American Academy of Nursing on Policy

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Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care

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American Academy of Nursing Primary Care Expert Panel

Executive Summary

Lack of full practice authority (FPA) for advanced practice registered nurses (APRNs) is a barrier to the provision of efficient, cost-effective, high-quality, and comprehensive health care services for some of our most vulnerable citizens (Agency for Healthcare Research and Quality, 2014; Buerhaus, DesRoches, Dittus, & Donelan, 2015; Pohl et al., 2010a; Seibert, Alexander, & Lupien, 2004). APRNs have the education, knowledge, skills, and experience necessary to provide basic and comprehensive primary care services; they are a ready workforce, ideally positioned to improve access to care, contribute to health disparities reduction efforts, and lower the cost of providing such care (National Center for Workforce Analysis Health Resources and Services Administration, 2013; Perloff, DesRoches, & Buerhaus, 2016). However, barriers at the state and national levels continue to prevent these highly qualified health care providers from practicing to the full extent to which their education and training have prepared them. It is the position of the American Academy of Nursing (academy) that FPA of APRNs is essential to achieving health equity.

Background

Despite the increase in the number of individuals who obtained health insurance under the Patient Protection and Affordable Care Act (ACA), 17% of U.S. women and 28% of U.S. men did not have access to primary care services in 2013 to 2015 (The Henry J. Kaiser Family Foundation, 2016a, 2016b). Rates of primary care access varied by race and ethnicity, with people from racial and ethnic minority backgrounds having least access; twice as many Hispanic men (47%) than white men (23%) reported not having a doctor (The Henry J. Kaiser Family Foundation, 2016a, 2016b). Other marginalized populations, including older adults, people who are poor or who live in rural areas, and people who are gay, lesbian, bisexual, transgender (including nonbinary or genderqueer), among others also have reduced access to comprehensive health services including primary care (Gates, 2014; Mather, Jacobsen, & Pollard, 2015; Ritchie, 2014; Ward, Schiller, Freeman, & Clarke, 2015; Weaver et al., 2014). People who do not have primary care providers have less access to the health care system as a whole, are less likely to obtain preventative health care services, and have worse health (Starfield, Shi, & Mackinko, 2005), contributing to increased health care costs and increased mortality (Hossain, Ehtesham, Salzman, Jenson, & Calkins, 2013; Office of Disease Prevention and Health Promotion, 2010; Weaver et al., 2014). The proposed repeal and potential replacement of the ACA (along with state Medicaid expansions, tax credits, and some coverage provisions) is concerning as it will dramatically increase the number of individuals who do not have access to basic health services, including primary care (Congressional Budget Office, 2017). Essential health benefits, such as emergency services, maternity and newborn care, preventive and wellness services, and chronic disease management, also face an uncertain future; if this coverage is eliminated, existing health disparities are likely to worsen

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(Congressional Budget Office, 2017). Access to high-quality, affordable, and comprehensive primary care health care services is critical to the health of our nation, and APRNs can help meet this need (Josiah Macy, 2010; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004).

APRN Workforce, Roles, and Scope of Practice

There are four distinct APRN roles: nurse practitioner (NP), certified nurse midwife (CNM), clinical nurse specialist (CNS), and certified registered nurse anesthetist (CRNA). Each role has a specific scope of practice that is based on their unique educational preparation and training and allows them to contribute to primary care in distinct and important ways (Federation of State Medical Boards, 2017; Safriet, 2002). APRNs bring a holistic as well as patient-centered and family-centered approaches to the prevention and management of complex health and behavioral issues addressed in various care settings across the life span. They work collaboratively with physicians and other members of the health workforce to optimize patient care and health. For example, NPs provide a range of comprehensive care services to address individuals' physical and mental health needs across the life span, and CNMs provide primary sexual and reproductive health services across the life span as well as post-partum care, childbirth, and care of newborns (Phillippi & Barger, 2015; Pohl et al., 2010b). CNSs and CRNAs increase access to affordable care services for populations in rural areas (Seibert et al., 2004). APRNs provide needed services to some of the most vulnerable populations in our society, including individuals from racial and ethnic minorities, Medicaid and Medicare recipients, residents of rural and frontier areas, and the uninsured and underinsured (Agency for Healthcare Research and Quality, 2014; Buerhaus et al., 2015; Seibert et al., 2004).

The ability of APRNs to practice to the full extent of their education and training is inextricably linked to state-level scope of practice[1] laws and regulations (National Coalition of State Boards of Nursing [NCSBN], 2008). At the state level, scope of practice for nurses is established either by legislative statute or by regulation, the Board of Nursing (BON), or other executive agencies (Buppert, 2014). Scope of practice in many states is limited by Board of Medicine (BOM) and/or Board of Pharmacy (BOP) oversight, removing the authority of nursing to govern APRN practice and licensure, and the ability for APRNs to practice to the full extent of their training as part of organized interprofessional health care teams (Hanson, 2014; Pohl et al., 2010a). Requirements such as mandated collaborative practice agreements (CPAs) and physician-supervised transition-to-practice periods[2] increase the cost of providing care, lead to gaps in care, and deter APRNs from working in these restrictive states, without any demonstrated improvement in safety or quality (Fauteux, Brand, Fink, Frelick, & Werrlien, 2017; Kleiner, Marier, Park, & Wing, 2014; Safriet, 2011).

State-level challenges to APRN FPA have been exacerbated by ambiguities at the federal level. For example, failure to define APRNs as primary care providers under the ACA left this matter up to individual states, which contributed to barriers to FPA such as inconsistent policies regarding reimbursement for services delivered by APRNs, including lower payment[3] rates (Brooks Carthon, Barnes, & Altares Sarik, 2015; Kurtzman et al., 2017; Safriet, 2002, 2011). Centers for Medicaid and Medicare prohibit APRNs from common tasks such as conducting admission evaluations and monthly assessments of patients admitted to skilled nursing facilities (American Association of Nurse Practitioners, 2012). In some cases, APRNs who have been authorized to perform within the full scope of their practice are later denied reimbursement for their services (Government Accountability Office, 2014), which limits patients' access to care. FPA for all APRNs in every state is further impeded by lack of consumer awareness of the type and amount of training APRNs receive and the services that they can provide, opposition from professional medical associations, and legislators who are tired from previous legislative attempts to widen APRN scope of practice (Safriet, 2011).

The Benefits of FPA

In states where NPs have FPA, benefits to patients, the health care system, and payers have been identified, including:

- Significantly fewer emergency room visits for nonemergency health care (Traczyndski & Udalova, 2013), lower hospitalization rates (Oliver, Pennington, Revelle, & Rantz, 2014), and expanded health care utilization, particularly among the most vulnerable (Traczyndski & Udalova, 2013; Xue, Ye, Brewer, & Spetz, 2016).
- Care provided at lower cost than physicians, including preventative care (Perloff et al., 2016; Traczyndski & Udalova, 2013).

[1] Scope of practice refers to "the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience" (Federation of State Medical Boards, 2017; p. 8).

[2] CPAs require that APRNs deliver care with physician oversight. APRNs often must pay for this mandated oversight and receive little actual oversight. Sometimes, these agreements are temporary, as in the case of transition-to-practice periods, which exist in 10 states. In these states, transition to practice requires that APRNs have physician oversight for a varying number of hours or years after which they can apply to work independently (Phillips, 2015).

[3] Nurse practitioners are reimbursed at rates of 65% to 85% lower than physicians for providing the same services of the same quality (Kurtzman et al., 2017; Safriet, 2011).

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