In September 2012 the American Academy of Family Physicians (AAFP) issued “Primary Care for the 21st Century,” a report that underscored the AAFP’s vision for a physician-controlled approach to health care. In the report, the AAFP called for limiting nurse practitioner and care through practice linked to teams under the supervision of physicians. The AAFP further offers the opinion that nurse practitioners autonomously functioning at the top of their license would lead to a two-tiered care system that would expose patients to inferior care. The above listed associations of the NP Roundtable disagree. The recommendations in the AAFP report are contrary to the advances required to promote and sustain an effective and efficient 21st century healthcare system, and are damaging to interprofessional relationships between healthcare providers and patients.

Definitions of Primary Care and Team-Based Care

The healthcare needs of our nation are beyond the scope of any one individual health discipline. Addressing the healthcare challenges and developing a strong provider workforce will require individual disciplines and policy leaders to move past one profession’s vantage and adopt definitions and concepts of care that reflect the overlapping ability of multiple and diverse disciplines to provide care to patients. The NP community has joined with other health policy leaders in adopting the definitions from the Institute of Medicine (IOM) for primary care and team based care. We recommend that federal and state policy makers to use these definitions in regulations and when establishing parameters for new reimbursement and care models.

Unlike the limiting, physician-centered view put forward in AAFP paper, the IOM definition of primary care is inclusive, leans in the direction of updated health policy, and provides the long-term flexibility to meet our nation’s needs. The IOM defines primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Likewise the IOM definition of team-based care, “… the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively, to the extent preferred by each patient.” provides for the full and complete use of the entire healthcare provider workforce while ensuring the needed flexibility to deliver care across diverse care settings, geographies, patient preferences and evolving models of healthcare.
The Institutes of Medicine, the Joint Commission, the Agency for Healthcare Quality and Research, the Patient-Centered Primary Care Collaborative, along with several other national and state healthcare stakeholders have adopted these definitions. By using these definitions, our healthcare system will be better positioned to capture the significant contributions that nurse practitioners and other advanced practice nurses and clinicians make in improving access to care and reducing costs when they are able to practice to the full extent of their educational preparation.

**Leadership in patient-centered care**

Care coordination is a hallmark of nurse practitioner care. The NP Roundtable has a longstanding history of support for coordinated care delivery models, including models of nurse-managed health centers and NP-lead patient-centered medical homes. In its paper, the AAFP misapplies the concept of care coordination to the accreditation and regulatory arenas. By attempting to create links between concepts of care delivery models and regulation, the AAFP fails to recognize the role of individual licensure and state licensure boards, and the realities of today’s healthcare environment where providers share overlapping knowledge and skills within separate disciplines.

Team-based care and other coordinated care models are systems of care delivery. They are not licensure concepts. Legislators and regulators should not impose requirements for individual clinician licensure that create situations where one health profession is prevented from engaging in their discipline of patient care without the willing permission from an professional in an outside (and in sometime economically competing) discipline by requiring a “team” in licensure and practice law.

Coordinated care and team care approaches to patient care are based on the following concepts:

- Healthcare teams consist of patients and their health care providers
- The health care team does not belong to a single provider
- Healthcare teams are dynamic, with the needs of the patient directing who best can meet their needs at any given point of time.
- Flexible frameworks are required for innovation and creation of emerging models to provide high quality care.

Current research on nurse practitioner-led models of care demonstrates the success of nurse practitioners as team leaders for primary care. It is worthwhile to note that while studies have demonstrated that adding an NP to a physician’s practice enhances access and patient satisfaction and decreases cost, there have been no studies to demonstrate that adding a physician to an NP’s practice would result in similar improvements in access, satisfaction or reduced cost of care. In nurse-managed health centers, the addition of a physician to meet state required practice laws is often a cost generator with no quality or safety benefits to patients. Nurse practitioner practices meet the criteria for the primary care medical home: patient centered, comprehensive, coordinated, accessible high quality and safe care.

The AAFP paper suggests that the impetus behind efforts at modernizing practice laws and regulations that “allow NPs to practice independently” is the primary care physician shortage. While the primary care physician shortage and the implementation of the Patient Protection and Affordable Care Act may have drawn added focus to the role NPs have been providing for the last fifty years, regulatory modernization of practice laws are based on decades of evidence to support the safety and quality of NP provided care. Updating practice laws that remove bureaucratic and physician centric restrictions that impair access, delay care, duplicate services, and drive increase healthcare costs is a natural progression of the role and is supported completely by independent studies over decades.
Nurse practitioners are qualified health care providers who undergo rigorous educational preparation that enables them to diagnose and treat acute and chronic illness as well as provide preventive care to their patients. All nurse practitioner educational programs are at the graduate level. The programs of study are based on strong scientific foundations including evidenced based practice, advanced assessment, pharmacology and the management of complex health systems. Programs of study build upon the bachelor’s program in nursing. This undergraduate platform of formal healthcare education allows NP students to begin their graduate level education at an expanded and focused level. Population focus is determined at the time of entry into the graduate program e.g. family, adult/gerontology, pediatrics, and women’s health. All NP programs are nationally accredited and held to standardized core curricula content.

The measure of educational effectiveness is outcomes. The clinical education model of different health professionals does differ. Although different, there is no evidence to suggest that one is superior to another in terms of outcomes, patient safety, or quality of care. Studies have demonstrated that nurse practitioner educational preparation yields safe, high quality health care. The IOM underscored these findings in the 2010 IOM Future of Nursing Report and called on state policy makers to updates practice laws to allow NPs to participate at the full extent.

**Conclusion**

The time is right to work together to solve the healthcare challenges facing our nation – not for creating models that attempt to promote one provider type over another and maintain antiquated “status quo” arguments, create bottlenecks, and restrict access by inappropriately limiting an individual clinician’s ability to practice through required linkage to a team. It’s time to create practice and policy environments where healthcare providers can practice to the top of their education, where patients can choose the provider that best fits their healthcare needs and goals and where artificial barriers to care have been eliminated.