



How State Scope-of-Practice Policies Impact NP Care

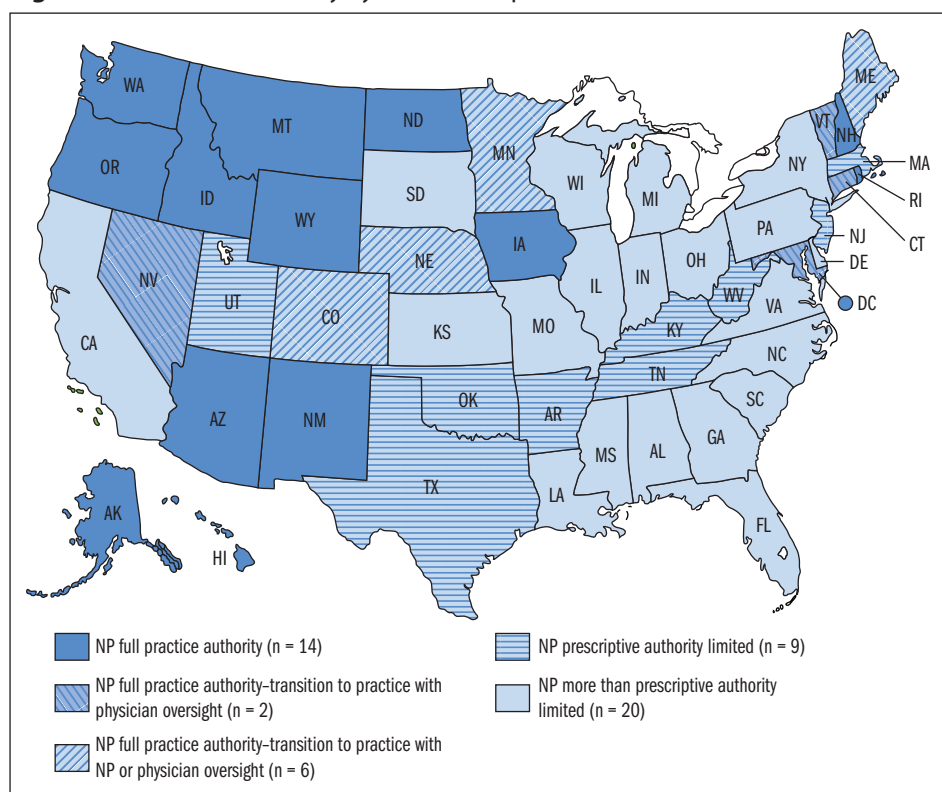
Three projects examine the effect of NP practice acts on access to health care.

State laws often restrict the ability of NPs to provide health care to the full extent of their education and training.¹ These state scope-of-practice laws vary greatly and regulate NPs' authority to diagnose and treat patients. Many states require NPs to practice under the supervision of, or in collaboration with, a physician or another advanced practice nurse.² With the demand for primary care services projected to continue to increase, giving full practice authority to NPs or removing NP scope-of-practice limitations is likely to increase patient access to care.³

To better understand how state scope-of-practice laws impact NPs, researchers at Temple University and the Centers for Disease Control and Prevention's Division for Heart Disease and Stroke Prevention (DHDSP) collected data on NP scope-of-practice policies at the state level. These data were generated by three projects that examined the effect of NP scope-of-practice acts and regulations on patients' access to health services and team-based care. These included a policy surveillance of NP scope-of-practice laws, a case report on the impact on NPs of full practice authority, and an ongoing policy impact study linking NP policy surveillance data to medication prescription fill data. Brief descriptions are provided below.

Policy surveillance of state scope-of-practice laws. In collaboration with the Temple University Center for Public Health Law Research, DHDSP staff systematically collected, reviewed, and double coded the NP practice acts and regulations in effect

Figure 1. NP Practice Authority by State as of April 2016



in the 50 states and the District of Columbia from 2015 through 2016, identifying key features of each. The results showed that, as of April 2016, 22 states provided full practice authority to NPs; however, six of these required a transition period of working either with another NP or with a physician, and two required a transition period of working either in collaboration with or under the supervision of a physician (see Figure 1).⁴ Twenty-nine states limited NP practice authority, of which nine limited NP prescribing and the remaining 20 required additional physician supervision or collaboration for other NP services. Three states made changes to their NP practice acts that affected full



practice authority during the two years studied: both Maryland and Nebraska removed their collaborating physician requirements, thereby allowing transition to full practice, and Colorado reduced the required transition to practice hours. Briefs, coding protocols, maps, and a summary analysis of the NP legal dataset are available at <https://lawatlas.org/datasets/nurse-practitioner-scope-of-practice-1460402165>. Additionally, a state law fact sheet describing temporal and geographic trends in NP practice authority is available at www.cdc.gov/dhdsp/pubs/docs/SLFS_NSOP_508.pdf.

Case report. DHDSP researchers interviewed NPs in Nevada and Minnesota about the impact of state law amendments granting them full practice authority with a transition-to-practice requirement. Nevada granted NPs full practice authority in 2013 and Minnesota followed in 2014. The interviews addressed three areas of interest: the challenges NPs experienced prior to receiving full practice authority, the barriers and facilitators NPs encountered as full practice authority was being implemented in their respective states, and any lessons learned since full practice authority was granted. According to interviewees, challenges prior to receiving full practice authority were the amount of time, effort, and costs involved in executing collaborative agreements with physicians.⁵ Barriers to full practice authority implementation included legal and institutional challenges, business costs, and the varied perceptions of an NP's quality of care compared to that of a physician. However, implementation facilitators were linked to perceived full practice authority benefits, including an increase in the number of practicing NPs, the ability to reach broader populations and underserved groups, and the freedom to innovate and improve health care delivery. Since full practice authority was granted, the NPs acknowledged having become a recognized resource on policy for their state legislators and having the ability to deliver more innovative care to meet population needs, but allowed that more time and education were needed to widely disseminate the value of NP full practice authority.⁵ The full case report is available at www.cdc.gov/dhdsp/pubs/docs/Nurses_Case_Study-508.pdf.

Policy impact study. The state NP scope-of-practice policy surveillance data analysis described above was expanded to cover the years 2009 through 2018 in order to examine the association between practice autonomy and the role of NPs in managing blood pressure and cholesterol. The resulting DHDSP longitudinal study

categorized each state by degree of NP practice autonomy (full practice, full practice after transition period, prescriptive authority limited, prescriptive and other practice authority limited) authorized in state law. This longitudinal legal dataset was linked to U.S. Census data and a national prescription fill database in order to examine the association between practice autonomy ratings, the degree of urbanicity, and blood pressure-lowering and/or cholesterol-lowering prescription fill counts attributed to NPs or other health care providers by state. The study is expected to be published this year.

Overall, still more information is needed to explore feasible and effective methods for ensuring accessible, affordable, and high-quality health care in an era of impending provider shortages and increasing patient need. Further research on the intersection between NP scope-of-practice laws, health care access, and patient care outcomes could provide necessary information to inform future decision-making. Over time, this research has the potential to educate providers, patients, and health care organizations on NP capacity and value in providing the health care services NPs are trained and educated to perform. ▼

Lauren N. Taylor is an Oak Ridge Institute for Science and Education fellow and Siobhan Gilchrist is an IHRC, Inc., public health policy analyst, both in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention, Atlanta. Contact author: Lauren N. Taylor, lmn7@cdc.gov. The authors have disclosed no potential conflicts of interest, financial or otherwise. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

REFERENCES

1. Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The future of nursing: leading change, advancing health*. Washington, DC: National Academies Press; 2011. Consensus study report; <https://www.nap.edu/catalog/12956/the-future-of-nursing-leading-change-advancing-health>.
2. American Association of Nurse Practitioners. *State practice environment*. 2019. <https://www.aanp.org/advocacy/state/state-practice-environment>.
3. Auerbach DI, et al. Nurse-managed health centers and patient-centered medical homes could mitigate expected primary care physician shortage. *Health Aff (Millwood)* 2013;32(11):1933-41.
4. Centers for Disease Control and Prevention. *State law fact sheet: a summary of nurse practitioner scope of practice laws, in effect April 2016*. Atlanta; 2018. CS277666H. https://www.cdc.gov/dhdsp/pubs/docs/SLFS_NSOP_508.pdf.
5. Centers for Disease Control and Prevention. *Practical implications of state law amendments granting nurse practitioner full practice authority*. Atlanta; 2018. https://www.cdc.gov/dhdsp/pubs/docs/Nurses_Case_Study-508.pdf.