

COMMENTARY

Unleashing the Nation's Nurse Practitioners

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Across rural America, the current lack of access to health care is not solely a lack of insurance; it encompasses a long-term lack of primary care providers.¹ Even in areas that do not currently have a primary care provider shortage, the influx of newly insured and the growing needs of the chronically ill will place new demands on the primary care workforce as the provisions in the Patient Protection and Affordable Care Act (PPACA) unfold. As states look for creative strategies to improve access to care, lower health care costs and improve quality of care and outcomes, a considerable segment of the health care workforce—nurse practitioners (NPs)—remain underutilized due to the diversity of state nursing practice acts. Many issues at the heart of rural health care—an aging, increasingly sicker rural population with a strong need for preventive and chronic disease care—fit well within the skills that NPs offer.

Over the past 20 years, a series of reports on NP scope of practice have consistently described barriers to NP practice including a wide range of state laws regulating NPs' ability to practice, diagnose illness, and prescribe medication for patients.²⁻⁵ Many of the nation's nurse practice acts, especially in rural states, have not been changed in decades, and thus do not reflect modern NP practice.² One way that state NP regulations vary widely is in the dramatically different requirements for NP practice. For example, 28 states continue some form of physician-delegation, requiring various degrees of physician supervision for NP practice, while other states support independent NP practice.² Some states require that *only* physicians may refer patients to physical therapy. Other states require a patient to be seen by a physician within 10 days if the patient's condition or treatment has

changed, or they impose rigorous restrictions on which medications NPs are authorized to prescribe. Some states require NPs to have a physician on-site 10% or more of the time, which places an added burden on physician time, raises costs, and shifts the physician away from direct patient care. Still others have an added requirement of an "internship" for up to 2 years with a physician or *podiatrist* prior to practicing on their own NP license. Moreover, some states place restrictions on NP prescribing, creating unfounded barriers to the management of patient conditions. For example, certain states permit NPs to prescribe only a 7-day course of medication, thereby creating a potential for incomplete treatment of an illness, the creation of drug-resistant microbes and poorer patient outcomes.

The above examples are regulations that comprise a continuum from independent practice to imposed supervision, and they differ dramatically from the recommendations established by the nursing profession. These outdated nurse practice acts not only lack an evidence-based rationale, but they can also negatively impact patients' access to care and the ability of an NP to fully serve patients in rural and underserved areas. These barriers impede the use and effectiveness of NPs as needed members of the health care team.

Health Reform and Policy Implications

Rural communities need primary care providers who are able to use their entire skill set. The PPACA underscores the need to reduce interstate variability because it dramatically expands opportunities for innovations designed to transform care delivery in all settings.

Moreover, multistate insurer strategies in the PPACA provide a rationale for consistent NP regulation and practice across the 50 states.⁶ It is necessary to increase the availability of qualified primary care health care providers in rural communities to improve health care outcomes through the use of health promotion strategies—an area that NPs are expert at providing. Moreover, the inconsistencies in state practice acts will thwart delivery system innovation and team-based models of care that will be necessary to meet the increased demand of a surge of newly insured and aging individuals needing primary care services. The PPACA has numerous provisions to expand access to rural health care, including an increase in nurse-managed health centers, expansion of the National Health Service Corps, research to investigate outcomes of home-delivered primary care and transition care, and the elimination of consumer copayments for prevention services. These expanded safety net strategies, delivery innovations, and bundled payment methods could be made far more successful with NPs practicing at the “top of their licenses.”⁷

The Evidence Base for NP Practice

The summary of 4 decades of research related to the safety and quality of NP-delivered care, across settings, indicates that NP care is at least equivalent to that of physician-delivered care with regard to quality and safety. In some studies, NPs have demonstrated stronger communication skills when dealing with patients.⁸⁻¹² Moreover, NPs have been credited with improving the geographic supply of providers because many NPs have been willing to locate to underserved rural areas where a dearth of physicians are willing to live and practice.¹

Opponents to NP full scope of practice conclude that patient safety is at risk with autonomous NP practice. The absence of safety and quality problems in states with updated practice acts (eg, Arizona or Wyoming who have large rural populations), as well as 40 years of experience and studies, suggest that there is sufficient evidence that consumers will be protected with modernized practice acts.¹³

A Rational Regulatory Framework

Regulators must protect the public by determining who is qualified to deliver services safely and without harm to the public, the only justifiable condition for defining scopes of practice.⁵⁻¹⁵ As states look for ways to expand high-quality, affordable health care, modernizing nursing practice laws will not address all of the daunting health

care problems, but it will correct problems created by needless and unfounded regulations. Removing barriers that have no rationale increases opportunities for innovation within a context of care that has been found safe over 4 decades.

To move the nation forward from the current patchwork of regulations, a new highly transparent and dynamic regulatory model has been developed for advanced practice nurses.^{15,16} The model recommends consistent NP licensure, accreditation, certification, and education based on valid, reliable processes, reflecting nationally recognized and accepted professional standards. The model has the potential to bring the states into a strong, standard nursing regulatory environment for NPs, and to make it possible for the rapidly growing NP workforce to be fully and safely utilized to meet consumer needs.

The Institute of Medicine, the Pew Health Commission, and others have long held that regulation needs to be evidence-based and related to quality rather than professional divisiveness.¹⁶⁻²⁰ The regulatory model for NPs is a significant forward-thinking approach, as health reform unfolds and the use of interstate medical homes and accountable care organizations become more prevalent as both delivery and payment strategies.

The regulation of health professions will continue to fall to the states. The current piecemeal, ad hoc approach to regulation of scope of practice for NPs is inappropriately political in most states. State legislators are asked repeatedly to adjudicate scope of practice challenges that occur within an adversarial context between nursing and medicine, a highly technical undertaking that state lawmakers may not be qualified to assess.¹³ As a result, some states, including New Mexico, Iowa, Texas, and Virginia have developed an independent authority to determine highly technical scope of practice disputes to insulate the legislators from narrow, territorial, and political interests.¹⁴ These professional turf battles are not in the public interest and do not put consumer protections, and health care safety, at the forefront.^{14,18,19}

Conclusion

Rural health care is a unique practice arena that requires a health workforce with a long-term dedication to communities and families. The wide variation of state requirements across the nation for NPs suggests that NP regulations lack a consistent, identifiable rationale for public safety, and limits on NP practice create an environment that prevents the full utilization of NPs in rural health.

Modernizing state nurse practice acts would be a wise mechanism for states that anticipate health care demand

surges, as access is expanded and as rural communities continue to struggle with health care workforce shortages and aging populations. The new advanced practice nursing regulatory model provides a framework for states to regulate NPs, building consistency among the states, which can improve patients' access to care.

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