



American Academy of Nursing on Policy

Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care



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Executive Summary

Lack of full practice authority (FPA) for advanced practice registered nurses (APRNs) is a barrier to the provision of efficient, cost-effective, high-quality, and comprehensive health care services for some of our most vulnerable citizens (Agency for Healthcare Research and Quality, 2014; Buerhaus, DesRoches, Dittus, & Donelan, 2015; Pohl et al., 2010a; Seibert, Alexander, & Lupien, 2004). APRNs have the education, knowledge, skills, and experience necessary to provide basic and comprehensive primary care services; they are a ready workforce, ideally positioned to improve access to care, contribute to health disparities reduction efforts, and lower the cost of providing such care (National Center for Workforce Analysis Health Resources and Services Administration, 2013; Perloff, DesRoches, & Buerhaus, 2016). However, barriers at the state and national levels continue to prevent these highly qualified health care providers from practicing to the full extent to which their education and training have prepared them. It is the position of the American Academy of Nursing (academy) that FPA of APRNs is essential to achieving health equity.

Background

Despite the increase in the number of individuals who obtained health insurance under the Patient Protection and Affordable Care Act (ACA), 17% of U.S. women and 28% of U.S. men did not have access to primary care

services in 2013 to 2015 (The Henry J. Kaiser Family Foundation, 2016a, 2016b). Rates of primary care access varied by race and ethnicity, with people from racial and ethnic minority backgrounds having least access; twice as many Hispanic men (47%) than white men (23%) reported not having a doctor (The Henry J. Kaiser Family Foundation, 2016a, 2016b). Other marginalized populations, including older adults, people who are poor or who live in rural areas, and people who are gay, lesbian, bisexual, transgender (including nonbinary or genderqueer), among others also have reduced access to comprehensive health services including primary care (Gates, 2014; Mather, Jacobsen, & Pollard, 2015; Ritchie, 2014; Ward, Schiller, Freeman, & Clarke, 2015; Weaver et al., 2014). People who do not have primary care providers have less access to the health care system as a whole, are less likely to obtain preventative health care services, and have worse health (Starfield, Shi, & Mackinko, 2005), contributing to increased health care costs and increased mortality (Hossain, Ehtesham, Salzman, Jenson, & Calkins, 2013; Office of Disease Prevention and Health Promotion, 2010; Weaver et al., 2014). The proposed repeal and potential replacement of the ACA (along with state Medicaid expansions, tax credits, and some coverage provisions) is concerning as it will dramatically increase the number of individuals who do not have access to basic health services, including primary care (Congressional Budget Office, 2017). Essential health benefits, such as emergency services, maternity and newborn care, preventive and wellness services, and chronic disease management, also face an uncertain future; if this coverage is eliminated, existing health disparities are likely to worsen

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(Congressional Budget Office, 2017). Access to high-quality, affordable, and comprehensive primary care health care services is critical to the health of our nation, and APRNs can help meet this need (Josiah Macy, 2010; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004).

APRN Workforce, Roles, and Scope of Practice

There are four distinct APRN roles: nurse practitioner (NP), certified nurse midwife (CNM), clinical nurse specialist (CNS), and certified registered nurse anesthetist (CRNA). Each role has a specific scope of practice that is based on their unique educational preparation and training and allows them to contribute to primary care in distinct and important ways (Federation of State Medical Boards, 2017; Safriet, 2002). APRNs bring a holistic as well as patient-centered and family-centered approaches to the prevention and management of complex health and behavioral issues addressed in various care settings across the life span. They work collaboratively with physicians and other members of the health workforce to optimize patient care and health. For example, NPs provide a range of comprehensive care services to address individuals' physical and mental health needs across the life span, and CNMs provide primary sexual and reproductive health services across the life span as well as postpartum care, childbirth, and care of newborns (Phillippi & Barger, 2015; Pohl et al., 2010b). CNSs and CRNAs increase access to affordable care services for populations in rural areas (Seibert et al., 2004). APRNs provide needed services to some of the most vulnerable populations in our society, including individuals from racial and ethnic minorities, Medicaid and Medicare recipients, residents of rural and frontier areas, and the uninsured and underinsured (Agency for Healthcare Research and Quality, 2014; Buerhaus et al., 2015; Seibert et al., 2004).

The ability of APRNs to practice to the full extent of their education and training is inextricably linked to state-level scope of practice¹ laws and regulations (National Coalition of State Boards of Nursing [NCSBN], 2008). At the state level, scope of practice for nurses is established either by legislative statute or by regulation, the Board of Nursing (BON), or other executive agencies (Buppert, 2014). Scope of practice in many states is limited by Board of Medicine (BOM) and/or Board of Pharmacy (BOP) oversight, removing the authority of nursing to govern APRN practice and licensure, and the ability for APRNs to practice to the full extent of their training as part of organized interprofessional health care teams (Hanson, 2014; Pohl et al., 2010a). Requirements such as mandated collaborative

practice agreements (CPAs) and physician-supervised transition-to-practice periods² increase the cost of providing care, lead to gaps in care, and deter APRNs from working in these restrictive states, without any demonstrated improvement in safety or quality (Fauteux, Brand, Fink, Frelick, & Werrlien, 2017; Kleiner, Marier, Park, & Wing, 2014; Safriet, 2011).

State-level challenges to APRN FPA have been exacerbated by ambiguities at the federal level. For example, failure to define APRNs as primary care providers under the ACA left this matter up to individual states, which contributed to barriers to FPA such as inconsistent policies regarding reimbursement for services delivered by APRNs, including lower payment³ rates (Brooks Carthon, Barnes, & Altares Sarik, 2015; Kurtzman et al., 2017; Safriet, 2002, 2011). Centers for Medicaid and Medicare prohibit APRNs from common tasks such as conducting admission evaluations and monthly assessments of patients admitted to skilled nursing facilities (American Association of Nurse Practitioners, 2012). In some cases, APRNs who have been authorized to perform within the full scope of their practice are later denied reimbursement for their services (Government Accountability Office, 2014), which limits patients' access to care. FPA for all APRNs in every state is further impeded by lack of consumer awareness of the type and amount of training APRNs receive and the services that they can provide, opposition from professional medical associations, and legislators who are tired from previous legislative attempts to widen APRN scope of practice (Safriet, 2011).

The Benefits of FPA

In states where NPs have FPA, benefits to patients, the health care system, and payers have been identified, including:

- Significantly fewer emergency room visits for nonemergency health care (Traczyndski & Udalova, 2013), lower hospitalization rates (Oliver, Pennington, Revelle, & Rantz, 2014), and expanded health care utilization, particularly among the most vulnerable (Traczyndski & Udalova, 2013; Xue, Ye, Brewer, & Spetz, 2016).
- Care provided at lower cost than physicians, including preventative care (Perloff et al., 2016; Traczyndski & Udalova, 2013).

² CPAs require that APRNs deliver care with physician oversight. APRNs often must pay for this mandated oversight and receive little actual oversight. Sometimes, these agreements are temporary, as in the case of transition-to-practice periods, which exist in 10 states. In these states, transition to practice requires that APRNs have physician oversight for a varying number of hours or years after which they can apply to work independently (Phillips, 2015).

³ Nurse practitioners are reimbursed at rates of 65% to 85% lower than physicians for providing the same services of the same quality (Kurtzman et al., 2017; Safriet, 2011).

¹ Scope of practice refers to "the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience" (Federation of State Medical Boards, 2017; p. 8).

- Fewer prescriptions for drugs commonly linked to overdose deaths (Schirle & McCabe, 2016).
- Reports of increased teamwork between NPs and physicians in primary care organizations (Poghosyan, Boyd, & Knutson, 2014).

Policies and Positions

2008: NCSBN releases the *Campaign for Consensus* (NCSBN, 2008), an initiative to encourage states to implement a consensus model for the standardization of regulatory requirements, such as licensure, accreditation, certification, and education of all four roles of APRNs.

2010: *The Future of Nursing* report is released in which The National Academy of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) in collaboration with the Robert Wood Johnson Foundation (RWJF) called for “nurses to practice to the full extent of their education and training ... [and] ... should be full partners, with physicians and other healthcare professionals, in redesigning healthcare in the United States” (Institute of Medicine, 2011; p. 4).

The ACA is passed, and in anticipation of the need to bolster primary care services, key provisions sought to increase access to clinical placements among graduate nursing students, the number of NPs who provide care in medically underserved areas, and access to primary care by the nation’s poor and underserved individuals (Brooks Carthon et al., 2015).

2010: The Center to Champion Nursing in America (CCNA)⁴ provided its support for *The Future of Nursing* and supported the development of state-level action coalitions to work on building infrastructure to implement the report’s recommendations (Brown, 2012). By 2012, 48 states had active state-level coalitions (Brown, 2012).

2016: The Veteran’s Administration (VA) finalizes a rule allowing three types of APRNs (NPs, CNMs, and CNSs) who work within the VA to have unrestricted practice authority for their work in the VA regardless of the state in which the individual VA hospital or facility is located (U.S. Department of Veterans Affairs, 2016).

2017: The ACA is in jeopardy, and an additional 14 million U.S. citizens would be without health insurance in 2018 (Congressional Budget Office, 2017). Proposed cuts to reproductive health and family planning reimbursement and essential health benefits threaten the health of our most vulnerable citizens (Congressional Budget Office, 2017).

American Academy of Nursing’s Position

Health care is a human right; as such, the increasing health care needs of the public, existence of disparities, and decreasing availability of primary care providers

are of concern to the academy. Allowing APRNs to have FPA has the potential to improve health equity while providing care that costs patients, health care systems, and payers less money. Furthermore, APRNs who are able to work to the full extent of their education and training have greater potential to identify creative approaches for solving problems within these systems, which will benefit nursing as a discipline, the larger health care community, and most importantly the public whom we serve (Safriet, 2011).

Therefore, the academy stands with the NCSBN, National Academies of Sciences, Engineering, and Medicine, RWJF, American Association of Retired Person (AARPs), CCNA, VA, National Governor’s Association (National Governors Association, 2012), American Hospital Association (American Hospital Association, 2013), Federal Trade Commission (Federal Trade Commission, 2014), and others in favor of removing all practice restrictions on APRNs, allowing them to practice independently and to the full extent of their education, training, and experience. We are also in favor of eliminating barriers to FPA such as BOM and BOP oversight and mandated CPA requirements. Furthermore, APRNs must be recognized for the quality of care that they provide and should be able to be reimbursed directly and at the same rate as physicians.

To this end, we provide the following recommendations:

- Congress should (a) reform the public and private payment systems to allow equitable independent reimbursement for APRN delivery of primary care in all settings, allowing direct remuneration from Medicare, Medicaid, and private payers for the care that is provided by APRNs; (b) enact global signature authority to allow APRNs to sign or complete forms related to patient care within their state, including ordering home health care; (c) allow nurse-led programs such as nurse-managed health centers to be acknowledged as essential community providers and reimbursed by Medicaid at 100%; (d) allow APRNs to join and independently operate accountable care organizations; and (e) standardize reimbursement reporting policies to help facilitate more throughput in health care systems (Josiah Macy, 2010).
- State Boards of Nursing should (a) remove all barriers and restrictions for APRNs in all four roles, in all states and federal agencies and clarify credentialing requirements for each role; and (b) ensure that scope of practice regulations conform with the NCSBN Practice Act and Model Nursing Administrative Rules (NCSBN, 2012) as suggested in *The Future of Nursing* report.
- State and federal legislators, policymakers, and public and private payers should use provider neutral language (e.g., replace physician with clinician or provider) in all state and federal health care legislation and reimbursement-related policies.

⁴ A collaboration between RWJF, the AARP, and AARP foundation.

- The VA should continue to support FPA for NPs, CNMs, and CNSs by making FPA mandatory in all VA facilities and amend the rule to grant CRNAs FPA as well.
- The Workforce Commission and Health Research Services Administration should be fully funded to provide leadership and develop infrastructure for collecting and analyzing interdisciplinary health care workforce data in collaboration with state licensing boards to assist in planning of future workforce needs (Schirle & McCabe, 2016).
- Nursing organizations and consumer-based organizations should work together to develop messages targeting consumers that aim to improve the public's understanding about the role and duties of APRNs (Safriet, 2011) and that "projects the image of APRNs as ... professionals who are strong and competent" (Lugo, 2016) to provide health care services in all practice settings and all individuals, and who do so in collaboration with other members of the interdisciplinary care team.

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