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Introduction

This paper critically explores Institute of Medicine (Institute of Medicine [IOM], 2010) recommendations; the continuing efforts to expand primary care services to newly insured populations; and, in this case, optimizing the role of advanced practice registered nurses by mitigating scope of practice barriers through better understanding of state policy regulations. This paper identifies current state regulatory policies related to primary health care services delivered by nurse practitioners (NPs) and considers these policies within the framework of scope of practice barriers. Through a multi-disciplinary lens of health care and public administration, the impact of state regulatory policy and its potential for obstruction of the expanding role of nurse practitioners in meeting primary health care needs of the newly insured is explored.

Background

Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2012) has four main goals linking prevention, health equity, healthy environments, and the promotion of healthy behaviors. Achieving Healthy People 2020 goals depends in large part upon access to preventative care and chronic care management. Meanwhile, implementation of the Patient Protection and Affordable Care Act (PPACA) is projected to add 32 million newly insured people into the U.S. system by 2014 (IOM, 2010). One significant challenge in attaining the goals of Healthy People 2020 is to provide equitable access to care for this population. Improving *access to care* would significantly decrease the prevalence of many chronic illnesses, including diabetes, hypertension, heart disease, and stroke which are major cost drivers in the U.S. health care system.

Conservative estimates identify 47,208,222 uninsured people in the United States, with 98.4% younger than 65 (U.S. Census Bureau, 2012) while another 25 million are underinsured (Rovner, 2009). Absent and inadequate coverage results in substantial limitations on health care access, contributing to poor health outcomes and creating serious financial burdens to society (Kaiser, 2002). Demographic data provide vivid pictures of the disparity between the insured and the uninsured: only 27.6 % of low income people over the age of 16 have health insurance, compared to 97.8% of people earning $75,000 a year or more, while 98.4% of people ages 65 and older have health insurance, only 87.5% of people under age 18 do (U.S. Census Bureau, 2012). *Healthy People 2020* links prevention, equity, healthy environments, and the promotion of healthy behaviors that depend in part upon access to preventative care and chronic care management. By 2014, PPACA will assure 32 million people are insured (IOM, 2010). Clearly, equitable access remains a significant hurdle in the U.S. health care system (Bodenheimer & Grumbach, 2009), and a challenge to attaining *Healthy People 2020 goals*.

This paper explores the influence of three fundamentals of a successful health care system identified by Wan (1995): the health system environment, resource availability, and access. Understanding the impact of state nurse practitioner regulatory policy on these key elements will inform public administrators, health administrators, and policy makers as they work to reduce access to care barriers. Barriers may be reduced by engaging the public sector in building capacity (Campbell & Conway, 2005), through financial contributions or policy regulation. Millions of newly insured will seek primary care services as the 2010 PPACA rolls out. The PPACA is expected to introduce $15 billion into the trillion dollar health care industry (Mays & Smith, 2011). However, appropriate allocation of these funds depends in part upon understanding implementation barriers to delivering health care to the newly insured. To complicate the process, while the access to care demands increase, a shortage of primary care providers has already been demonstrated in the U. S. (Center to Champion Nursing, 2011). The IOM (2010) put nursing at the forefront of mitigating this primary care provider shortage. One solution is advanced practice registered nurses (APRN) who could play a significant role ameliorating these primary care shortages, yet only if scope of practice barriers are clearly identified and addressed.

One approach to increasing access to care is to maximize utilization of the services of APRNs (Fairman, Rowe, Hassimiller, & Shalala, 2011; IOM, 2010). Several studies have suggested there may be correlations among restrictive regulatory policies of specialized APRNs, access to care, and health outcomes in vulnerable populations (Rudner, O'Grady, Hodnicki, & Hanson, 2010; Sonenberg, 2010). The Institute of Medicine Report on the *Future of Nursing: Leading Change, Advancing Health* (2010) puts nursing at the forefront of mitigating the shortage of primary care providers with eight recommendations that optimize the roles of nurses and APRNs in improving access to primary care services for newly insured populations. This study will elucidate the role scope of practice reform could have in transforming state and local health policies to improve patient access to nurse practitioner services.

Consensus Model for APRN Regulation (2008)

After a four yearlong consensus-building effort by dozens of stakeholders including: educators, certifying bodies, 50 state boards of nursing and educational accrediting agencies, a national framework for educating, accrediting, licensing, and regulating APRNs was recommended. The Consensus Model Recommends that: "…boards of nursing shall be solely responsible for regulating all advanced practice nurses" who "…must be licensed as independent practitioners with no regulatory requirement for collaboration, direction or supervision" (National Council of State Boards of Nursing, 2008).

Methods

Design The design of this health policy research study is a secondary data analysis. The sample was the 50 states of the United States of America. The sources of data included the Kaiser Family Foundation *State Health Facts*, the American Academy of Nurse Practitioners (2011), US Census Bureau, and the National Center for Health Workforce Analysis (2002).

Measurement of State Regulation of Practice of APRNs The National Center for Health Workforce Analysis (2002) gathered data related to state regulatory policies of nurse

practitioners (NP), one group of APRNs, and designed a scale to define their scope of professional practice. The scale is an additive scale, with a total possible score of 100, comprised of a set of indices in *three distinct categories*: 1) *Legal status* (Optimal Score=20), which authorizes and protects NP practice; 2) *Reimbursement* (Optimal Score=40), which includes specification of Medicaid payment rates for NP services; and 3) *Prescriptive authority* (Optimal Score=40), which authorizes extent of NP prescriptive authority.

Data Analysis The analysis of the data included calculating the Pearson Correlation Coefficients to determine the association between numbers of nurse practitioners practicing in each given state with each of the given state's regulatory categories. *Legal status* was reflected by the scope of practice law requiring physician supervision for an NP to diagnose and to treat. The *reimbursement* category was measured as the percentage of the physician rate that an NP was reimbursed for Medicaid services delivered in each state. Finally, the extent to which an NP was authorized to prescribe and whether a physician co-signature was required was identified as well. In those cases where a significant association was found between NP population practicing and regulatory scope of practice score, exemplar population health outcomes were considered in the association. Select preliminary results can be found in Table 1.

Findings and Health Policy Implications

Among other findings, the association between collaboration/supervision with an MD and prescriptive authority was highly significant ($p <.01$). This finding might reflect a barrier to access to care if the patient has to return for a separate visit for a prescription from a physician. Furthermore, there was a positive correlation between the regulation requiring MD supervision for prescriptive authority and prevalence of hypertension (% HTN). This suggests there may be fewer successfully treated hypertensives in areas where NPs cannot prescribe independently, again suggesting compromised access to care, and thus potentially ineffective disease management. Additionally, a significantly ($p<.05$) negative association was identified between number of NPs and prevalence of obesity (% obesity). This again suggests a potential inadequate access to care in areas where there are fewer NPs practicing.

The health policy implications of these preliminary findings include the current lack of a central data source for APRN practice patterns, costs, or outcomes. APRNs, as a professional group including NPs, have the promise to play a vital role in expanding access to care for vulnerable populations if state practice acts are consistently less restrictive in the 3 categories of regulation: legal status, reimbursement, and prescriptive authority.

Recommendations include the need for states to modernize regulatory policies and reduce restrictions on APRN practice by utilizing evidenced-based regulations such as the *Consensus Model for APRN Regulation* as the national framework.

Future Research on APRNs

APRN care and quality metrics need to be developed and included in national data sets. Also methodologies on cross-national data on APRNs should be improved to include patient outcomes in primary care. In order to realize the potential of APRN practice in expanding access to care to vulnerable populations and to improve health

outcomes, research should be conducted on the impact of least-restrictive APRN state practice acts and their links to obesity, hypertension rates, and other health outcomes, particularly in patient populations supported by Medicaid.

Key questions related to regulatory policy remain: 1) Do patients in states with laws that allow APRNs to practice within their full educational and licensed scope have greater access to primary care than those in states with more restrictive state practice acts?; 2) Do states with laws that allow APRNs to practice within their full educational and licensed scope have better population health outcomes than states with more restrictive state practice acts?; and 3) What are the key regulatory policies that affect APRN practice?

References

Bodenheimer, T.S. & Grumbach, K. (2009). *Understanding Health Policy: A Clinical Approach* 5th ed. New York: Lange Medical Books/McGraw Hill.

Campbell, P. & Conway, A. (2005). Developing a local public health infrastructure: The Maine turning point experience. *Journal of Public Health Management and Practice*. 11 (2): 158-64.

Center to Champion Nursing (2011). Access to Care and Advanced Practice Nurses

A Review of Southern U.S. Practice Laws. AARP Foundation and the Robert Wood Johnson Foundation Retrieved from http://www.achi.net/HCR%20Docs/2011HCRWorkforceResources/Access%20to%20Care%20APNs.pdf

Fairman, J.A., Rowe, J.W., Hassimiller, S., & Shalala, D. (2011). Broadening the scope of nursing practice. *New England Journal of Medicine*. 20;364(3):193-6.

Institute of Medicine (2010). *Future of Nursing: Leading Change, Advancing Health*. Washington, D.C.: The National Academies Press.

Kaiser Foundation, H.J. (2002). *Underinsured in America: Is health coverage adequate? The Kaiser Commission on key facts*. Retrieved 11/13/09 from: http://www.kff.org/uninsured/upload/Underinsured-in-America-Is-Health-Coverage-Adequate-Fact-Sheet.pdf

Mays, G.P. & Smith, S. (2011). Evidence links increases in public health spending to declines in preventable deaths. *Health Affairs;* Aug 2011; 30, 8

Rovner, J. (2009). The Richard and Hinda Rosenthal Lecture 2008: *Prospects for health reform in 2009 and beyond*. Washington D.C.: Institute of Medicine National Academies Press.

Sonenberg, A. (2010). Medicaid and State Regulation of Nurse-Midwives: The Challenge of Data Retrieval. *Policy, Politics, and Nursing Practice* 11: 253-25

U.S. Census Bureau (2012). *American Fact Finder*. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_S2702&prodType=table

U.S. Department of Health and Human Services. (2012). *Healthy People 2020*. Retrieved from: http://www.healthypeople.gov/2020/default.aspx

Wan, T.T. H. (1995). *Analysis and Evaluation of Health Care Systems: An Integrated Approach to Managerial Decision Making*. Baltimore: Health Professions Press.

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