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The Full Practice Authority Initiative: Lessons Learned From Nevada

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ABSTRACT

A qualitative, multiple-participant case study design was employed to identify legislative barriers to full practice authority legislation and how they were overcome during Nevada's 2013 legislative session. Eight barriers were identified: lack of a clear vision; lack of physician support; inability to address all stakeholders; lack of a strong coalition; lack of vital resources; nurse practitioner role recognition; community and regulatory organizations; and social media. Efforts to overcome these issues are described. The findings may be useful in states vying for full practice authority legislation, and may act as a stepping stone toward addressing the provider shortage in the United States.

Keywords: autonomous practice, barriers, full practice authority, health policy, legislation, nurse practitioner

INTRODUCTION

In the United States there is a vast and increasing shortage of primary care providers to serve the population's health care needs. The aging population, combined with the increase in individuals obtaining health insurance, adds further to the shortage of health care providers. Currently, 65 million Americans live in areas of primary care shortage, and adults across the nation are unable to promptly access primary care services.[1] For the period between 2005 and 2025, the overall number of necessary primary care visits is projected to increase by 29%, secondary to the aging population.[2] More specifically, the number of visits to a primary care provider is estimated to rise from 462 million visits in 2008 to 565 million visits in 2015.[3]

Nurse practitioners (NPs) have been identified as providing an answer to this critical health care shortage. NPs armed with full practice authority (FPA) are being touted as the ultimate solution to the shortage of primary care providers, thereby improving access to health care.[4] Currently, only 20 states and the District of Columbia provide FPA for NPs.[5] On June 3, 2013, the Governor of Nevada signed into law Assembly Bill 170, which amended the practice requirements of NPs in the state.[6] Although the NPs' scope of practice was unchanged, this bill provides NPs the ability to practice independent of physician oversight and to their full extent of education and training.

The purpose of this study is to describe specific legislative barriers to introducing and obtaining FPA for NPs, and to recognize how these barriers were overcome during Nevada's 2013 legislative session. A multiple-participant case study was conducted using key informants from the state of Nevada.

BACKGROUND AND SIGNIFICANCE

Secondary to the overhaul of the Affordable Care Act, many American's were provided with access to health insurance. From October 1, 2013 to February 1, 2014, 3.3 million people enrolled in insurance plans provided by the Affordable Care Act.[7] On September 19, 2014, the Obama Administration announced that 7.3 million US residents who signed up for health insurance under the Affordable Care Act had paid their first month's premiums. With increasing access to health care for US residents, there is an additional need for primary care providers to help remedy the existing shortage.[8]

NPs have provided health care services to medically underserved populations for several decades now. NPs have also been used in primary care and specialty clinics working with physicians. According to Newhouse et al.,[9] NPs currently serve a vital role in improving patient care by providing high-quality services. Furthermore, multiple studies found that patients seen by NPs had high levels of satisfaction, superior patient outcomes, and efficient cost-effectiveness in clinical settings.[10-12]

Legislative restrictions in many states currently prevent NPs from practicing to the full extent of their education and training. In fact, currently, NPs in 31 states are limited by legislative restrictions. Some of these restrictions limit the type of patient an NP can see, specify which tests an NP can order, and constrain the NP's prescriptive ability.[13] Physician oversight is the main factor separating the various types of practice across state lines.[14]

A literature review was performed exploring the various barriers to autonomous practice of NPs in the US, and to identify the legislative barriers to FPA. Multiple barriers to autonomous practice for NPs were identified. Autonomous practice barriers included a conflict between the medical and nursing roles, lack of NP role recognition, financial challenges, and a lack of business knowledge.[15-17] Barriers to autonomous practice caused by policy limitations were the most frequently mentioned in the literature review, whereas others included limited scope of practice,[18] limited prescriptive authority,[19] limited clinical privileges,[20] certification,[5] credentialing limitations, and reduced reimbursement rates.[21]

Despite the evidence of these barriers, there was a gap in the literature identifying barriers explaining why FPA legislation is not signed into law as often as it is introduced to the legislature. MacDonald et al.[22] reported the importance of forming a strong alliance is an essential component to introducing legislation. Although it may be implied that a lack of a strong alliance may be a barrier to FPA legislation, this was not directly stated. Other behaviors to improved legislation included accessing the media, personally meeting with legislators, and improving public awareness; however, these were not identified as barriers and were not related to FPA legislation.[22,23]

VanBeuge and Walker[6] examined the journey of attaining FPA in the state of Nevada, but they did not mention legislative barriers. Insight into the process of introducing and implementing FPA legislation in Nevada consisted of 5 key steps. Although some barriers can be inferred from their article, there was no direct mention of specific legislative barriers.

METHOD

In this investigation we employed a qualitative, multiple-participant case study design. The method was chosen to best obtain the perspectives from experts in the field. Further, case study designs may be used to apply some findings to similar settings. It is therefore possible that findings from this study may be used to inform those seeking to move more states toward FPA.[24]

CONCEPTUAL FRAMEWORK

For NPs to have an even greater impact on access to health care in the US, work must continue toward removing restrictive legislative barriers. Kotter's[25] change management model was used to guide this research study, as it has been highly successful for instituting change in many disciplines, including leadership, education, and nursing.

INCLUSION CRITERIA AND FINAL SAMPLE

Participants were sought to represent the perspectives of 4 groups who may have influenced the efforts toward FPA in Nevada: a physician; a community-based NP; a nursing leader or NP activist; and a state legislator. To best speak to the process of attaining FPA, participants were sought who were actively involved in the advancement of FPA legislation and attended the 2013 legislative hearings in the state of Nevada. No participants were excluded due to age, gender, ethnicity, or race. Although recruitment included the search for a physician actively involved in the process, no physician volunteered to participate, and several specifically declined. The final sample consisted of a community-based NP, a nursing leader, a nursing activist, and a state legislator.

ETHICAL CONSIDERATIONS

The study was approved by the institute review board before recruitment began. Confidentiality and anonymity were ensured throughout the study. Questions were limited to the specific experiences relating to legislative barriers to FPA. Pseudonyms were used to de-identify the participants.

RECRUITMENT

Recruitment flyers were sent to 3 organizations: the Advanced Practice Advisory Board; the Nevada Advanced Practice Nurse Association (NAPNA); and the Nevada State Board of Nursing. Snowball sampling was then used to identify further potential