

ARKANSAS

POLICY RECOMMENDATIONS

ADDRESSING ARKANSAS'S
HEALTH SERVICES SHORTAGES BY
EMPOWERING NURSE PRACTITIONERS



**ARKANSAS CENTER FOR
RESEARCH IN ECONOMICS**

UNIVERSITY OF CENTRAL ARKANSAS

The Problem

Arkansans do not have enough primary care health service providers. This shortage makes it difficult for patients to see health service providers and manage chronic conditions. Rural patients, people on Medicaid, and children in ARKids are especially vulnerable.¹

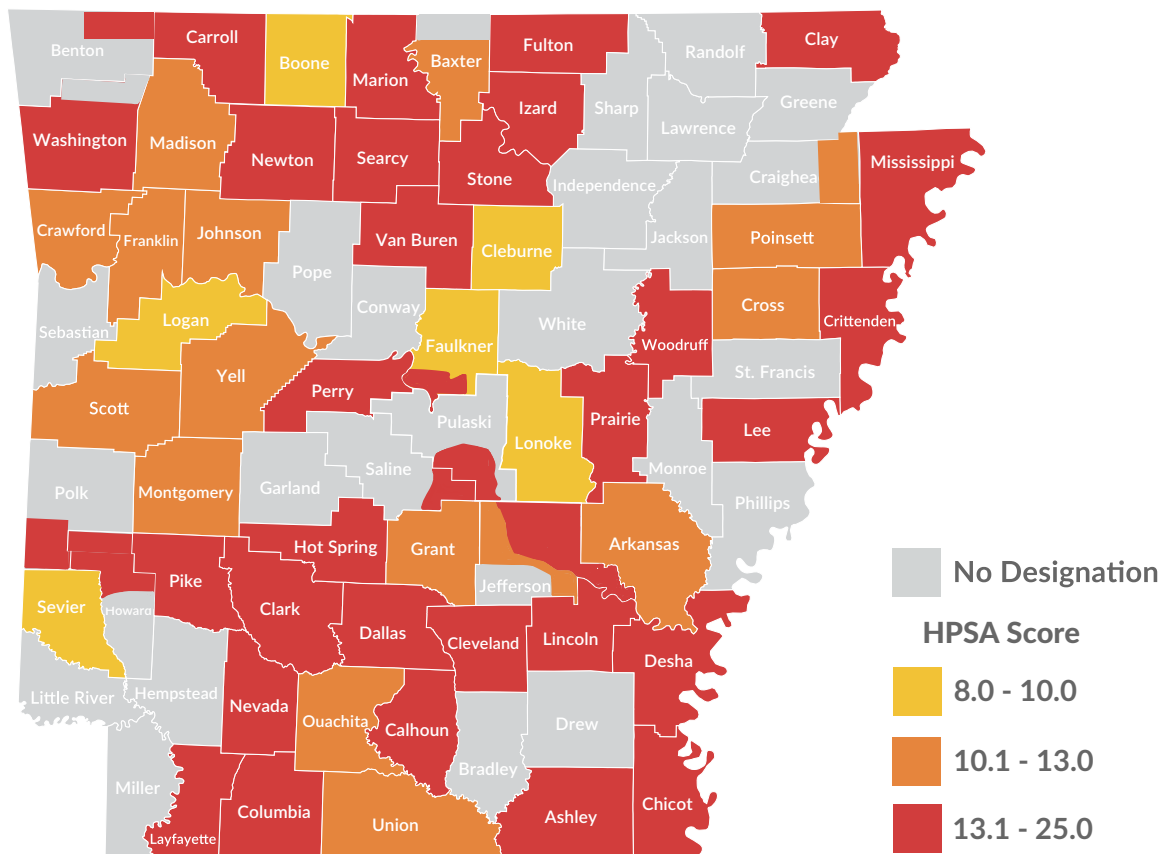
Example

The two following maps from the Arkansas Department of Health are based on data from the Human Resources and Service Administration. They show the seriousness of this problem. The first shows Arkansas's primary care health professional shortage areas and the second shows medically underserved areas (which takes into consideration the needs of the populations).

Certain populations need more providers than others. When this is considered, we can see that **too many Arkansans do not have access to the care they need**. Fifty-nine counties are medically underserved, another 15 are partially underserved.

Arkansans on Medicaid and ARKids have an even tougher time finding primary care providers. As of July 2020, Arkansas's total Medicaid enrollment was 839,653. Medicaid child and CHIP enrollment was 380,815.

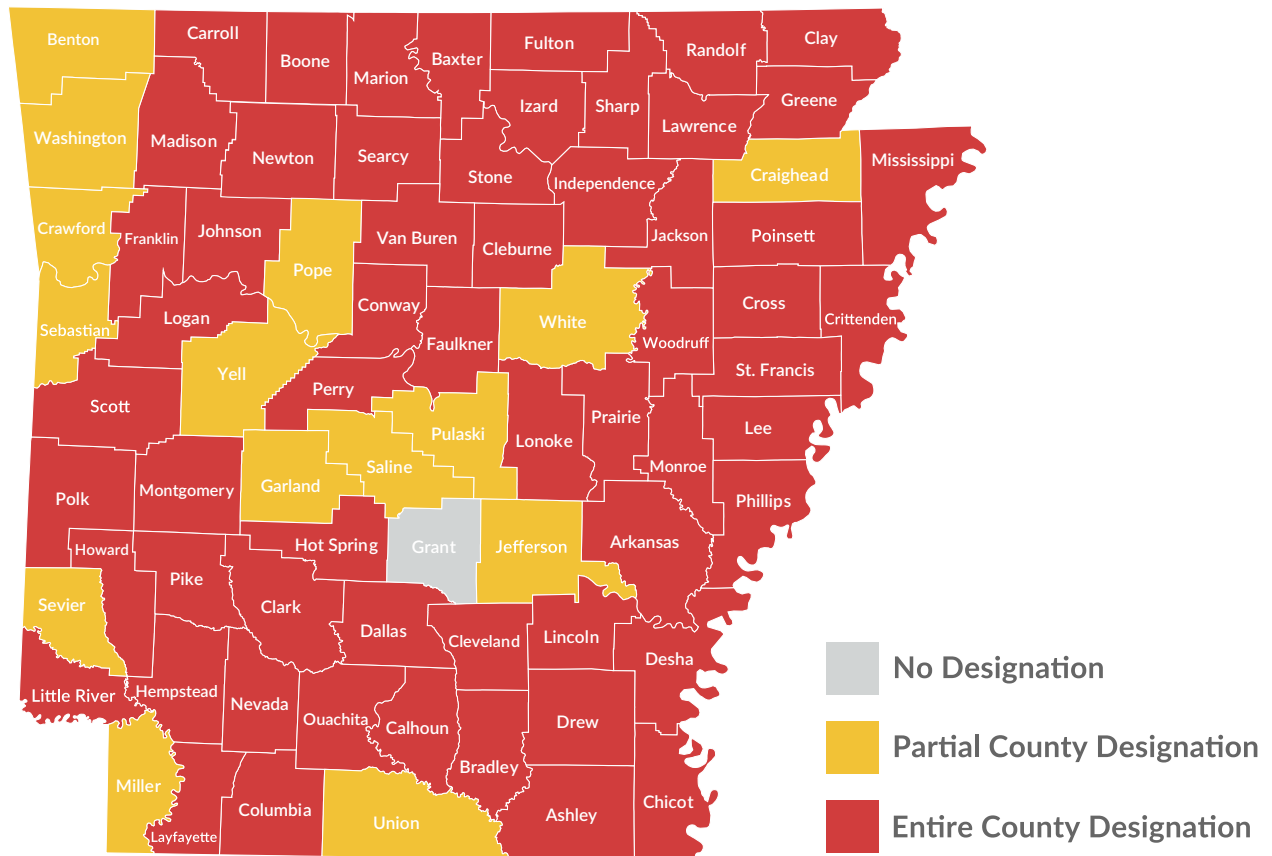
Arkansas Primary Care Health Professional Shortage Areas (HPSA)



Source: Arkansas Department of Health, Health Resources and Services Administration (HRSA)

Example, continued

Arkansas Medically Underserved Areas (MUA)



Source: Arkansas Department of Health, Health Resources and Services Administration (HRSA)

The Solution

1. Increase access to care by **allowing nurse practitioners to be designated primary care providers (PCP)** for Medicaid and ARKids patients.
2. Expand the use of nurse practitioners by **allowing them to work without state required collaborative practice agreements.**

Patients normally receive non-emergency and non-specialist care from their primary care provider and clinical problems outside the scope of primary care are referred to specialists. Primary care providers coordinate care across specialists. Nurse practitioners are already allowed to be designated primary care providers for Medicare and Veterans Affairs.^{2,3} Allowing nurse practitioners to be designated primary care providers for Medicaid and ARKids patients as well **increases the supply of providers for Arkansans.** More potential patients help nurse practitioners make enough money to build and sustain successful practices in poorer or more rural counties.

Twenty-two states and the District of Columbia allow nurse practitioners to practice and prescribe without mandated physician collaboration or supervision, and for good reasons. **Collaborative practice agreements are costly** in multiple ways and the best academic research suggests that the outcomes for patients are the same or better.⁴ A recent study found that nurse practitioners in Florida paid an average of \$1,048 per month to collaborating physicians.⁵ That's over \$12,000 a year out of nurse practitioners' pockets. They also cost nurse practitioners and collaborating physicians time documenting administrative requirements.⁶ For physicians, collaborative practice agreements can make their insurance more expensive.⁷ Nurse practitioners are particularly vulnerable to the threat and reality of physicians cancelling agreements and this **may dissuade them from making them or expanding their practices.**

Nurse practitioners and physicians may still voluntarily enter into these agreements if they find them mutually beneficial. Patients can choose not to go to nurse practitioners for primary care if they prefer physicians.

The state shouldn't restrict nurse practitioners from providing primary care or mandate costly and unnecessary agreements. **Arkansans need and deserve more choices.**

Frequently Asked Questions

Question

Answer

Why are nurse practitioners a good solution to Arkansas's primary care provider shortage?

Nurse practitioners are a quickly growing medical profession. From 2010 to 2017, the number of NPs increased from about 91,000 to 190,000.⁸ Most NPs are certified in an area of primary care and work in primary care.⁹ And they are more likely than physicians to work in rural and underserved areas.^{10,11} From 2009 through 2017, the number of physicians per 3,500 patients increased by 14.3% in rural counties. But the number of nurse practitioners per 3,500 patients increased by 90.1% in rural U.S. counties.^{12,13}

Don't we already have NPs working with and for physicians?

Yes, but allowing nurse practitioners to work independently has been shown to increase the number of hours nurse practitioners work.¹⁴ Furthermore, nurse practitioners are more likely to practice in rural counties when they have increased scope of practice.¹⁵ When regulations allow nurse practitioners a full scope of practice, areas with shortages of primary care health professionals, including rural areas, attract higher numbers of nurse practitioners, which helps resolve the shortages and states with full scope of practice regulation attract more nurse practitioners.¹⁶

Do nurse practitioners provide substandard care?

Nurse practitioners are registered nurses with either a master's or doctoral degree in nursing practice. They complete graduate coursework and clinical hours. A considerable body of academic research indicates that the primary care provided by NPs is as good as that provided by primary care physicians.¹⁷ These studies employ the gold standard of academic evidence, the randomized control trial, and are published in high-quality journals including *Journal of the American Medical Association*. A Federal Trade Commission examination in 2014 concluded that NP training and experience frequently exceed what is necessary to protect consumers.¹⁸

Frequently Asked Questions *continued*

Question

Answer

How do patients with chronic conditions fare when they're treated by nurse practitioners?

In states that allow nurse practitioners to work independently, patients with chronic conditions that can lead to preventable emergency room visits have better outcomes, routine checkups were more common, patient reported care quality was higher, and emergency room use was lower in these states. Physicians, NPs, and patients all enjoyed cost savings.¹⁹ A 2019 article published in the journal *Medical Care Research and Review* concludes that "state regulations restricting NP SoP [scope of practice] do not improve the quality of care."²⁰

Could nurse practitioners help with Arkansas's diabetes problem?

Two national studies of diabetes patients find that NPs provide comparable care for diabetes.

- Similar health and spending outcomes between two groups of patients, one cared for by nurse practitioners and the other by physicians.²¹
- Diabetes patients in states with expanded scope-of-practice (SOP) laws are more likely to take their medication than patients in states without SOP expansion.²²

Could relaxed requirements for nurse practitioners worsen opioid abuse in Arkansas?

A 2019 report from the CDC entitled "Promising State Strategies"²³ highlighted the importance of prescription drug monitoring programs²⁴ in reducing opioid abuse, overuse, and overdose. The CDC recommends monitoring programs to "promote responsible prescribing and identify patients who may be misusing opioids." The Arkansas Department of Health has a prescription drug monitoring program²⁵ dating back to 2015. Nurse practitioners are not allowed to independently prescribe opioids in Arkansas.

Suggested Reading

ACRE Resources

- Mitchell, M., Helms, Z., and Pfaff, J. (2018). [Solving Arkansas's Primary Care Problems by Empowering Nurse Practitioners](#). The Arkansas Center for Research in Economics.
- Mitchell, D. (2018, December). "[Better Health Care](#)." Arkansas Democrat-Gazette.
- Mitchell, D. (2016, October). "[Nurse Practitioners: Good for Patients, But a Bitter Pill for Doctors](#)." The Hill.

Additional Resources

- Adams, E. K., & Markowitz, S. (2018). "[Improving efficiency in the health-care system: Removing anticompetitive barriers for advanced practice registered nurses and physician assistants](#)." The Hamilton Project, 8, 9–13.

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13. Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2020). Implications Of The Rapid Growth Of The Nurse Practitioner Workforce In The US: An examination of recent changes in demographic, employment, and earnings characteristics of nurse practitioners and the implications of those changes. *Health Affairs*, 39(2), 273-279.
14. Markowitz, S., & Adams, E. K. (2020). *The Effects of State Scope of Practice Laws on the Labor Supply of Advanced Practice Registered Nurses* (No. w26896). National Bureau of Economic Research.

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ACRE Experts



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Dr. David Mitchell is the Director of the Arkansas Center for Research in Economics. He earned his B.S. and MA in economics from Clemson University and was awarded his PhD from George Mason University. While at George Mason, he had the pleasure of studying under two Nobel laureates: James Buchanan and Vernon Smith. Prior to earning his PhD, he worked in the insurance industry in both the United States and Germany. Before starting at the University of Central Arkansas, he taught at St. Mary's College of California, Washington and Lee University, and the University of South Alabama. At the University of Central Arkansas, Dr. Mitchell teaches Principles of Economics, Public Finance, and Econometrics. His research interests include state-level public finance and entrepreneurship policy. He has published in the *Southern Economic Journal*, the *Journal of Small Business Management*, the *American Journal of Managed Care*, and *Forbes.com*.

About ACRE

The Arkansas Center for Research in Economics (ACRE) is an Arkansas focused research center housed in the College of Business at the University of Central Arkansas. ACRE scholars and policy analysts use research and analysis to find solutions for Arkansas's problems. Our research focuses on barriers to employment, taxes and subsidies, good governance and government transparency.

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