The Question for Full Practice Authority in Tennessee

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ABSTRACT

Granting nurse practitioners and other advanced practice registered nurses full practice authority has been shown to improve patients' health outcomes and access to essential health care services. This article includes a reflective description of several aspects of the work of a legislative task force convened to address advanced practice registered nurses practice authority in Tennessee. Distractions and distortions used by physician task force members, lessons learned from the task force deliberations, policy implications, and the next steps for future advocacy efforts are discussed to help nurse practitioners in other states seeking full practice authority.

Keywords: APRN education, full practice authority, health care access, nurse practitioners, access

The practice environment for Tennessee nurse practitioners (NPs) is among the most restrictive in the United States.[1] Although the stated purpose of a Scope of Practice Task Force, commissioned by the Tennessee General Assembly (TGA) in 2016, was to "make recommendations on the implementation of a plan to allow health care providers to work to the full extent of their education, experience, and training and identify … unnecessary regulation" (Box 1).[2] There has been no change in the state's restricted practice authority status. Several positive changes were negotiated, but collectively they were insufficient, and agreement on these changes required the imposition of a 3-year moratorium on practice authority legislation.

The resistance to progressive change in practice authority seen in Tennessee is similar to experiences in other restrictive states, many of which are located in the southeastern United States and are relatively conservative. There is a growing realization that advancing full practice authority in the remaining resistant states will require new strategies. To facilitate future work in Tennessee and the other restricted- and reduced-practice authority states, an examination of the distractions and distortions used by task force members who opposed easing of NP practice regulations and a discussion of key lessons learned, policy implications, and next steps is presented.

DELIBERATIONS AND OUTCOMES

The task force met 4 times and polarization between the physician and nurse members was apparent from the first meeting. Advanced practice registered nurses (APRNs) envisioned a route to autonomous practice, or at least a less restrictive environment, an idea the physician task force members resisted from the beginning.

The second meeting included presentations by a Tennessee Department of Health (TDOH) physician and a Tennessee Board of Nursing (TBON) consultant on opioid prescribing, NP practice and prescribing, and disciplinary actions against Tennessee NPs for overprescribing. Task force members agreed that regulations were not being enforced adequately and that there was a dearth of TDOH resources for investigating potential abuse. At the third meeting, APRNs gained agreement to provide evidence-based presentations about APRN education, clinical outcomes, patient satisfaction, and the economic impact of granting full practice authority.

During the final meeting, members were divided into small discussion groups tasked with identifying

Box 1. Task Force Objectives

Tennessee Public Chapter 1046, Section 3A[2]

The task force shall

1) Develop a plan to educate the public and healthcare professionals about the advantages and methods for a transformative healthcare delivery system that addresses the need for accessible, equitable, and affordable care provided by the appropriate healthcare professional;
2) Make recommendations on the implementation of a plan to allow healthcare providers to work to the full extent of their education, training, experience, and certification; and
3) Identify
   (A) Barriers to the adoption of best practices, including, but not limited to unnecessary regulation and lack of access to primary care providers; and
   (B) Potential public policy options to address any barriers identified pursuant to subdivision (a)(3)(A)

consensus on proposed recommendations that could be taken to the TGA. When the groups reported to the entire task force, only minimal progress was apparent. At the meeting's conclusion, each task force member was given the opportunity to express his or her major concerns and offer solutions for bringing the 2 groups into better agreement. Although the task force had no definitive or measurable outcomes, it seemed that working together had allowed some seeds to be planted and several connections to be made among select task force members.

DISTRACTIONS AND DISTORTIONS

Task force physicians drew attention away from assigned objectives (Box 1) using 4 key distractions and distortions. These distractions and distortions are not unique to Tennessee and include the following:

1. Assaulting the adequacy of APRN education because it does not follow the format of medical education (distraction)
2. Dismissing evidence of the cost, quality, effectiveness, and acceptability of APRN-provided care (distortion)
3. Denying health care access problems exist in the state (distortion)
4. Blaming APRN prescribers for the state's prescription drug abuse epidemic (distortion)

APRNs working toward full practice authority in other states have cited their opposition's use of similar tactics.[3,4] Nurse task force members attempted to respond to these tactics with evidence and logic. However, citing facts and analytical reasoning proved ineffective at dispelling misconceptions and false statements stemming from resistance to APRN full practice authority.

APRN EDUCATION

There is no disputing that medical school education is longer than APRN education. However, comparing years of education and clinical hours physicians and APRNs have before practice is irrelevant to their ability to provide high-quality care that improves health, saves money, and satisfies patients. If evidence-based medicine is the standard, then care should be evaluated using clinical and patient—satisfaction outcomes, not the number of years of education.[5] The argument to limit APRNs' scope of practice because physicians have more education and clinical preparation underscores a growing realization that physicians may be overprepared to deliver the majority of direct primary care services and are therefore better suited to roles related to population health management and caring for populations with complex needs. Indeed, health care experts are calling for the transformation of primary care service delivery as well as the roles of physicians and other team members.

DISMISSAL OF SCIENTIFIC EVIDENCE

The physicians refused to recognize the evidence presented by nurses during task force proceedings. Lazure, Cramer, and Hoeblheinrich noted that physicians often refute evidence by questioning methodology.[6] One physician member said that nothing less