settings has declined steadily over the last three decades. Currently, about 15% of all PAs work in rural areas.⁴ Since the rural health workforce has proportionally more primary care providers than the urban workforce, this decline is partially explained by the emergence of roles for PAs in surgical specialties and sub-specialties of internal medicine. In the early 1970s, about 69% of all PAs practiced in primary care.² Though PA education continued to emphasize primary care, by 2015, the proportion had dropped to 22%.⁵ More stringent admissions requirements, increased length of training, cost of training, emerging roles for PAs in specialty medicine, and substantial salary differentials between primary care and specialty PAs may also have affected primary care participation rates among PAs.⁶⁻⁸ However, even though the proportion of PAs serving rural communities has declined, PAs are an important part of the rural health care workforce. They are more likely than primary care physicians to practice in rural areas,⁴ and they work in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Health Professional Shortage Areas (HPSAs) at high rates.⁹⁻¹¹

Larson EH, Coulthard C, Andrilla CHA (2018). **What Makes Physician Assistant (PA) Training Programs Successful at Training Rural PAs?**

WWAMI Policy Brief #164. Retrieved from:
https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2018/06/RHRC_PB164_Larson.pdf

What Makes Physician Assistant (PA) Training Programs Successful at Training Rural PAs?

Background

- PAs more likely than PCPs to choose rural areas
- Rural PA production is concentrated to few programs
- Programs range from 0% to >50% of grads choosing rural practice

Results and Conclusions

- Most successful programs:
 - (1) have a mission related to rural health
 - (2) target recruitment for rural students
 - (3) have clinical rotations in rural areas.

Methods

- Survey of 194 PA programs in 2016, modeled after MD and NP instruments, high response rate (89%)
- Program responses compared to indicator from previous study identifying programs with high rural output and their distinguishing characteristics

Overall

- Illustrates the proportion of PA programs actively preparing students for rural practice
- Demonstrates what commonalities exist between programs successfully placing PAs in rural areas
- Comes from an organization (WWAMI) known for their research on rural practice and access to care.

Larson EH, Coulthard C, Andrilla CHA (2018). What Makes Physician Assistant (PA) Training Programs Successful at Training Rural PAs? WWAMI Policy Brief #164. Retrieved from: https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2018/06/RHRC_PB164_Larson.pdf

The economic effect of a physician assistant or nurse practitioner in rural America

Fred C. Eilrich, MS

ABSTRACT

Revenues generated by physician assistants (PAs) and NPs in clinics and hospitals create employment opportunities and wages, salaries, and benefits for staff, which in turn are circulated throughout the local economy. An input-output model was used to estimate the direct and secondary effects of a rural primary care PA or NP on the community and surrounding area. This type of model explains how input/output from one sector of industry can be the output/input for another sector. Given two example scenarios, a rural PA or NP can have an employment effect of 4.4 local jobs and labor income of \$280,476 from the clinic. The total effect to a community with a hospital increases to 18.5 local jobs and \$940,892 of labor income.

Keywords: physician assistant, NP, rural healthcare, workforce, economic impact, multiplier effect

The contribution of physician assistants (PAs) and NPs in rural America has emerged as an indispensable asset at a time of diminishing physician resources.^{1,2} Workforce statistics from the federal Agency for Healthcare Research and Quality (AHRQ) showed that proportionately, PAs and NPs, particularly those in primary care, were more likely to practice in rural areas than physicians.³ In addition to providing healthcare, PAs and NPs make economic contributions to rural communities: The increased patient volume from expanded use of PAs or NPs in a rural clinic increases revenue. The increased revenue creates full- and part-time employment opportunities and wages, salaries, and benefits (labor income) for additional clinical staff.

Although undocumented, some factors could affect the volume and type of patients seen by a PA or NP, such as authorization as a primary care provider and hospital

admissions. Furthermore, public and private payer-specific laws and policies determine which services can be billed, payment rates, whether PAs and NPs have provider status with assigned patient panels, and whether they can be paid directly.⁴ Many payers set fee schedules lower for PAs and NPs. For example, the national PA and NP fee schedule from Medicare is 85% of the physician fee schedule amount.⁵

The total economic effect of a PA or NP can be greater when the community has a hospital. The community hospital is not only an integral part of the local healthcare system, but a major provider of jobs and labor income in the community and surrounding medical service area. Additional hospital effects occur when a PA or NP contributes to the local hospital's inpatient admissions and outpatient visits. The increased revenue creates more jobs and labor income for the local economy.

The primary care clinic and local hospital generate direct jobs and labor income from their revenues. In turn, secondary effects occur when the new income is circulated throughout the local economy: Additional jobs and labor income are created as the clinic and clinic employees buy goods and services within the local economy. In some small communities, the addition of just one clinician can have a substantial income multiplier effect.⁶

The importance of a PA or NP and the medical contribution to the community can be measured with quality improvements in residents' health. However, the economic contribution often is not considered or quantified. A report was designed to estimate the total (direct and secondary) economic effects to full- and part-time employment and labor income that rural PAs or NPs have upon the clinic/hospital and ultimately the community they serve.⁷ The results are intended to provide local leaders a model they can apply local data to in order to estimate the economic effect of a PA or NP.

METHODS

Multipliers from an input-output (I/O) model were used to measure the economic importance of a PA or NP to a rural economy. The multiplier measures the interdependence among various producing and consuming sectors of the economy. Any change in economic activity is referred to

Eilrich FC. The economic effect of a physician assistant or nurse practitioner in rural America. *JAAPA*. 2016;29(10):44-48. doi:10.1097/01.JAA.0000496956.02958.dd

Fred C. Eilrich is a project analyst for the National Center for Rural Health Works at Oklahoma State University in Stillwater, Okla. The author discloses that this research was funded by a grant from the US Department of Health and Human Services' Health Resources and Services Administration, Federal Office of Rural Health Policy.

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The economic effect of a physician assistant or nurse practitioner in rural America

Background

- PA and NP medical contributions to a community are often measured by residents' health
- Economic contribution often is not considered or quantified
- 2016 study

Results and Conclusions

- When PAs move to work in rural areas, the area has a positive economic effect, including employment of medical staff, and creation of new jobs in the community
- Total modeled effect was \$280K at clinic with no hospital activity and \$940K at clinic and hospital

Methods

- Modeled after rural PCP economic impact study
- Multipliers from input-output (I/O) model used to measure economic importance of PA/NP
- CMS FTE PA/NP productivity standard = 50% of PCP (!)
- HRSA 0.75 FTE PA/NP to PCP weight for projections

Overall

- Strong quantitative demonstration that PA and NP employment has a positive economic impact on rural or underserved communities.
- Illustrates how PAs and NPs expanding into rural areas can do more than just improve access to care

Eilrich FC. The economic effect of a physician assistant or nurse practitioner in rural America. *JAAPA*. 2016;29(10):44-48. doi:10.1097/01.JAA.0000496956.02958.dd

Impact of nonphysician providers on spatial accessibility to primary care in Iowa

Sean G. Young PhD¹ | Thomas S. Gruca PhD² | Gregory C. Nelson MA, RN³

¹Department of Environmental and Occupational Health, University of Arkansas for Medical Sciences, Little Rock, Arkansas

²Tippie College of Business, University of Iowa, Iowa City, Iowa

³Office of Statewide Clinical Education Programs, Carver College of Medicine, University of Iowa, Iowa City, Iowa

Correspondence

Sean G. Young, PhD, Department of Environmental and Occupational Health, University of Arkansas for Medical Sciences, 4301 W. Markham St. #820-11, Little Rock, AR 72205-7199.
Email: SGYoung@uams.edu

Funding information

College of Public Health at the University of Arkansas for Medical Sciences; University of Iowa

Abstract

Objective: To assess the impact of nonphysician providers on measures of spatial access to primary care in Iowa, a state where physician assistants and advanced practice registered nurses are considered primary care providers.

Data Sources: 2017 Iowa Health Professions Inventory (Carver College of Medicine), and minor civil division (MCD) level population data for Iowa from the American Community Survey.

Study Design: We used a constrained optimization model to probabilistically allocate patient populations to nearby (within a 30-minute drive) primary care providers. We compared the results (across 10 000 scenarios) using only primary care physicians with those including nonphysician providers (NPPs). We analyze results by rurality and compare findings with current health professional shortage areas.

Data Collection/Extraction Methods: Physicians and NPPs practicing in primary care in 2017 were extracted from the Iowa Health Professions Inventory.

Principal Findings: Considering only primary care physicians, the average unallocated population for primary care was 222 109 (7 percent of Iowa's population). Most of the unallocated population (86 percent) was in rural areas with low population density (< 50/square mile). The addition of NPPs to the primary care workforce reduced unallocated population by 65 percent to 78 252 (2.5 percent of Iowa's population). Despite the majority of NPPs being located in urban areas, most of the improvement in spatial accessibility (78 percent) is associated with sparsely populated rural areas.

Conclusions: The inclusion of nonphysician providers greatly reduces but does not eliminate all areas of inadequate spatial access to primary care.

KEYWORDS

advance nurse practitioners, physician assistants, primary care, spatial access

Young SG, Gruca TS, Nelson GC.
Impact of nonphysician providers on spatial accessibility to primary care in Iowa. *Health Serv Res.* 2020;55(3):476-485.
doi:10.1111/1475-6773.13280

1 | INTRODUCTION

The aging of the US population, the obesity epidemic, and insurance reforms are increasing the demand for primary care services.^{1,2}

At the same time, the number of adult primary care physicians is not expected to grow at a pace sufficient to meet this expected increase.^{3,4} High levels of professional burnout among family medicine physicians⁵ and an increasing number of primary care doctors

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Impact of nonphysician providers on spatial accessibility to primary care in Iowa.

Background

- Demand for primary care is increasing, PCPs not growing fast enough to meet demand
- Access to care steps = 1) insurance, 2) physical proximity, and 3) capacity of providers
- What is the impact of PAs and NPs on spatial access (2 & 3) to primary care in Iowa?

Results and Conclusions

- The addition of PAs and NPs to the primary care workforce reduced unallocated population by 65 percent (2.5% of IA population)
- Most gains come from sparsely populated rural areas

Methods

- Constrained optimization model to allocate demand (population) to capacitated supply (providers)
- 423 PAs at FTE = 0.89, 1,114 NPs at FTE = 0.59
- Population data from American Community Survey
- Info on geographic HPSAs for primary care from HRSA

Overall

- Strong quantitative methodology with good data sources
- NP FPA in IA provides comparison to non-FPA/OTP states
- Highlights challenges posed by urban/rural providers maldistribution on primary care access
- Opportunity to improve HPSA determinations

Young SG, Gruca TS, Nelson GC. Impact of nonphysician providers on spatial accessibility to primary care in Iowa. *Health Serv Res.* 2020;55(3):476-485. doi:10.1111/1475-6773.13280



Impact of state scope-of-practice laws on nurse practitioner-provided home visits



Zainab Toteh Osakwe, PhD, NP^{a,*}, Ryung S Kim, PhD^b, Chinedu U Obioha, MSc^a, Jennel C Osborne, RN, MSNed, MPhil, PhD^c, Nafin Harun, MA^d, Rose Saint Fleur-Calixte, PhD^e

^a College of Nursing and Public Health at Adelphi University, 1 South Avenue, Garden City, NY, 11530, United States

^b Department of Epidemiology and Population, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, NY 10461, United States

^c Harriet Rothkopf Helmsman School of Nursing, Long Island University, 1 University Plaza, Brooklyn, NY 11201-5372, United States

^d Center for Health workforce Studies, School of Public Health, University of Albany, SUNY, 1 University Place, Ste 220/Rensselaer, NY 12144, United States

^e Department of Community Health and Social Medicine, CUNY School of Medicine, Townsend Harris Hall, Suite 313, 160 Covert Avenue, NY 10031, United States

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ABSTRACT

Millions of older Americans receive nurse practitioner (NP)-provided home based primary care (HBPC). Little is known about how state scope-of-practice (SOP) laws may impact use of NP-home visits. Using 2017 Centers for Medicare and Medicaid Services Provider Utilization and Payment Data Public Use File (PUF), we examined the impact of state SOP laws on the use of NP-home visits. The PUF file was merged with the 2017 American Community Survey to assess area-level median income. Over 4.4 million home visits were provided to 1.6 million Medicare beneficiaries. NPs represented the largest share of providers (47.5%). In states with restricted SOP laws, compared to NPs, physicians and physician assistants had higher odds of providing HBPC. In states with reduced SOP laws, compared to NPs, physicians and PAs had decreased odds of providing HBPC. Our study provides evidence that SOP restrictions are associated with decreased utilization of NP-provided HBPC.

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Introduction

A large and growing population of older adults in the United States are home bound. Homebound individuals have difficulty accessing office-based care, leading to poor health outcomes such as higher rates emergency department (ED) visits and hospitalizations.^{1,2} The use of home based primary care (HBPC) is one approach to prevent these poor outcomes, by bringing medical care to the homes of individuals who have difficulty accessing office-based care.^{3–6} Despite the apparent benefits of HBPC, recent data points to the severe shortage of HBPC providers, with only about 12% of the nation's 2 million homebound patients receiving HBPC.^{5,6} The current HBPC provider scarcity is in part due to the escalating primary care physician shortage.^{3,7} This shortage is projected to intensify as the population ages and the national shortage of primary care physicians escalates.⁸

While access to HBPC is a growing national concern, it poses a serious problem in rural areas, which have long faced health professional shortages and barriers to needed healthcare services.^{9–11} About 77% of rural counties are designated as Primary Care Health Professional Shortage Areas (PC–HPSAs).¹² Earlier work has shown that residents of rural

areas live more than fifteen or thirty miles from any provider who makes substantial number of home visits.¹³ Nurse practitioners (NPs)—the fastest growing segment of non-physician primary care providers,¹⁴ represent a valuable group of providers that can help address the HBPC workforce shortage. The NP workforce will increase by an estimated annual growth of 6.8% compared to 1.1% for physicians by 2030.⁸ Indeed, NPs are increasingly utilized in the provision of HBPC in the U.S.^{15,16} Despite this reliance on NP-home visits, barriers exist that prevent NPs from being optimally utilized in the delivery of HBPC in the U.S. Notably, state-based regulations that guide NP practice are defined by scope of practice (SOP) laws. SOP laws vary by state, and in some states, limit the ability of NPs to provide care without direct physician oversight.¹⁷ In addition to these state-based regulations, some payers have restrictions that impose additional restrictions to NP autonomy. For example, Medicare accountable care organization (ACO) regulations stipulate that patients managed by NPs cannot participate in ACO models unless first seen by a qualified physician.^{18,19} In the delivery of HBPC, an NP's ability to perform services such as signing a 'Do Not Resuscitate' order or prescribing controlled medications for symptom-control also varies depending on the state in which the NP practices.²⁰ Researchers have found that less restrictions on NP SOP improves access to NP-provided care.^{21,22} Yet, no study to our knowledge has investigated the impact of SOP laws on the use of NP-home visits.

*Corresponding author.

E-mail address: zosakwe@adelphi.edu (Z.T. Osakwe).

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Impact of state scope-of-practice laws on nurse practitioner-provided home visits

Background

- Use of Home-Based Primary Care (HBPC) one approach to prevent poor outcomes in older home bound adults
- Access to HBPC is serious issue in rural areas
- Little known about impact of SOP laws on use of NP-home visits

Results and Conclusions

- In states with restricted NP SOP laws, physicians and PAs had higher odds of providing HBPC.
- In states with reduced NP SOP laws, physicians and PAs had decreased odds of providing HBPC.

Methods

- Cross-sectional analysis of 2017 CMS provider utilization and payment data merged with 2017 American Community Survey data
- Identified clinical visits to private residences
- Classified states based on 2016 NP SOP laws

Overall

- National in scope study provides evidence that SOP restrictions are associated with decreased NP provided HBPC
- May be useful in drawing parallels to impacts of PA SOP restrictions, methodology is clear and replicable for PAs
- No detail on specific components of restrictive laws that may be driving impact

Osakwe ZT, Kim RS, Obioha CU, Osborne JC, Harun N, Saint Fleur-Calixte R. Impact of state scope-of-practice laws on nurse practitioner-provided home visits [published online ahead of print, 2021 Apr 3]. *Geriatr Nurs*. 2021;42(3):674-680. doi:10.1016/j.gerinurse.2021.03.002

Example of Talking Points

AAPA research has found that PAs are interested in rural and underserved areas (AAPA 2022). This is similar to research with psychiatric nurse practitioners (Chapman 2018).

Research from Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center (RHRC) has shown that PA programs that have a mission of training PAs to work in rural locations, that actively recruit students from rural areas, and place students in clinical rotations (Larson 2016, Larson 2018).

There is a dearth of strong research that addresses the distribution of PAs in rural areas, particular in more recent years (Henry 2011).

In a few demonstration projects, when NPs have been granted full practice authority, a greater proportion of NPs have moved into rural areas. Even when the majority of the NPs have moved to urban areas, there is still a significant increase in access to care for patients in rural locations (Young 2020, Holmes 2019, Patel 2019, Barnes 2018, Neff 2018, Yang 2017).

Example of Article Summaries to Support the Talking Points

PAAs increase access to care by working in rural and underserved areas

AAPA 2022 PA Interest in Rural Settings, Medically Underserved Areas, and Health Professional Shortage Areas

Objective: To identify PAs perceived barriers to rural practice and their willingness to work in rural settings.

- Interest in working within a rural setting varied among PAs based on their specialty and years clinically practicing.
- Perceiving rural locations as undesirable or lacking job opportunities for spouses were significant barrier to the willingness to practicing in these settings.
- While PAs recognize there are job opportunities in rural areas, the willingness to practice in these locations varied by career experience, specialty, and where they grew up.

Patel 2021 Role and Growth of Independent Medicare-Billing Otolaryngologic Advanced Practice Providers

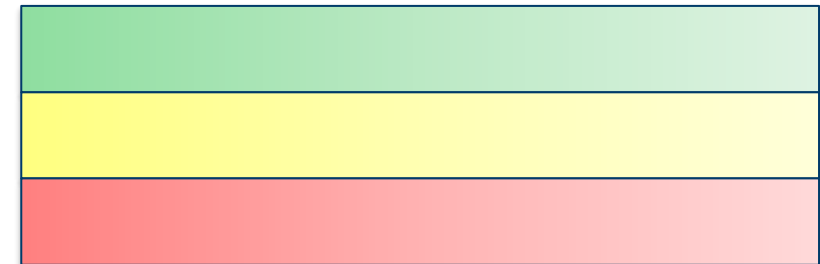
Patel RA, Torabi SJ, Kasle DA, Pivirotto A, Manes RP. Role and Growth of Independent Medicare-Billing Otolaryngologic Advanced Practice Providers. Otolaryngol Head Neck Surg. 2021;165(6):809-815. doi:10.1177/0194599821994820

Objective: “To evaluate the role and growth of independently billing otolaryngology (ORL) advanced practice providers (APPs) within a Medicare population.”

- There is a significantly greater proportion of APPs working in otolaryngology in rural settings compared to physicians.
 - In 2017, 13.6% of APPs in otolaryngology were in rural areas compared to 8.4% of physicians in otolaryngology.

Pause for Discussion

What is one action you plan to take following this session to more effectively integrate research into your advocacy efforts?



**The best people to show the
value of PAs are PAs.**

Final Thoughts

Benefits of Research Know-How

1. Show value of PAs
2. Counter inaccurate claims about PAs
3. Advocate for PA-positive legislation
4. Advocate for better PA-environment in employment setting
5. PAs have a better work environment and more opportunities
6. Patients have greater access to higher quality care

Questions

Contact us at Research@aapa.org

Learn more at: www.aapa.org/research

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