Nurse Practitioner Full Practice Authority: Eliminating Barriers to Healthcare Provider Access

Terri Brown DNP, FNP-BC

Saint Mary of the Woods College

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Terri Brown

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Abstract

Nurse Practitioner full practice authority denotes the ability to provide patient care without the requirement of a collaborative agreement, no supervision or conditions for practice. Full practice authority is needed more now than ever before due to the increasing limited access to care. The current health care crisis in the United States is multifaceted, realized by a growing population, aging population, increased healthcare utilization through expansion of Medicaid and the Affordable Care Act (ACA) model of care and physician shortages. Nurse practitioners are well trained to address the needs of providing safe and effective patient care. State Board of Nursing regulations has failed to keep up with changes in clinical practice while collaborative practice agreements have made barriers to providing care. Twenty-three states and the Veterans Administration currently enforce Nurse Practitioner full practice authority. Legislative changes are necessary to remove the limitations and barriers in states with reduced and restricted practice. Nurse Practitioner full practice authority is necessary to meet the challenges in healthcare access. Nurse Practitioner full practice authority will eliminate barriers to healthcare provider access.

Key words: Nurse Practitioner, full practice authority, healthcare access, Medicaid, ACA mode of care, State Board of Nursing, collaborative practice agreements, Veterans Administration.
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Introduction

Nurse Practitioners (NP) known as an Advanced Practice Registered Nurse’s (APRN), have been caring for patients in the United States for well over 50 years since the first certificate program development in 1965. NPs are a vital component of the nation’s primary care workforce with more than 234,000 licensed and over 75% of practicing NPs providing primary care (AANP, 2018). Other areas of care include Acute Care, Cardiology, Dermatology, Endocrinology, Geriatrics, Pediatrics, Orthopedics, Pulmonology, and Psychiatrics. NPs are staffing diverse settings including urgent clinics, emergency rooms, jail/prison infirmaries, retail clinics, faith-based clinics, health centers and a number of specialty practices. You will find NPs providing care to patients where care needs exist.

There is a growing nationwide struggle to meet population health care needs and gaining provider access. Government agencies including the Health Resources and Service Administration and the Health and Human Services have historically been overseeing healthcare access and targeting ways to make improvements and narrow the gaps in care. Despite the agencies oversight, provider shortages continue to increase along with patient volume and there is no immediate relief in sight. Current provider shortage projections estimate the shortage effect to be anywhere from 14,900 to 35,600 positions needed in primary care by 2025 (AAMC, 2017).

As noted previously NPs are assuming a number of provider roles in healthcare to alleviate the burden of access need. NPs are educated and trained to address patient needs but the ability to provide full scope of care has become increasingly congested with limitations and barriers as the access needs continue to mount. The Future of Nursing notes “although APRNs are highly trained and able to provide a variety of services, they are prevented from doing so
because of barriers, including state laws, federal policies, outdated insurance reimbursement models, and institutional practices and culture” (IOM, 2011). Legislative language and regulations need to be updated to reflect the current NP role in providing care. Scope of practice laws need to also reflect these changes. Full practice authority, meaning no requirement of a collaborative agreement, no supervision or conditions for practice, would largely diminish the practice barriers allowing NPs to practice to the full extent of their education and training as heralded by the IOM (2011). Healthcare provider access would improve along with the ability to provide all aspects of primary care service. This informative paper examines the NP role and background, education and trading; state board regulation and licensure; patient healthcare access need; and how changes such as full practice authority for NPs will remove practice barriers to patient care, improve access to care and reduce healthcare disparity. A thorough discussion of the limitations and barriers to practice that NPs face daily in current restricted practice setting will provide the reader with sufficient evidence and understanding of the relative need for NP full practice authority. Finally recommendations on making these changes will be made.

**Background**

**Nurse Practitioner Role and Education**

As nursing curriculum across the country was being revised and transitioned to Baccalaureate nursing, the Master’s degree nursing was recognized as limited to functional nursing roles as no clinical roles existed at the advanced level (Ford, 2016). Both professional and academic nursing groups recognized that a clinical nurse specialist role in nursing needed to be developed. According to Dr. Loretta Ford (2016), a developer of the first NP certification, challenges were made among various nursing faculty groups to discern clinical appropriateness
and content within their own specialty of academia for clinical development and inclusion. Dr. Ford stated that the physician shortage in public health presented the opportunity to try this new model of nursing. The project prepared graduate pediatric nurses to take on a role oriented toward defining the health status of children and helping parents with parenting (2016) (Keeling, 2015). Together Dr. Loretta Ford, assistant nursing professor, and Dr. Henry Silver M.D. developed the NP certificate program at University of Colorado in 1965 to be followed by the Masters of Science in Nursing (MSN) program at the College of Boston in 1967 (AANP, n.d. a). According to Dr. Ford (2016), the concept of the NP role was to “work in collaborative, collegial relationships with physicians to provide care to children and low-income families closing the gap between the health care needs and the ability to access and afford primary health care” (2016). Nursing had long been providing care in a much similar fashion through programs such as the Visiting Nurses of the early 20th century, Frontier Nursing and the Indian Health Service (Keeling, 2015).

Once the program was established and recognized, the momentum to expand the role of the NP was sparked by Health, Education and Welfare Secretary Elliott Richardson in establishing the Committee to Study Extended Roles for Nurses in the 1970’s. The committee’s aim was to advise and make recommendations to the secretary regarding the nursing workforce, supply, education, and practice. Kalisch and Kalisch (as cited by Keeling, 2015) noted that Secretary Richardson had a particular interest in the feasibility of expanding nursing practice as a means to alleviate the physician shortages the country was experiencing. Following the review of the healthcare need landscape and formal expansion of nursing, the committee concluded that extending the scope of the nurse’s role was essential to providing equal access to healthcare for
all Americans (Keeling, 2015). The continued growth and expanding scope of NP practice is seen by the increasing role NPs provide throughout the continuum of healthcare.

The NP education has continued to expand in just the same fashion as need for healthcare provider access has. The once NP certificate program has progressed from the MSN to the now terminal degree of Doctor of Nursing Practice (DNP). The MSN remains the minimum degree required and the most common in the field. There are a number of specialty Masters level NP programs are available including Acute Care; Adult; Emergency; Family Practice; Gerontology; Neonatal; Nephrology; Pediatric; Psychiatric; and Women’s Health.

Core competencies of the DNP include research, theory, and statistics as common components with emphasis on evidence based practice application. Each program varies on the total clinical hour requirement where the student is paired with a clinical preceptor to learn and practice clinical skills building upon class experiences and study. NP clinical hours are built upon the foundation of Registered Nurse (RN) training and clinical experience (Barnes, H., 2015; McHugh & Lake, 2010) with additional clinical hours focused upon expanded physical assessment. The terminal DNP degree has closed the gap of knowledge that many NPs were reporting in their practice including areas of management information technology, evidence based practice and policy synthesis (Lenz, 2005)

**Certification and Licensing**

All graduating NP professionals from accredited programs of study are eligible for certification. Certifications include Family Practice; Adult; Geriatric; Pediatric; Acute Care/Critical Care; Dermatology; Oncology; School; Urological; and Women’s Health. Achievement of certification signifies successful passed an assessment of professional knowledge in their population focus. Certification is not only used as achievement recognition
but is also used by regulatory bodies to signify that the graduate has attained the requirements to practice as an NP in the focus area (AANP, n.d.). The following is a list of the current NP certification bodies:

- American Academy of Nurse Practitioners Certification Program
- American Association of Critical Care Nurses Certification Corporation
- American Nurses Credentialing Center
- Certification Board for Urological Nurses and Associates
- Dermatology Nursing Certification Board
- National Certification Corporation
- Nephrology Nursing Certification Commission
- Oncology Nursing Certification Corporation
- Pediatric Nursing Certification Board
- National Certification Corporation for Obstetric, Gynecologic, and Neonatal

Following completion of required education and training candidates must submit a written application to the credentialing body along with required documentation for testing. After successful completion of the certification test, the NP is awarded certification recognition and credentials as designated by the certification body. To date, certification is not mandatory in every state as regulatory requirements differ state to state.

Following collegiate completion of an accredited NP program individual application to state boards of nursing must be made to complete further state requirements to practice. Again, application and requirements of licensing vary state to state. State licensing is designed to translate the scope of practice to protect the population. In states with reduced and restricted practice state licensing will incorporate a Collaborative Practice Agreement which is an
agreement between a physician that the NP will practice in “collaboration” with and will be practice restricted to the terms as designated by the physician.

In an effort towards uniformity of practice, a collaborative effort among more than 40 nursing organizations came together to develop a General Consensus Model of regulation for the future of advanced practice nursing. This model is designed to align the interrelationships among licensure, accreditation, certification, and education which will provide uniformity and portability of practice regulation. While many states have taken up portions of the Consensus Model there still is no uniformity in adaption which hinders portability of the NP practice.

To date, NP practice laws and regulations are specific to each state. Appendix A illustrates the differences in practice authority that exist by state (ANNP, 2018). States that have full practice authority, indicated by the green color on the map, have practice and licensure laws that permit NP’s to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatment, prescribing of medications and controlled substance under the exclusive licensure authority of the state board of nursing. As of January 1, 2018, there are 23 states that permit full practice authority for NPs with reduced and restricted license state NP groups lobbying for legislative changes for full practice authority. The 27 states with current reduced or restricted practice include: Alabama, Arkansas, California, Delaware, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Mississippi, North Carolina, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin.

The U.S. Department of Veterans Health Affairs (VHA) which employs NPs throughout the United States in hospitals and clinics, passed full practice authority to current employed NP’s allowing them to practice to the full extent of their education and training in January of 2017. In
a release by the U.S. Department of Veterans Affairs (2016) Secretary of Health, David Shulkin stated “The regulation change increases our capacity to provide timely, efficient, effective and safe primary care, aids VHA in making the most efficient use of APRN staff capabilities, and provides a degree of much-needed experience to alleviate the current access challenges that are affecting VA”. The VHA is also ahead on portability of practice by not requiring state-specific licensing. This means, for example, that a NP from one state can travel to another and practice without filing for a new state license. By passing full practice authority to NPs and providing portability of individual licenses the VHA is removing barriers to care for veterans.

**Understanding Factors of the Healthcare Crisis**

The healthcare crisis is a multidimensional condition in the United States. Disparity or inequalities of populations throughout the nation often result in poorer health outcomes, limited ability to access healthcare and social indifferences to healthcare. The cost of healthcare is high and many people suffer either inadequate insurance coverage or no insurance coverage making care inaccessible. The growing physician shortage also limits provider coverage and accessibility. Many have trouble securing a provider of care, scheduling timely appointments and getting necessary medication refills.

**Access and Need for Healthcare**

**Healthcare Disparity.** According to the Kaiser Foundation (Ubri & Artiga, 2016), health care disparity refers to differences in health between population groups. Populations in the United States are separated by many dimensions. Social and economic differences prelude all agents of healthcare disparity. Health equity is a challenging goal given the many factors that contribute to optimal health.
Social determinants of disparity are considered the conditions in the places where people live, learn, work and play. According to healthypeople.gov (2018), social determinants of health include access to health services and resources. See Appendix B diagram of Social Determinants of Health (SDOH). The suggested strategy recommended by Healthy People 2020 is the application of a “health in all policies” strategy, which introduces improved health for all and the closing of health gaps. Both health equality frameworks require more providers trained in health promotion and patient education.

The most common inequalities in healthcare delivery are due to the widening economic inequality. There are geographic locations where poverty levels are high and where individuals may become isolated from health systems due to demographic shifts caused by poverty. According to Dickman, Himmelstein and Woolhandler (2017) health inequality are observed by the 10-15 year life expectancy of wealthy exceeding the poorest. Poverty often results in demographic shifts in geographic location resulting in Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) (bhw.hrsa.gov, n.d.). See Appendix C HPSA map. According to the Van Vleet and Paradise (2015), fuller integration of NPs in primary care can increase access in underserved rural and urban areas where the social disparity is high, closing the health care gap to access. One program integrating NPs into these areas is the Nurse Corps which identifies sites as HSA or MUA.

**Physician Shortage.** Physician shortages in the 1960’s gave rise to the opportunity for the role of the NP. In present day, we have a new increasing shortage of physicians in primary care due to multiple factors: higher number of primary care physicians nearing retirement age of 65; fewer primary care residencies; decreased funding for graduate medical education; competition for medical residencies; supply and demand of physicians dependent on geographic location;
fewer students selecting primary care in lieu of higher wages in specialty practice; population growth and aging population; influx of new insured patients from the ACA healthcare reform and widened Medicaid coverage. A recent study conducted for the American Association of Medical Colleges (2017) noted the United States will face a shortage of between 40,800-104,900 physicians by 2030 posing a risk for patient care. Approximately 33,000 additional physicians will be needed in the next 10 years due to population growth and another 10,000 physicians projected will be needed to serve the aging population (Peterson et al., 2012). What is being done to alleviate this crisis: The AMA is seeking additional funding to subsidize the losses in GME and grants for residency. Rural health groups are sponsoring residencies and providing education and lodging stipends to medical students who agree to work a term of service for the sponsorship. Despite this, recruiting into the rural areas remains problematic with many areas short staffed with no potential candidate for 2-4 years.

Political threats to immigration status and possible deportation pose an additional threat to immigrant medical students and physicians which the United States has historically relied upon. Foreign medical graduates and students with Deferred Action for Childhood Arrivals (DACA) status are threatened with potential deportation in new legislative bills which are based on a political frenzy to tighten U.S. borders. Foreign medical students and graduates complete a medical education and/or residency program under DACA and further utilize financial assistance programs such as MUA to work. If deported, the healthcare system loses two-fold, the new medical residents that would alleviate a portion of the current crisis and those immigrant physicians currently working in the healthcare system (Japsen, 2017).

**Wellness Movement.** According to the United Health Foundation 2016 Annual Report, “the United States compared with other developed nations continues to rank at or near the
bottom in indicators of mortality and life expectancy while at the same time exceeding other countries health spending”. Our healthcare system is purposefully moving towards wellness, disease prevention and chronic disease management rather than illness focus. Care will require a different approach utilizing patient education and coordination of care services rather than a “bandage system” triaging of acute care needs. Anticipatory care and guidance to help patients work towards wellness is a new movement for healthcare. The ACA has focused care and reimbursement models on quality indicators of care and wellness.

A cross-sectional study of NHANES data (King, Matheson, & Chirina, 2013) identified the baby boomers to have a longer life expectancy but with more chronic illness and disease. This aging population was found to have more hypertension, high cholesterol and increasing prevalence of diabetes and cancer. Translated, baby boomers are living longer lives with more chronic disease and illness than previous generations and will require a greater use of healthcare management later in life to manage chronic disease and to promote wellness.

**Increase Utilization of Primary Healthcare.** As noted previously, population growth will be the greatest expected increase in primary care with aging and insurance expansion also contributing to the higher utilization. Population growth in the U.S. is projected to increase annually by 0.9 percent from birth and immigration bringing new patients into the healthcare market. Baby boomers nearing retirement will be faced with changing healthcare needs plagued with more chronic diseases and requiring more managed healthcare. Other growth surges into the health care system included: Incorporation of the ACA expansion of Medicaid coverage to lowest incomes families; federal subsidies helping private buyers purchase insurance; young adult coverage made available by parental health plans until age 26; coverage ensured regardless of health status; and the requirement of insurance coverage in lieu of financial penalty. In a study
by Bradbury, Golee, and Steen (2001), it was noted that uninsured patients are generally sicker patients when compared to insured patients. Many of the newly insured have not been treating a chronic disease or not receiving sufficient screening to detect disease and illness. Fortunately the younger age groups coming into the healthcare market are generally better in health than aging and low-income minorities.

**Changing Clinic Practice Affects the CPA.** CPA is currently a requirement for NP practice in states with restricted or reduced practice. Given the recent health care reform and numerous changes to practice regulations, physicians are more often found working for organizations rather than having an independent practice. Many physicians are finding the transition a welcomed opportunity allowing them to focus on patient care rather than business operations. This transition has its own implications intertwined with NP CPA. The CPA was originally defined when physicians were primarily independent practitioners, choosing to augment practice by the incorporation of the NP. In present healthcare organizations, the physician is now an employee required to participate in a CPA. The physician has no financial interest or investment in the NP CPA. The current design utilization does not constitute a collaboration of practice but rather a requirement of physician employment. Further elaboration will be discussed in the concrete example.

**NP Healthcare Limits and Barriers**

A number of factors limit the NP role and construct barriers to providing patient care. Limitations in NP practice are embedded in the language of the state regulations and translated through the state board of nursing, such as a CPA. Barriers to NP practice are embedded within legislative policies and healthcare models that do not specify NP inclusion or participation. Insurers often base reimbursement models based on outdated scope of practice limitations which
hinders NP reimbursement. Medicare policies limits NP ability to provide full scope of care to established patients. Institutional and organizational policies and culture prohibit the NP from admitting patients to hospitals often requiring the patient to be rerouted through the Emergency Department.

**State Board of Nursing Regulations and Scope of Practice.** Individual activities NPs can perform, the degree of physician oversight and the CPA are all regulated by the state’s Board of Nursing as delegated by state legislation. The State Board of Nursing is designed to guide nursing practice and to protect citizens from harm by the laws that regulate nursing. CPA is a central element in NP state regulations and to the discussion of full practice authority. The agreement gives layman the impression of direct oversight of practice that insures a safety net of supervised NP practice. A recent study by Rudner and Kung (2017) noted that physician NP oversight in a restricted practice state of Florida ranged from no oversight to extensive oversight. The CPA specifics vary by state and does not insure active collaboration exists between the NP and physician but rather defines oversight. Oversight is typically made through retrospective chart following care delivery with critiques to the care given and can be made unique to each practice environment. According to Vleet and Paradise (2015), physician oversight of practice can be financially burdensome to NPs, problematic for physicians, and confusing for policymakers and members of the public, who mistakenly think the agreements facilitate true collaborative care. Removal of the CPA will: eliminate financial burdens to the NP and practice; eliminate the confusion of policymakers, physicians, and the general public; improve patient access to care; improve insurance coverage and access by alleviating language constraints.

**Federal, Institutional and Insurance Limits.** An example of a federal limitation is found in the ACA model of care called The Independence at Home Demonstration which provides home-based primary care services to Medicare beneficiaries with chronic illness and
functional limitations. This program recognized NPs as potential leaders but created limitations and barriers when the ACA deferred each state to determine the scope/limitation in leading this team of care. This action at the federal level creates barriers for patients when the NP function is not explicitly and clearly defined. In some situations, the complete purpose of the program dies at the state level with the NP unable to fulfill the program objective. Fauteux, Brand, Fink, Frelick, and Werrlein, (2017) noted that federal limits of NP practice create delays in care, raise the cost of care, and hamper patient’s ability to locate primary care and other health services.

Another federal model limitation, the Patient-Centered Medical Home, imposed limitations on the NP workforce by excluding the NP from provider status (Carthon, Barnes, & Sarik, 2015). The Patient-Centered Medical Home is a development plan to transform how primary care is organized and delivered. According to the U.S. Department of Health and Human Services (n.d.), this model is patient focused coordinated care delivered through the primary care physician to ensure the necessary care is received when and where it is needed in a manner that is easily understood. As the number of patients in the healthcare system increase and the physician shortage increases this program comes out of development excluding the NP as a provider of care again only to bottleneck the healthcare system and limit patient timely access to care. These two examples illustrate how language in federal policy limits and creates barriers to NP care.

Institutions limitations for NP may begin in the state regulations that prohibit NP hospital admitting privileges. Other limitations are created by the individual institution bylaws. In 2012 CMS attempted to redefine medical staffing that would permit other professionals to practice to their full scope. Despite the CMS redefinition medical staff membership and hospital privileges remain subject to existing state law and business preferences.
Public payer Medicare limitations include the NPs inability to order/authorize hospice care or home health care while able to recertify. Medicare models reimburse NPs at a rate of 85% of the physician fee. The differences in reimbursement impede NP ability to practice independently since compensation for like services is compensated at the reduced rate. According to Hain (2014), some private payers limit NPs from practicing independently of a physician by not paying directly or reimbursing at a lower rate.

**Concrete Examples of Limits and Barriers.** The limitations and barriers to NP access to care are so complex and interrelated a few concrete examples are included to further understanding:

- Practices where physicians retire or vacate positions while holding an NP CPA, the NP and practice are left without a physician and the NP is unable to prescribe, bill and provide care in the practice without the CPA. This is a particularly vulnerable position for both the NP and the practice with direct barriers to providing patient care. This problem is confounding with the growing numbers of retiring physicians or physicians moving in and out of practices there will be less opportunity for CPA while the numbers of graduating NPs is growing. A recent study by Peterson, Rayburn, and Liaw (2016) concluded that the baby boomer physicians are approaching their retirement at 60 to 65 with few remaining in part time practice later in life.

- Private insurance payers making stricter limitations for reimbursements based on outdated restrictions of the scope of practice (SOP). This limits the ability of the NP to bill and be paid directly. Even in states with full practice authority, out of date SOP may hinder or limit reimbursements.
Public insurance payers’ policies such as Medicare policy for not allowing NPs to order Home Health and durable medical equipment for Medicare recipients. Patients are required to make a physician appointment which may be time delayed or the NP in many cases is required co-signature from the physician to provide patient care.

Reimbursement payment schemes at 85% of the physician 100% payment for the same service. This is an antiquated model much similar to inequalities of salaries in the gender pay gap. Some practices may use an “incidence to” billing which has a number of restrictions to the visits in order bill at 100%. The physician must originate the plan of care, NP care must be an extension of that care without a new problem. This scheme may limit access to care if the NP is only seeing patients for follow up. New patients will be turned away from care in practices where the physician panel is full.

NPs are well trained in patient education, wellness promotion, and evidence-based practice. This preparation will alleviate the shortage of care by providing wellness promotion and coaching along with chronic disease management. The NP role in healthcare is not to replace physician care but rather improve patient access to care, addressing acute needs and coordinating chronic care. In all healthcare schemes, interprofessional collaboration in practice is needed where professionals work as a team to coordinate patient care to the highest potential.

**Organizations Supporting NP Full Practice Authority**

The list of leading health organizations, policy-makers and consumer advocates supporting NP full practice authority is growing as new research suggest that NPs can alleviate
the healthcare shortage and improve access to care. The following is a list of organizations recognized for making public statements of support for NP full practice authority.

➢ IOM

The IOM report *The Future of Nursing: Leading Change, Advancing Health* (2011) suggests that nurses take on a greater role in healthcare to address the aging population. The report called for the removal of laws, regulations, and policies that limit NP from providing the full scope of healthcare allowing them to practice to the full extent of their education.

➢ National Governors Association (NGA)

In a statement released in 2012, the NGA recognized the current healthcare shortage and recommended that states ease NP scope of practice restrictions and make modifications in reimbursement policies that would allow an increase of NPs providing primary care.

➢ American Association of Retired Persons (AARP)

AARP has historically been supportive at the state level when NPs are working with state legislation for full practice authority. The organization has periodically released statements of support when senate or house bills involving NP practice change for full practice authority are up for discussion. The Association is concerned with ensuring that retired persons have access and choice to the health care.

➢ Bipartisan Policy Center (BPC)

In the BPC’s report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, several recommendations are made to improve NP “flexibility” in practice. The report calls for changes in Medicare and Medicaid by
eliminating outdated statutory or regulatory requirements that interfere with states’ ability to regulate and determine the scope of practice such as the condition for collaboration for reimbursement. Even in states with full practice authority, there is regulatory language that continues to invoke barriers to NP practice. The report adds that relaxing scope of practice restrictions will allow teams of providers more flexibility to decide how best to divide up clinical responsibilities in service to patients (Collins, 2013).

➢ Federal Trade Commission (FTC)

The FTC states that proposals limiting NPs scope of practice unfairly limits competition in healthcare. The commission is in full support of the expanded scope-of-practice regulations for advanced practice registered nurses and issued a policy paper supporting NP advocacy efforts for unrestricted practice. The FTC has accused opposing groups such as the AMA as making strong opposition to scope of practice changes to thwart competition in the healthcare industry.

➢ Josiah Macy Foundation

Conference proceeding from 2010 recognized significant obstacles to NP practice supported by physician organizations. The monograph promotes hope for new dialogue of who will provide primary care and provider preparation. Recommendations included changes to state and national regulations and laws that will clarify the scope of practice of NPs as independent primary care providers.
VA

The VA stepped out amid government agencies to promote NP full practice authority in a number of releases. In January 2017 the agency went on to grant full practice authority despite state laws. The VA has been faced with an influx of Vietnam veterans reaching geriatric care and the new Iran veterans. NPs were recognized for utility, ability, and quality of care to address the veteran needs of care.

Studies of NP Quality Outcomes

There is a growing body of research providing evidence that removing NP practice restrictions can improve access to care without compromising the quality of care. A study by Timmons (2016) in the study The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on Medicaid Patient Access found licensing requirements for physician assistants and NPs affect medical outcomes for Medicaid recipients by raising costs. In another study by Zue, Ye, Brewer, and Spetz (2016) a systematic review of the impact of state NP scope of practice revealed that in states with a greater scope of practice had a greater provision of care by NPs and expanded health care utilization, especially among rural and vulnerable populations. Many study findings suggest that NPs in primary care settings perform as well as physicians in terms of clinical outcomes and patient satisfaction (Swan, Ferguson, Chang, Larson & Smallldone, 2016). A study in the Journal of the American Medical Association examining Primary Care Outcomes in Patients Treated by NPs or Physicians (Mundinger et al., 2000) it was concluded that NPs with the same authority, responsibilities, productivity and administrative requirements, and patient populations as primary care physicians, patients’ outcomes were comparable. These are but a few of the numerous examples of research finding
limitations to practice impeding access, quality of NP care and clinical outcome, and patient satisfaction. Finally, the systematic review *The Quality and Effectiveness of Nurse Practitioner Care* (Stanik-Hutt, 2013) concluded that care by NPs, CNSs, and CNMs produced patient outcomes that were similar to those related to care provided by physicians.

Despite several searches of the negative impacts and outcomes of NP care and patient dissatisfaction of NP care none were found. A number of medical organization sites and physician blogs expressed this claim but no reference to studies were found to substantiate the claims. The Physicians Foundation Report *Accept No Substitute: A Report on Scope of Practice*, Isaacs and Jelline (2012) identified the lack of studies to support the foundation stand to prevent expanding NP scope of practice with recommendations on such studies to be conducted.

**Opposition to NP Full Practice Authority**

Groups opposing NP full practice authority are composed largely of physician interest groups and medical organizations. The AMA and other physician groups argue that NPs don’t have sufficient training compared for an M.D. or D.O. The groups insist that the NP cannot provide same services safely and require physician oversight to be considered safe. According to Dr. S. Permut, Board Chair, American Medical Association (2016) in his response to the VA mandate for NP full practice authority, “we believe that providing physician-led, patient-centered, team-based patient care is the best approach to improving quality care for our country's veterans. We feel this proposal will significantly undermine the delivery of care within the VA.”

The Physicians Foundation Report *Accept No Substitute: A Report on Scope of Practice*, Isaacs and Jelline (2012) discusses challenges that physicians and their organizations are faced with the growing demand for non-physician providers expanded scope of practice. Concern was made on the relationship between NPs and large corporate groups such as retail clinics provide a
potential to shift the balance of power further toward non-physician providers. Jeline (2012) also
commented with concern about restoring the physician as the linchpin of the healthcare system
and expressed fear that the system would flounder or become “rudderless” with the NP in that
position.

Conclusion

The NP role was developed to fill a functional advanced level need in nursing. Once a
demonstration project by Dr. Loretta Ford was completed, it was evident that nurses were well
equipped to fill physician shortage needs in the public health clinic as Pediatric NPs. This led the
way for the development of the advanced role of NP. Professional education of the NP now
culminates through the MSN, adjunct Masters with a certificate or DNP. Upon graduation the NP
obtains certification and state licensing which differ by state. The U.S. has 3 variations in
practice: full practice authority; reduced practice authority; and restricted practice authority. Full
practice authority refers to no requirement of a collaborative agreement, no supervision or
conditions for practice. (See Appendix A for state practice status).

The current state of healthcare, barriers, and limitation of access to NP care was explored.
Access to healthcare service is limited by the social, and economic disparity. Poverty is the
major access limitation due to individual’s lack of insurance and demographic isolation from
health service resulting from poverty. Wellness, physician shortage, and increased utilization of
primary care are putting a strain on the current healthcare service. Physician shortage is apparent
and increasing as many physicians near retirement and fewer are pursuing family practice due to
a combination of factors. Increased utilization due to population growth, baby boomers reaching
retirement, and living longer furthers the strain in the healthcare system.
Healthcare access barriers include antiquated State Board of Nursing regulations and scope of practice. Regulations have failed to keep up with the evolving NP role. Federal, institutional and insurance limitations are creating barriers to NP access. Examples from the Patient-Centered Medical Home and the Independence At Home Models illustrate how language in federal policy limits and creates barriers to NP provision of care. There remain boundless information and evidence to support that NP full practice authority will eliminate barriers to healthcare access.

There are documented studies that support the quality of NP care along with organization and government agency consensus on the utilization and necessity for the NP to practice to the full scope of their education and training. Language changes at the legislative level are paramount to articulate the true utilization of the NP role into SOP. Opposing groups to eliminating CAP are largely physician groups that advocate against expanding SOP with primary concerns of financial and authority loss in the healthcare system.

Further progress towards full practice authority requires that NPs become active members in their trade professional groups to better advocate at the national, state and local levels. In 2013 both the American Academy of Nurse Practitioners and the American College of Nurse Practitioners merged to one collective body to form the American Association of Nurse Practitioners at the national level. This will align the organization to better advocate for patients, eliminate confusion in membership, and allow for a better legislative platform. NP advocacy groups must partnerships with other allied health professionals and grass root efforts to build a substantial political support able to supersede opposing groups. Full practice authority requires NP advocacy and activism to eliminate the barriers to NP practice.
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Appendix A

2018 Nurse Practitioner State Practice Environment

- Full Practice
  State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine and National Council of State Boards of Nursing.

- Reduced Practice
  State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care or limits the setting of one or more elements of NP practice.

- Restricted Practice
  State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team-management by another health provider in order for the NP to provide patient care.

Source: State Nurse State Practice Acts and Administration Rules, 2017
©American Association of Nurse Practitioners, 2017

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Appendix B
Social Determinants of Health 5 Key Areas

Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of SDOH.

Source: HealthyPeople2020.gov
Source: HRSA Data Warehouse [https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx]