Past Event: 2022 NCSBN APRN Roundtable- Impact of COVID-19 Pandemic on APRN Practice: Results from a National Survey Video Transcript

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Event
2022 NCSBN APRN Roundtable

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Presenter
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- [Ruth] Well, it's my distinct pleasure to be participating this year at the National Council of State Boards for Nursing, APRN Roundtable. I'm going to be presenting today on behalf of my colleagues on the results of a national survey that we conducted during the COVID-19 pandemic, to really focus on identifying barriers that existed for APRN practice before the pandemic, and also the impact of the COVID-19 pandemic on APRN practice.

I'm Ruth Kleinpell and I'm currently at Vanderbilt University School of Nursing, and together with Mavis Schorn, who's at Vanderbilt, we collaborated with Carol Myers who's at the University of Tennessee College of Nursing, and Wendy Likes who's at the University of Tennessee Health Science Center College of Nursing. I have no disclosures as it relates to this presentation.

And, as we all can acknowledge, the pandemic was certainly a challenge to the healthcare system and it certainly impacted Advanced Practice Registered Nurses. Within our state of Tennessee, we initially embarked to conduct a survey that would be statewide to look at the impact of the COVID-19 pandemic.

And once we started to network with others nationally, there was a need to really look at nationally what was occurring with respect to APRN practice. So that was really the result of why we launched the survey at a national basis. Shown here on this slide from the American Association of Nurse Practitioners, there were a number of states that had executive orders issued during the COVID-19 pandemic.

In fact, a total of 21 states had executive orders that were issued. There were 5 in which APRN restrictions were lifted in entirety and then the remaining 16 had easing of some restrictions and Tennessee was one of those states. We had an executive order that was issued in March of 2020 that removed some of the requirements for APRNs to have their mandatory chart reviews and their every 30-day visit by the collaborating physician, among other minor releases to APRN practice.

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And so, we wanted to see what the impact of that was but also had interest in looking at the impact of the executive orders that were also issued in other states. We were able to publish the results of the survey that parent study in nursing outlook and I'll be highlighting today some of those results as well as some of the ongoing work that we're doing with respect to the survey.

So the survey was national, as I indicated, and the focus was really on describing the pre-pandemic state practice barriers that existed for APRNs to determine the effect of the pandemic-related executive orders in states that had reduced or restricted practice, and then also to explore the effects of the pandemic on APRN practice.

We had a number of respondents nationally. The survey was launched on June 1st, 2020, and closed on September 23rd, 2020. And we had 7,467 APRNs respond that represented all 50 states. As shown here, majority of the respondents, over 6,000, were nurse practitioners, but we also had representation from the other APRN roles including certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialist.

And we have to acknowledge all of our colleagues from their respective specialty organizations and from the AARP, Access to Care Coalition, and others that really helped us disseminate the information out to states and we also individually contacted the State Board of Nursing and Executive Director.

So we owe a huge thank you to all of those who helped to disseminate the survey and resulted in us having the sample size that we did. So with respect to respondents by region, we had representation from all four regions of the United States. More, however, from southern states, and we felt that that was because we were located here in the south and we did actively disseminate quite heavily to our colleagues within our region.

We did receive responses as indicated from all 50 states and this map shows the respondents with respect to those states where we had greater than 500 and ranging then from states that we had less than 50.

But it still gave us the ability to look at practice in all of the states as a result of having representation. We also had representation and I think this is an important part as shown in this map. We had representation from states that had reduced practice, restricted practice, and full practice authority and this will come into play later when I highlight some of the results.

But we were able to really look at the differences between State Practice Authority states. Now, Tennessee is a reduced-practice state and we had intently wanted to look at what practice had impacted APRNs in Tennessee because that's the state where we reside but we were also able to do that in other states as well. So as shown on this slide, with respect to practice setting, we had a mix of individuals practicing in urban as well as suburban and rural settings.

We also were able to look at length of time employed as APRN and majority had at least five or more years of experience to be able to reflect... I think this is important to be able to reflect on their APRN practice, specifically as it relates to barriers to practice and how that over time has impacted patient access to care and patient care in general.

Additionally, as shown on this slide, with respect to Practice/Work Settings, we had a number of individuals working in a variety of settings, including Ambulatory/Outpatient, Inpatient, Long Term

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Care as well as other settings. As shown on this slide, majority of respondents had a master's degree or a Doctor of Nursing Practice.

And in terms of barriers to practice, pre-pandemic, the barriers that were reported most frequently, as shown on this slide, range the gamut in terms of looking at aspects of APRN practice, whether it was home health approval being restricted or hospital admitting privileges or the need to have a collaborating or supervising physician, or the need to have physician co-signature on orders.

These were actually the most frequently reported barriers to practice that existed pre-pandemic. Additionally, requirements for paying collaborative/supervising physician, the ability to have prescriptions needing a physician co-signature, and then supervision of procedures even within APRN scope of practice. And, we know that these continue to exist today.

Other barriers that were identified pre-pandemic is the inability to initiate Do-Not-Resuscitate orders or the ability to sign birth certificates. So we intently looked at the Impact of the COVID-19 Pandemic on APRN practice and saw a number of ways that the pandemic had impacted APRN practice.

And, in fact, APRNs were really showcased well on national media and news with respect to the intent roles that they took upon themselves to really help to improve screening and access a number of ways that they were looking at reconfiguring their roles to having CRNA serve on airway teams, and intubation teams working in intensive care unit settings, working in different settings within their health system network.

Others were identifying factors that they encountered with respect to the pandemic, even looking at being responsible for overseeing that staff knew the correct ways of donning and doffing and protective personal equipment and isolation precautions.

Other ways that APRNs indicated the pandemic impacted their practice was with respect to telehealth visits. Some were asked to do other aspects of duties or being deployed and some had to travel as a result of the pandemic to help with coverage in other areas of their health system or in rural areas.

Other impacts of the pandemic on practice was having to work in other specialty areas due to patient care needs, having altered schedules because of perhaps fewer patients being seen in the clinic setting, or being furloughed or for instance elective surgery stopping and having to relocate and practice as an APRN in another area. Other areas and this I think was really one of the take-home messages for me is that we saw barriers to practice reported in all practice environment states, whether it was reduced, restricted, or full practice authority.

Now, being an APRN myself for over 20 years I think I've always had this perception that in full practice authority states that there are no barriers to APRN practice and that in case was not accurate. We had reports from those practicing in full practice authority states that, in fact, they encountered the same barriers that were reported by colleagues in reduced and restricted practice states.

And those ranged from restricted hospital admitting privileges to restricting such things as home health ordering, still requiring physician co-signature, and even supervision of procedures that were in their scope of practice. As shown here on this slide in all practice environment states reduced, restricted, and full practice authority, APRNs were reporting that they still had difficulties with respect to being able to order supplies, durable medical supplies that were requiring physician signature, prescriptions still needing co-signature.

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They had encountered opportunities where they were trying to refer or consult others but it was declined because they weren't APRN or they were restricted based on health insurance credentialing. So regulatory barriers were very predominant in the APRN reports in the survey, and obviously, those range from the fact that APRNs receive only 85% reimbursement.

physician payment was required for collaborating physicians, they were restricted with respect to ordering certain tests or procedures, or again needing a co-signature for orders. So we were able to publish since that original parent study a number of additional aspects related to the survey.

We recently had a publication in Nursing Administration quarterly, where we were able to highlight the key role that nurse administrators play in reducing institutional barriers to APRN practice. And many of these barriers are ones that we can address in our daily care in terms of really identifying what is within our hospital system or clinic bylaws, and how can we start to make changes on some of those restrictions to APRN practice.

So as shown on this slide, some of the institutional barriers to care that were reported were such things that hospital bylaws restricted on practice unnecessarily. Such things as orders being required for blood products, or durable medical supplies, looking at procedures, needing supervision, or, again, they were declined as a referring or consulting provider, or in some cases, lab results were not given to them because it went directly to the collaborating physician versus the APRN.

So certainly, with respect to implications, really looking at removal of unnecessary barriers, particularly in these institutional or non-regulatory barriers to ensure that, for instance, APRNs have representation on medical staff committees, or that we look at institutional barriers that exist and actively advocate for their removal, and look at, again, reviewing bylaws and actively advocating to remove barriers to APRN practice that really are outdated.

We were able to also publish. This was one that was recently published in Policy, Politics & Nursing Science, looking particularly at barriers to practice and how they varied in different types of practice environments, restricted versus reduced versus full. And as shown here on this slide in this table, it highlights that, again, across the board, APRNs practicing in all types of practice environment states reported similar barriers and I think that this is really something for us to start to address nationally.

I think in those states that were trying to advocate for full practice authority that's beneficial but we also need to be looking at once we get full practice authority, how can we ensure that institutional barriers or other non-regulatory barriers to APRN practice can be removed?

And as shown here on the second half of this slide, the barriers really range from a number of key areas, whether it is reimbursement related or such things as even the requirements for collaborative practice agreement payments, and physician-only procedures within the organization. So one of our initial areas of focus was really looking at the state of Tennessee.

And so we were able to conduct a secondary data analysis and do really focus groups with APRNs from the state of Tennessee as a particular focus as well. So we were... Dr. Carol Myers was able to work with her colleagues to interview 15 APRNs from the state of Tennessee as a secondary component of the national survey and they did interviews with these APRNs and found a number of findings that the state practice barriers did not improve patient care outcomes and that the supervisory requirements really impose unnecessary expense and wasted time for both physicians as well as APRNs.

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And oftentimes, that care is impeded due to outdated supervisory requirements. Tennessee is one of only 11 restricted practice states. It requires a collaborative practice agreement with a physician. It requires a monthly collaborative practice fee to the physician. It limits APRN practice with respect certain aspects.

We're only one of four states where APRNs cannot prescribe physical therapy and this was really an eye-opener for me. I had lived and worked for over 15 years in the State of Illinois which is a reduced practice state. And after relocating here to Tennessee, the past seven years, I really see the impact of a restricted practice state in terms of APRN practice and have actively worked to help advocate for removal of those as well.

We were also able to look at specific comments that were made by APRNs with respect to the mental health challenges not only to patients but also to health care providers. So Dr. Carol Myers lead another manuscript that is published in Issues in Mental Health Nursing that just focuses on this aspect.

They were able to really look at with those Tennessee's APRN interviews the impact on mental health. And here are just some of the select findings that the APRNs reported in those interviews were really there was a shortage of psychiatric care. Really the issues in trying to manage patients during the pandemic who were really undergoing quite stressful conditions and truly trying to provide care to them was a challenge to APRNs as well.

The use of telehealth was something that we saw widespread nationally evolve and really helped to change the landscape for APRN care and we know that telehealth will continue to remain an important component of care. But some of the highlights of the interviews that reflected on telehealth was that most of the respondents, the APRN respondents, did not use telehealth prior to the pandemic but were using it daily during the pandemic and we know that it really has changed the landscape with respect to the use of telehealth in healthcare.

So that has been a positive thing that has occurred with respect to the pandemic. So, in summary, I wanted to highlight a bit about some of the barriers to APRN practice that the APRNs reported. And, you know, it was clear that even in full practice authority states barriers continue to exist. The waivers that changed majority of APRN practice, in fact, in our state of Tennessee, the waiver was lifted in May.

So it was just several short months of being in effect. I know that there are states where the barriers were lifted and remain lifted, and that's positive. In other states, they really will not be reimposed and that's also beneficial as well. But I think the pandemic highlighted that APRNs rose to the occasion to be able to meet healthcare needs and did so without any undue impact when waivers were released.

So that therein lies really evidence that these barriers are unnecessary to APRN practice and should be removed. We saw that the APRN workforce was deployed in a number of ways during the pandemic to help meet healthcare needs.

And in some cases were even impacted economically if they were working in clinics that were closed or that saw a decrease in patients. So with respect to implications, obviously we know nationally that we need to continue to address barriers to APRN practice. We need to actively support and advocate for removal of these barriers. We need to advocate that CMS approve APRNs as healthcare providers who can order such things as home health or diabetic shoes or durable medical equipment and to really advocate that insurance companies limit their prohibiting of limited credentialed providers to physicians alone.

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So we hope that the results can also be used to support APRN Full Practice Authority. That is one of the ways that we're using the data here in the state of Tennessee. In terms of actionable steps, we've actually been able to implement some of these initiatives here within our state and advocate for others to do the same.

Certainly, a first step is to address your State Practice Barriers and then also to learn from those who have successfully removed barriers within their state. So as I indicated, Tennessee is one of those 11 states that has restricted practice. It really is a barrier to practice with respect to having a lifelong supervision of a physician collaborating practice agreement, the requirement to pay a collaborating physician on average within the state, it's about $1,500 to $3,000 per APRN.

And Tennessee is one of those 15 states nationally that has no limits to the number of APRNs that a physician can supervise or oversee or collaborate with. And, on average, physicians are making $74,000 or more with respect to serving as a collaborating practice physician within the state.

So it really is time to address removal of some of these barriers. So as a result of our participation in the survey, we were able to publish in the Tennessee Nurse Association and present twice at their conference to really help disseminate not only the results, but also strategies to our APRN colleagues within the state of Tennessee.

We were also able to create infographics and other messaging to our state legislators and we have actively been outreaching to all of them to share the stories that we have heard within the interviews, but also to share the results of the national survey to our state legislatures. We recently wrote an op-ed in "The Tennesseean", which is our local newspaper, to really highlight the importance of removing outdated restrictions on APRN practice.

Now, within the state itself, we have been advocating since 2015 with legislation and have not been able to have it successfully passed. And most recently in the session currently, we had a bill that was supported and it was discussed within our Commerce Committee.

It did not move out of committee but there definitely has been positive support for removing APRNs. There was a Senate hearing and I just want to share with you a little clip of this because I think it really highlights that legislators are finally realizing here within our state due to the ongoing advocacy, not only of the Tennessee Nurses Association, but of APRNs individually and collectively, that barriers to practice need to be removed.

- [Senator Bailey] All right. Members, we're now back on the calendar item number 24. Senator Lundberg, should we take a break before this deal?

- [Senator Lundberg] Mr. Chairman, are you in a yes mood?

- Yes.

- Yes? Then, no, we shouldn't take a break.

- Depends on what the question is. Chairman Lundberg, you're recognized on Senate Bill 0176.

- Thank you, Mr. Chairman. We were here a year ago with the same bill. And a year ago, we talked about Advanced Practice Registered Nurses and the scope of practice. And I would love to tell you that a lot has transpired over the last year. Unfortunately, Mr.

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Chairman, that is not the case. So let me go back to telling you what this bill will do. If the bill were passed today, what would change with Advanced Practice Registered Nurses? Nothing. Nothing would change in the scope of practice of what these APRNs are able to do. What it would change is what's called the collaborative care between doctors and nurses.

And this is not an anti-physician bill, not at all. Physicians are a vital, critical, important not only to our health but our economy. But we took what was collaborative care, which was supposed to be a care model, and it became Mr.

Chairman and committee, a business model where these nurses submit their charts for review 30 days after they were reviewed. And, Mr. Chairman, I think that's that's unfair. I'd like to pass something out to the committee if I may, Mr. Chair.

- Yes, you may, sir. One of the clerks can assist us in this.

- And to get the bill before us, I do have an amendment, Mr. Chairman.

- The Chair will move the Senate Bill 0176. Vice-Chair Swann will be second on the motion of Senate Bill 0176. There is an amendment that makes the bill, is that correct Chairman Lundberg? Okay.

This is amendment 015713.

- Yes, sir.

- The chair will move the amendment. Vice-Chair Swan will be second on the motion to the amendment and you're recognized on the amendment, sir.

- Thank you, Mr. Chairman. And just following up, in the conversations we've had with TMA, and when we were here a year ago, Julie Griffin from TMA and I don't know if she's in the audience right now, stood before you and she looked at me and I trust her greatly. I have a very solid relationship, I believe with her. And she said, "You and I will sit and chat."

And you asked us to sit and chat and us being those nurses and physicians. Well, the last meeting we had was December 13th and I came up from Bristol for that meeting. It was a very short meeting, took four minutes because I was irritated that decision makers from the physicians weren't available.

Well, literally four days later, Molly Pratt, representing TMA, called my office and talked to my legislative aide. And at that time, I said, "I want you to write down as close to verbatim that conversation so that I can share it with this committee." Mr. Chairman, that is what you have before you. And here it is, "The doctors are philosophically opposed to this legislation. There is no common ground to be found between the TMA and TNA in this bill. A joint coalition meeting to go through this bill section by section in an attempt to find compromise and common ground would be a waste of your time and that isn't something she wants to do. She does not want to anger you further by having to drive to Nashville for a meeting to hear the same thing from the doctors that was said by lobbyists last week. There is no room for this discussion."

Meanwhile, during the pandemic, we lifted that collaborative care so that that practice could take part. In the amendment you have before you, which is a continuation of that what we did is said, "Okay, let's graduate this in." We took the counties that are identified by ECD as rural counties, and there are 90 of them, and said, "Let's grant full practice authority in those 90 counties right now."

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And that's, in general, what the amendment does, Mr. Chairman. And again, whether it's the amendment or the bill, I will tell you and reiterate to you that the scope of practice does not change. We often, when we talk about legislation, we're referring to a regulatory scheme.

This financial scheme, not by all physicians, but by some as a business model needs to end. Because if you're a physician and you have 20 APRNs who report to you, and you charge each of them $2,000 or $3,000 a month for chart review, you can do the math, that's a pretty good little side business.

And, Mr. Chairman, I don't know where you want to go. I'm sure both sides are here. I know the APRNs are, I'm sure the TMA is here and would like to rebutton so... But we all know, frankly, the contents of this bill and I tell you, that statement right there from what came to my office four months ago, is accurate and I don't think there is room for the other side to talk.

So Mr. Chair depends on where you want to go.

- Thank you, Chairman Lundberg, and certainly appreciate your diligence that you've given on this bill. Members, you've heard an explanation of the amendment. We'll adopt the amendment to go on to the bill. Are there questions regarding the amendment before we adopt it and come back for questions and statements regarding the bill?

Seeing none, you're voting to adopt the amendment to go on the bill. Those in favor say aye. Aye. Opposed like sign amendment is on the bill. We're back on the bill as amended. Questions for the sponsor. Let me say, Chairman Lundberg, that there are several members of this committee and others that have worked diligently with you in the past several weeks to get it to where it is today.

And so as the chair of the committee, I personally thank you for your willingness to work with those that have worked with you.

- Thank you, Mr. Chairman. And, I appreciate the input.

- And so we appreciate that very, very much. You know, we have this bill and then there's another bill, which is the Physician's Assistant Bill, that's also moving through the legislature. And what would really be good is if all of those could be combined together and we have one comprehensive bill to address the entire situation that we're faced with.

And as someone that represents a rural district, I can tell you that if it hadn't been for PAs and Nurse Practitioners, especially during the pandemic, we wouldn't have had health care. And when you represent a small rural county, that's all they have, and as far as health care providers are either a PA or an NP.

I certainly believe that this legislation is definitely needed. However, I will say that I would like to see a complete comprehensive bill that would encompass all of those.

And what I would say is that, if this committee would so choose, we would like to be a task force for this coming summer and make sure that we have all stakeholders involved from the nurse practitioners to the physician's assistant with your leadership, in this and see if we can't come back next year and pass early on in session, a good comprehensive bill, taking all of these ideas that you've placed in this amendment for all of those that would be effective.

Chairman Watson, you're recognized.

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- [Senator Watson] Well, I want to say a number of us on this committee have been down this path before with other areas. I remember sitting in a committee talking about Certificate of Need and hearing that the hospitals wouldn't go here and the surgical centers wouldn't go there. At the end of the day, sometimes the arrogance of these groups get out in front of them.

At the end of the day, it is our responsibility to determine what the policies will be. I think while I've read the comments that are on this piece of paper, I think it is up for us to set what the goalposts will be. If the committee chooses to do a task force, I hope I would be able to participate in that because of my experience, having worked on the Certificate of Need process demonstrates that if the legislature decides where they want an issue to go, then they have the ability to guide and direct the different stakeholders in that direction.

And so I think if we go in that direction, I would hope to be a part of it because I've seen how effective that can be when the legislators get in the room and work out the problems, and not leave it to the special interest groups to work them out.

- Thank you, Chairman Watson. Chairman Lundberg, you're recognized.

- Thank you, Mr. Chairman. I don't disagree. And just a parliamentary or a procedural question for you, because the other bill that you refer to about PAs was not assigned to Commerce, but I think directly to Health. To merge those then would it come out of here to Health because I would pledge then to stop there and with a sponsor, I think it was Senator Bell's bill.

I'm just curious logistically.

- Well, as as far as you know, and I will certainly yield to other members, I understand that if your bill moved out of this committee that it would go to the Health Committee. However, in my opinion, that you would be better served, having us work on the task force trying to merge those together and move on whether the bill came out in next session all the way into Health or it moved through here first, you have our commitment.

Because, as you know, many members on this committee have worked with you for the last several weeks. You have our commitment that we will do due diligence regarding this legislation and putting a taskforce together. So I understand your question but I think that there's many members on this committee that are with you and for you.

But we would definitely like to see us be able to work with you on this task force. Chairman or Senator Reeves you're recognized.

- [Senator Reeves] Appreciate that. And I'd very much like to be on this task force as well. I know you've worked hard on this. I know there's a lot of groups that are very frustrated by this that are trying to bring it together. But this is a trend. It's happening nationwide. There's no question about it that we're going to have to find a way to get nurse practitioners and PAs in situations where they can function in some of these rural communities.

And I think one of the things that made the CoN process so effective, Chairman Watson, is that we went into it with the attitude of we're going to pass something and to me that really kind of set the bar. So we're going to pass something. I think that's fair enough.

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- Members, I will..are there further questions? Seeing none, I will move to send Senate Bill 0176. We're not doing a summer study but we are creating a task force. I'm assuming Chair Watson will be second on that motion. And so you're voting to since, without objection, we'll do this by voice vote.

Those in favor of Senate Bill 0176 going to a created Task Force say aye. Aye. [Inaudible] Ayes have it. Let the party begin, Senator Lundberg.

- Thank you, Mr. Chairman. And, thank you, committee. And if I may, I do appreciate the input and the direction and I think we all want to achieve the same goal.

- So as you can see, in that video clip, there is growing awareness from our state legislatures to really look at removal of barriers. We have been challenged, however, because of resistance from our State Medical Association. But we're hopeful that we can see some positive changes in the next legislative session. Now, one of the other strategies I highlighted was really looking at lessons learned from other states and I was able to have a conversation with Mary Graff, who's a good friend and colleague I served with on the board of the American Nurses Credentialing Center.

And while time does not allow me to play that video clip, I did want to highlight that, you know, Mary has been really an advocate in her state, mobilizing APRNs and others to look at removal of unnecessary restrictions within their state. They started in 2016 with really trying to raise awareness of legislatures. They have weekly visits to the legislature that Mary helps to lead and take others down.

They take information flyers, with take-home messages. They really have helped to be able to showcase to the legislators the importance of removing APRN barriers, and they feel they'll be successful. This next session, they have over 100 legislators that have now signed on to their bill.

So I think we need to really network a bit more in terms of what are strategies that other states are finding useful and replicate those as well. So thank you so much. I look forward to our open discussion. I really want to hear the stories of others with respect to strategies that you have used within your state.

So, thank you so much.

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