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Policy Review and Recommendation: Full Practice Authority for Nurse Practitioners in the Southwestern United States

Sara J. Rowe
University of St. Augustine for Health Sciences

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Sara J. Rowe, BSN, RN

School of Nursing, University of St. Augustine for Health Sciences

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Doctor of Nursing Practice Program and is Approved by:

Dr. David Liguori, DNP, APNC, NP-C

Dr. Bandi Davini, DNP, APRN-BC

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University of St. Augustine for Health Sciences
DNP Scholarly Project
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Student Last Name:	**First Name:**	**Middle Initial:**
Rowe	Sara	J

E-mail:
s.rowe@usa.edu

Title of DNP Project:

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Abstract

This policy analysis investigates the benefits of full practice authority (FPA) for Nurse Practitioners (NPs) in the Southwestern United States, using Arizona as an FPA model and California and Tennessee as comparison states. The PICO question that directed the project is: for NPs practicing as advanced practice nurse practitioners within the Southwestern United States region (P), does a comprehensive policy recommendation for FPA for NP-led clinics in the secondary education space (I) compared to existing variable approaches within the region (C) improve access to care and direct or indirect patient outcomes as endorsed by the literature (O)? A comprehensive literature review revealed that the United States is experiencing a significant primary care provider shortage. Although NPs are educationally prepared, tested, certified, and licensed to provide comprehensive patient care, California and Texas continue regulatory restrictions on NP scope of practice. These practice restrictions exacerbate the care shortage, especially in rural and primary health professional shortage areas. Furthermore, the literature search revealed consistent support of FPA by critical stakeholders, such as the American Association of Nurse Practitioners, the American Nurses Association, and the Consensus Model. Policy briefs advocating for evidence-based recommendations for FPA are presented for dissemination to the legislative bodies, professional organizations, and the state boards of nursing. Eliminating practice barriers allows NPs to practice to the fullest extent of their education and training. This results in greater access to care, reduced healthcare costs, increased quality of care, and works to lessen health disparities.

Policy Review and Recommendation: Full Practice Authority for Nurse Practitioners in the Southwestern United States

A shortage of primary care providers (PCP) is a mounting problem in the United States, exacerbated by an aging population, population growth, and the Affordable Health Care Act expanding insurance coverage for a more significant portion of the population. The Association of American Medical Colleges (AAMC, 2021) predicts a shortage of up to 48,000 primary care physicians by 2034.

The nurse practitioner (NP) role was developed in the 1960s due to a lack of primary care physicians (Keeling, 2015). NPs serve as healthcare providers capable of combining advanced practice medical services with nursing skills to meet the primary care needs of populations, particularly filling a gap in rural and underserved areas (Keeling, 2015). Evidence demonstrates that states with NP full practice authority (FPA) have improved healthcare access and reduced healthcare disparities (Chesney & Duderstadt, 2017). The NPs' ability to practice to the fullest extent of their education should not be interfered with by government restrictions or requirements for anti-competitive supervision (Chesney & Duderstadt, 2017). This policy review serves to provide evidence of the benefits related to NP FPA for populations, healthcare systems, and society, identify existing barriers to overcome, and propose a policy recommendation to the certifying boards of nursing in the Southwestern states to work toward FPA and eventual consensus model implementation to improve access to care, patient outcomes, and allow for standardized practice.

Significance of the Practice Problem

The United States is experiencing a primary care physician shortage projected to increase in the coming years (Malayala et al., 2021). Physician shortages in primary care are attributed to tiresome charting, oversight from federal agencies, complex payor structures, restrictive quality-based reimbursement programs, and an overall lower reimbursement rate than other

specialties (Levin & Bateman, 2012). Population aging and growth, physicians reaching retirement age, and increased access and demand from marginalized minority populations continue to impact the shortage and strain the system (AAMC, 2021).

Health disparities in access to care reflect more significant societal health inequities, resulting in population-specific variations in wellness outcomes, notably in marginalized groups (Shahidullah et al., 2023). Promoting and maintaining health, preventing and managing disease, and reducing disability require equitable healthcare access (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021). Primary care is evidenced to prevent disease and mortality and is associated with positive health outcomes, indicating that access to health care is an essential social determinant of health (SDOH). The lack of PCPs presents a compounding barrier to care accessibility.

NPs are critical to increasing access to primary care (Thompson, 2019). However, to be an effective solution, NPs nationwide must be empowered to practice at the highest level of their education and training. FPA allows NPs to work under the exclusive licensing authority of the state board of nursing without physician oversight (American Academy of Nurse Practitioners [AANP], 2023b). States requiring oversight and restricted practice are associated with higher disease burdens and care costs, geographic disparities in health care, and lower national health rankings (AANP, 2023b). States with FPA have more primary care NPs, benefiting healthcare systems, patients, and society by increasing care availability and decreasing costs. Research has reliably demonstrated that NPs improve the quality of care for patients, especially with chronic disease, and the care provided by NPs can be a considerable contributor toward healthcare equity in the United States (NASEM, 2021).

In 2018, a consensus model was created by the Advance Practice Registered Nurses (APRN) Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee to standardize APRN regulations for education, licensure, and FPA

(Mack, 2018). This APRN model could potentially increase state-to-state practice mobility and access to NP care across the United States. Standardized utilization of APRN practice at the highest level will improve access by removing barriers to healthcare, especially in underserved and rural populations (Mack, 2018).

Based on the large body of evidence on cost-effective and safe NP care, there is a national movement by the Institute of Medicine (IOM), the Federal Trade Commission (FTC), the National Governors Association (NGA), the Veterans Health Administration, and the Bipartisan Policy Center to remove all FPA barriers (American Nurses Association [ANA], 2015). The American Nurses Association (ANA) strongly supports FPA without transition to practice requirements for all advanced nurse practice roles (ANA, 2015). The AANP supports the Consensus Model for APRNs and the adoption of the NCSBN Model Practice Act (AANP, 2023c). As of now, more than half of U.S. states and U.S. territories have adopted FPA licensure laws, which allow for protecting patients' choices, improving access to care, decreasing primary care shortages, and streamlining care (AANP, 2023c).

Policy evaluation and restructuring must be guided by evidence. Legislative policy based on best practices is critical to improving healthcare systems and patient outcomes. This requires revising the scope of practice (SOP) laws, public health policies, state laws, and reimbursement rules. Based on the evidence, implementing FPA licensure for NPs will increase access to care, improve patient health, and reduce healthcare costs (Myers et al., 2020). Advocating for FPA to benefit patients and populations will require tenacity and dedication to address oppositional and legislative challenges (Chesney & Duderstadt, 2017).

Purpose of the Policy Project

Primary health care is a vital service associated with improved control of chronic conditions, increased disease prevention, and lower healthcare costs (Okpala, 2021). Access to primary care is additionally associated with increased equity and lessened health disparities,

especially among communities in rural or underserved areas. Nevertheless, gaps persist in the inaccessibility of PCPs and services. These inequities are one factor that led to the Healthy People 2020 initiative to prioritize the goal of increased access to primary care (Okpala, 2021).

The population of focus was NPs working in the Southwestern states, as practice restrictions significantly affect their ability to be of maximum benefit to their patients. Three states were selected for review: Arizona (AZ), California (CA), and Texas (TX). The project had two main objectives. First, the evidence of the practice problem was established via an appraisal of the literature and identifying themes. This goal was accomplished via a comprehensive literature review and establishing evidence themes by the sixth week of the project timeline. The second aim was to develop a policy brief for dissemination to three key stakeholders by week 40 of the project timeline. The overall goal of this work was to contribute towards the attainment of policy ratification towards FPA for NPs in the Southwestern states.

Policy Problem Statement

For NPs practicing as APRNs within the Southwestern United States region (P), does a comprehensive policy recommendation for FPA for NP-led clinics in the secondary education space (I) compared to existing variable approaches within the region (C) improve access to care and direct or indirect patient outcomes as endorsed by the literature (O)?

Population

The population was NP care providers in the Southwestern states. The United States has over 355,000 licensed NPs (AANP, 2023c). CA has the most practicing NPs, with 19,130 employed; TX has 18,820; and AZ has approximately 6,240 (U.S Bureau of Labor Statistics, 2023).

Intervention

The intervention was a comprehensive policy recommendation to contribute to further progress toward FPA for NPs in the Southwestern states, with the implementation of the APRN

Consensus Model. Dissemination was via the submittal of policy briefs to the legislative bodies, professional organizations, and the NCSNB.

Comparison

The comparison includes FPA in AZ, contrasted to more restricted CA and TX practice states. AZ was selected as an exemplar for SOP, as rule R4-19-508(A) does not require physician collaboration or supervision, regardless of specialty, for NP-independent practice (Arizona Board of Nursing [AZBON], 2021).

Outcome

The outcomes included increased access to primary care and population health in the Southwest states and future consensus for FPA throughout the United States. Eliminating practice barriers will improve patient health, reduce healthcare costs, improve access to care, and ensure efficient provision of high-quality care (Rajan et al., 2021).

Utility of Policy Review

The IOM identifies evidence-based practice (EBP) as a core competency for all healthcare providers (Dang et al., 2022). The foundation of policy development and recommendation must be based on evidence. This policy review and recommendation for NP FPA in the Southwestern states strives to enhance NPs' ability to contribute to improved care quality, safety, and access, thereby indirectly improving patient outcomes (Dang et al., 2022).

The SOP for NPs has historically been restricted. While some states have passed legislation to allow FPA, many maintain restricted practice policies, limiting the contribution of NPs towards improving care and access to care in the nation. NPs are qualified to assume leadership roles and translate research into everyday practice (Dear et al., 2022). Substantial evidence demonstrates that NPs provide high-quality, cost-effective care that improves patients' health and increases their satisfaction. (Myers & Alliman, 2018). As NPs can perform 90% of

care traditionally provided by PCPs, they are an excellent resource to help address the current PCP shortages (Fraser & Melillo, 2018).

Stakeholder engagement and buy-in are critical to the success and potential future implementation of policy recommendations. The stakeholders associated with this policy recommendation include NPs in the Southwestern states working in NP-led clinics in the secondary education space, doctors, registered nurses, state legislators, the AANP, the American Nurses Credentialing Center (ANCC), and individual state nursing boards.

Nurses must engage in nursing practice policy processes, identify goals, and promote communication and dissemination to target audiences (Myers & Alliman, 2018). This policy recommendation worked toward FPA in the Southwestern states and the adoption of the Consensus Model for NP practice, thus contributing to increased access to care, reduced healthcare costs, and improved patient satisfaction and outcomes (Myers & Alliman, 2018).

Analytical Framework

This policy analysis was structured based on the Policy Analytical Framework from the Centers for Disease Control and Prevention (CDC) POLARIS (2019). The evidence collection was augmented using the Johns Hopkins University (2022) evidence-based model (JHEBP). The CDC framework is a systematic policy development process that assists professionals in addressing community public health issues. The framework encompasses five domains: problem identification, policy analysis, strategy and policy development, policy enactment, and policy implementation.

Problem identification included discovering the practice problem via a systematic literature search and identifying the root cause and evidence of the resulting public health issue of restricted access to health care. Stakeholders included physicians, NPs, patients, healthcare organizations, legislative bodies, state boards of nursing, NP national organizations, and communities. Engaging stakeholders in this policy stage helps to frame and understand the

problem accurately (CDC, 2019). The policy analysis revealed restricted practice policies that construct the problem and how the policy recommendation for FPA in the Southwestern states would work towards a resolution. In the strategy and policy development stage, an actionable plan to compose the policy recommendation as a policy brief and plan for dissemination to national NP stakeholders was selected. The enactment stage included securing authorization for policy implementation from stakeholders who support the policy and those in opposition (CDC, 2019).

Finally, the policy implementation stage included educating those affected by the policy, those who must implement the policy, changing administrative operations to adapt to the new policy, and monitoring progress (CDC, 2019). This project's implementation was an ongoing process requiring revision of the SOP laws, public health policies, state laws, and reimbursement rules for payers. This project contributed to the evidence as the NP profession advocates for FPA to benefit their patients and populations.

Evidence Search Strategy, Results, and Evaluation

After identifying the practice problem, the best available evidence related to the problem and potential solutions must be located and appraised for strength and quality (Dang et al., 2022). EBP translates the most significant scientific evidence with the best available practical evidence. EBP translation is accomplished via a structured evidence search of selected databases for keywords (Dang et al., 2022).

Search Strategy

An electronic literature search of the Ovid, Pro Quest, and CINAHL (Cumulative Index to Nursing and Allied Health Literature) databases was utilized for the literature search. The review also included the AANP and ANCC websites. The key terms for all searches included nurse practitioners, SOP, primary care, and consensus model. The primary Boolean operators AND and OR were utilized consistently for all searches. Search strategies unique to each database

were used and detailed in the results section. Medical subject headings (MeSH) headings included nurse practitioners. For consistency, the key terms used were the same across all databases. Inclusion criteria included the publication date from 2018 to 2023, the English language, peer-reviewed, and the U.S. region.

Results

The database search of CINAHL included the extra limiters of human subjects, excluding Medline, and produced 31 articles. After inclusion and exclusion criteria were applied, 16 articles remained. The database search of ProQuest included the additional limiters of the following publication titles: The Journal for Nurse Practitioners, The Lancet, Primary Healthcare Research and Development, Systematic Reviews, and Nursing Economics, and produced 96 articles. After inclusion and exclusion criteria were applied, nine articles remained. The database search of OVID included the additional limiter of the last three years and produced 207 articles. After the application of inclusion and exclusion criteria, seven articles remained. Two duplicate articles were identified and removed from the remaining 32 articles. In total, 32 articles were eligible for full-text review. After a full-text review of all eligible studies, eight met eligibility for inclusion in the final evaluation.

Exclusion criteria included articles not addressing nurse practitioners, nurse practitioner SOP, or primary care. Articles addressing specialty practice, such as emergency care, endocrinology, and cardiology, were excluded. Inclusion criteria included articles that address primary care practice and the SOP for nurse practitioners in the United States.

Evaluation

The selected articles were graded using the JHEBP model. The articles were graded as Level 3 or 5 and grades A or B (Dang et al., 2022). One systematic review was selected and graded as Level 1 and Grade B. Five articles with Level 3 evidence were selected. Finally, two

articles graded at Level 5 were utilized based on the consensus guidelines and usual methods. These articles are listed in Appendix A and Appendix B.

Many studies indicate that independent practice authority for NPs improves patients' quality of care and satisfaction and can be an effective solution for PCP shortages and improved healthcare access. Jeongyoun et al. (2020) found that independent practice and prescriptive authority for NPs resulted in statistically significant increases in NP visits and decreases in physician assistant (PA) and PCP visits. Mack (2018) stated that all supporting entities, APRNs, and educational programs must continue working toward promoting and implementing the Consensus Model for APRN regulation across the United States, which would eliminate barriers and expand access to healthcare for patients. NPs are well-positioned to provide health promotion and prevention services, improving patient health (Mack, 2018).

In a first-of-its-kind study of the impact of state-level SOP policies on NP work environments within organizations, Poghosyan et al. (2022) found that NPs practicing in primary care in states with less restrictive SOP are more likely to have favorable work environments that support NPs' ability to deliver high-quality, safe care. It is recommended that policymakers work to remove state-level restrictions on NPs, and practice administrators should improve NP work environments to promote high-quality patient care outcomes.

Overall, research indicates that policy modification of SOP regulations for NPs is necessary to work towards improved health and healthcare access in the United States (Smith et al., 2019). Outdated licensure laws create barriers to patient access. Future changes are necessary for the profession to evolve, adapt, and contribute to problem resolution. The use of reframing principles will serve the NP community throughout transitions. Smith et al. 2019 recommend using the Model for Health Policy Making in the United States, which describes federal systems and applies to state, county, and local government policy-making processes. As leaders, NPs are qualified to advocate for their profession and lead the charge with policy recommendations.

Critical Appraisal of the Evidence with Themes

A review of the selected articles included in Appendix A and the systematic review in Appendix B revealed five apparent themes. The themes were further supported by the evidence relating to the potential impact NPs can have on improving patient outcomes, increasing access to care, and alleviating the primary care shortage when practice restrictions are removed.

Primary Care Shortage

The United States has long experienced a shortage of PCPs (Rajan et al., 2021). The deficit is only growing as the U.S. population ages and demand increases. Stakeholders, including the IOM, recommend regulatory changes to expand the NP SOP to help address the shortage (Rajan et al., 2021).

Primary care is associated with improved health outcomes and lower healthcare costs (Friedberg et al., 2010; Ying et al., 2018). Largely rural locations and primary health professional shortage areas (HPSAs) face extraordinary challenges in meeting primary care demands. Research by Ying et al. (2018) showed that the United States had 3.8 million residents in rural areas and 94.5 million in HPSA counties. Enacting FPA for NPs can improve the health and wellness of many vulnerable residents and increase overall access to care (Ying et al., 2018).

Nurse Practitioners Qualifications

For provider recognition, NPs must have a minimum of a master's or doctoral degree and submit to a rigorous national certification examination (Mack, 2018). NPs adhere to a code of ethical practice, clinical research, and peer reviews, while continuing education and professional development are required to maintain licensure (Mack, 2018). NPs focus on the health of the person, their families, and the community. Areas of emphasis are health education, prevention of disease, and health promotion. When NPs educate and help patients with healthier lifestyle choices, healthcare costs are reduced. Patients with NP providers for primary care have been shown to have lower medication costs, need fewer emergency room visits, and

have shorter lengths of stay in the hospital (Mack, 2018). Studies on NP care and the need for expanding roles show a similar level of care and statistically equal patient outcomes compared to primary care physicians (Timmons, 2017). Additionally, these patients report significantly high satisfaction levels for care received (Mack, 2018).

Barriers to Full Practice Autonomy

NPs have provided primary care since the 19th century (Mack, 2018). The SOP for NPs varies in the United States. Some states still require collaboration with physician oversight. NPs are expert clinicians who diagnose and treat patients, focusing on disease prevention, health promotion, and managing patients' overall care (Mack, 2018). The 2011 Institute of Medicine report, "The Future of Nursing: Leading Change and Advancing Health," highlighted the importance of removing practice barriers for NPs by removing state regulations, policies, and laws that prevent NPs from practicing at the fullest extent provided by their education (Mack, 2018).

Ultimately, these barriers affect patients with gaps in treatment and limited access to essential primary care and preventative services (Mack, 2018). In states requiring physician supervision, NPs experience restricted prescribing rights for medication and medical equipment and limitations to services at skilled nursing facilities. These restrictions decrease providers' time to provide patient care and increase the cost burdens on NPs and patients (Mack, 2018).

Individual state laws determine the level of autonomy and physician oversight required (Jeongyouncost et al., 2020). Research shows a significant variation in demand for NP care across states with varied SOP regulatory rules. States with restrictive regulations see less growth in the NP labor force, while states with FPA have more patient demand for NP primary care. NPs improve care quality by substituting or complementing the care traditionally provided by physicians, thereby improving access to care (Jeongyoun et al., 2020).

Lack of Consensus

With varying regulations, a consensus model was created by the APRN Consensus Work Group and the NCSNB APRN Advisory Committee in 2008 to work towards standardizing APRN education and licensure, accreditation, and certification (Mack, 2018). Implementing this model could allow practice mobility and increase patient access to NP-led care (Mack, 2018).

Barriers to the consensus model exist, including state and federal regulations, insurance requirements, and reimbursement variations (Mack, 2018). NPs are reimbursed at 85% of the physician rates. This reimbursement discrepancy began with the Budget Balance Act of 1997 and created a substantial barrier that created a financial incentive to require physician oversight in many states. Achieving full billing authority is needed to realize FPA and, ultimately, full consensus model implementation (Mack, 2018).

Nurse Practitioner Contributions and Costs

Although NPs provide primary care, practice barriers limit their contributions (Poghosyan et al., 2022). Despite the intention of improving safety, evidence related to collaborative agreements shows no association with improved care or reduced costs. Removal of restrictive licensing can increase access while maintaining quality and reducing costs (Jeongyoun et al., 2022). Increased access will decrease preventable conditions, hospitalizations, and emergency visits, improving patient health, treatment outcomes, and healthcare costs (Rajan et al., 2021).

A study by Rajan et al. (2021) found that diabetic patients receiving physician care had 12% higher costs than those receiving NP care in one year. Patients with cardiovascular disease had 4% higher costs. A study by Timmons (2017) found similar results, showing an 11.8% to 14.4% reduction in costs for NP care compared to physicians. The researchers note that important considerations in cost reductions include the potential for assigning higher disease-burdened patients to physicians. However, their study did homogenize for disease-specific cohorts and disease burden with the Nosos risk score (Rajan et al., 2021).

Organizational benefits of hiring NPs include lower salary expenditures compared to physicians, lower cost of care, improved quality of care, and excellent patient satisfaction (Laurant et al., 2018; van den Brink et al., 2021).

Policy Review Recommendation Statement

Upon rigorous review of the evidence derived from a comprehensive literature search, using the PICOT question and grading of the evidence, five themes were identified supporting the practice problem and removing practice barriers for implementing FPA for NPs in the Southwestern states. The themes include primary care shortage, NP qualifications, barriers to FPA, lack of consensus, and NP contribution to the problem.

There is ample high-quality evidence related to the practice problem. All evidence was graded using the JHEBP model and is documented in Appendices A and B. Evidence is consistent that NP care is equal to or better than care provided by physicians, and NPs provide cost-effective medication and primary care management (Abraham et al., 2019; Gellar & Swan, 2021). No articles documented adverse outcomes associated with NP-provided care. NPs use a comprehensive approach to patient care and possess clinical expertise in diagnosis and treatment, focusing on health management and primary prevention (Mack, 2018). Poghosyan et al. (2022) advise removing state-level restrictions on NP SOP, allowing NPs to work to the full extent of their education.

NPs play a role in political activism and can positively influence access to care, SOP regulations, and reimbursement rules (Mack, 2018). All supporting entities, NPs, and educational institutions must continue promoting the Consensus Model for APRN Regulation in the United States. The model will decrease barriers to practice and increase healthcare access, especially in underserved and rural areas (Mack, 2018).

Based on the strength and quality of the evidence, the policy recommendation is for FPA for NPs in the Southwestern states to increase access to care, improve patient outcomes, and

reduce healthcare costs, with progression towards adopting the Consensus Model for uniformity in education, certification, and SOP throughout the United States.

Policy Analysis and Evaluation Plan

The CDC Polaris framework (2019) was utilized for this policy recommendation project to guide the appraisal process and develop a recommendation statement for implementing FPA in the Southwestern United States. The CDC Polaris framework is concerned with protecting the health of communities and populations through policy development. Policies can be an effective way to improve population health. The policy process presented by the CDC includes five domains, of which the policy review and recommendation process is summarized below.

Problem Identification

The first step in the formation of the policy recommendation was the development of a problem statement. After collecting and evaluating the evidence from a comprehensive literature search, information was systematically selected and graded to support the problem statement and indication for FPA for NPs in the Southwestern states.

With the growing primary care shortage, health disparities in access to care result in population-specific alterations in health outcomes, most notably in marginalized groups and rural areas (Shahidullah et al., 2023). Equitable access to care is an SDOH critical for promoting and maintaining population health (NASEM, 2021). Evidence supports that access to primary care is associated with positive health outcomes and disease prevention. NPs can play a vital role in increasing access to care, but only when practicing at their highest level of education (Thompson, 2019). States without practice restrictions have more NPs providing essential primary care and greater access to care for many populations (Traczynski & Udalova, 2018).

Policy Analysis

Each state's nurse practice act and SOP for NPs were reviewed. Differences were highlighted, with the state of AZ being the exemplar of FPA for NPs with no physician oversight

or transition to practice requirements. Table 1 summarizes the similarities and differences between the selected states.

The State of Arizona

AZ was selected as an exemplar for SOP, as NPs have FPA. According to the Nurse Practice Act, rule R4-19-508(A), AZ does not require physician supervision, regardless of specialty (AZBON, 2021). NPs have prescribing and dispensing authority, and those with an active Drug Enforcement Administration license can prescribe, order, administer, and obtain Schedule 2, 2N, 3, 3N, 4, and 5 (AZBON, 2021). NPs can refer to physical therapy, authorize disabled parking permits, and sign Do Not Resuscitate orders and death certificates. AZ has no statutory Provider Orders for Life-Sustaining Treatment (POLST) form (AZBON, 2021).

The State of California

CA has historically been a restricted practice state for NPs. In 2020, Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) was signed into law, creating two new categories of NPs (California State Board of Registered Nursing [CABON], n.d.). The first category, a 103 NP, works under the provisions of BPC Section 2837.103 in a group setting with at least one physician practicing within the same focus as the NP. The second category, 104 NPs, may work outside a group setting in their certified focus population or open an independent practice. These new categories do not significantly extend the current NP SOP but allow additional practice authority (CABON, n.d.). The traditional NP role remains, and there is no requirement to transition to a new category. NPs can refer to PT, approve disabled parking permits, and sign POLST forms. However, they cannot sign Do Not Resuscitate orders or death certificates (AANP, 2023a). Although CA has seemingly made progress, there has been no substantial expansion to NP SOP, and practice restrictions remain.

The State of Texas

New legislation has been presented regarding SOP changes in TX; currently, NP licensure is restricted by the requirement of physician delegation and supervision (AANP, 2023d). According to TX code 301.152, NPs must maintain written agreements with physicians throughout their careers. NPs must keep a prescriptive authority agreement with a physician but are limited to specific settings and diagnoses on Schedule II medication. NPs can refer to physical therapy, approve disabled parking permits, and sign death certificates. However, they are not authorized to sign Do Not Resuscitate orders. A POLST program is being developed for the state of TX (AANP, 2023d).

Strategy and Policy Development

This policy recommendation required revising state nurse practice acts, SOP laws, public health policies, and payer reimbursement rules (Chesney & Duderstadt, 2017). Advocating for FPA to benefit populations will require tenacity and dedication to address oppositional and legislative challenges (Chesney & Duderstadt, 2017). Working towards FPA requires key stakeholder engagement. The AANP (2022) aims to empower NPs to advance person-centered, equitable, high-quality health care for diverse populations and is a trusted resource in guiding policy revision. This policy recommendation was submitted to the AANP for consideration. The ANCC is another critical stakeholder in removing NP practice barriers and working toward FPA in the United States. The ANA (n.d.) advocates for NP practice and believes patients are served best when various qualified professionals are accessible and work collaboratively, for which SOP must reflect the professionals' true capabilities and education. This policy recommendation was submitted to the ANA for consideration.

Policy Enactment

Revising state nurse practice acts is a long-term and ongoing process supported by policy evaluation and recommendations. Dissemination of the policy recommendation to nursing

organizations, such as the AANP and the ANA, which serve as critical drivers of policy change and advocacy for SOP laws, worked to further the evidence and support the need for change.

Policy Implementation

Working towards FPA for the Southwestern states with the eventual goal of transitioning to the Consensus Model for NP practice builds each state's capacity to continue implementing policies that further support access to care, healthcare education, and reduced costs.

Policy Discussion and Recommendations

This policy analysis project sought to support and advocate for implementing FPA in the Southwestern states. Involvement in nursing policy advocacy is considered an essential aspect of the social mandate for nurses (Chiu et al., 2021). The project's two main objectives included establishing and grading the evidence regarding the practice problem via a comprehensive literature review and developing policy briefs for dissemination to the legislative bodies, NP professional organizations, and the state boards of nursing. After completing a comprehensive literature review, the objectives were met, and five consistent themes were identified supporting the recommendation of adopting FPA in the Southwestern states.

A primary care shortage in the United States is predicted to worsen (Malayala et al., 2021). Health inequities intensify the lack of access to primary care, resulting in more significant societal health inequities and population-specific variations in wellness outcomes, notably in marginalized groups (Shahidullah et al., 2023). The evidence consistently shows that NPs significantly increase access to primary care when given the ability to practice at the highest level of education (AANP, 2023b; Thompson, 2019). However, barriers to FPA include federal regulatory barriers, APRN practice authority by state, transition to practice regulations by state, and economic challenges (Klienpell et al., 2023).

Nurse practice acts that include FPA for NPs allow for better utilization of the full scope of NP services that can lessen gaps in access to care and decrease health inequities (Moore et

al., 2020). As the world continues to face challenges, such as the coronavirus, updated nurse practice acts that allow FPA are imperative. Policy growth involves creating solutions for problems and includes analysis, synthesis, and evaluation of evidence and the recommendations of stakeholders. Stakeholders include NPs, NP organizations, state boards of nursing, legislators, and patients. NPs, as patient advocates, must engage in policy change by educating decision-makers on the benefits of implementing FPA for NPs (Moore et al., 2020). Stakeholders, including the IOM, recommend regulatory changes to expand the NP SOP to help alleviate PCP shortages (Rajan et al., 2021).

Essential to the process of policy change is effective communication with key stakeholders. A 2020 systematic review by Ashcraft et al. (2020) evaluated the effectiveness of dissemination methods and found that early engagement improves the strategic value of research products, such as policy briefs to policymakers. A policy brief exhibiting value and relevance to the policy under evaluation will likely interest decision-makers. Early engagement should include legislators, healthcare organizations, professional organizations, state boards of nursing for the target states, and patients (Ashcraft et al., 2020).

Endorsements from professional organizations should be included in advocacy efforts as nursing organizations are critical platforms for policy advocacy to influence policy changes to benefit patient populations (Chiu et al., 2021). Additionally, policy advocacy efforts from nursing organizations often garner less scrutiny and are potent influencers in shaping policy processes and outcomes (Chiu et al., 2021). The AANP maintains that states that restrict NP practice with limited licensure authority have more significant geographical health care disparities and PCP shortages, increased cost of care, more significant disease burden, and lower national health rankings (AANP, 2023b). According to the AANP, the benefits of FPA for NPs include improved access to care, decreased costs, more efficient care delivery, and protection of patient's right to see the provider of their choice by removing anti-competitive licensing restrictions preventing

patient-centered care. The AANP advocates the removal of barriers to FPA via policy change, supports the Consensus Model for APRNs, and advocates the adoption of the NCSBN Model Practice Act (AANP, 2023b). The Consensus Model may be considered the APRN Model of Regulation for the future, recognizing four APRN roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner (NCSBN, 2008).

The Consensus Model recommends that states enact uniformity in APRN roles, licensure, accreditation, education, and certification (NCSBN, n.d.). When states have differing regulatory requirements, each border presents license portability challenges, preventing access to high-quality APRN care. With the adoption of the Consensus Model in the Southwestern states, the uniformity of licensure would allow APRNs to travel to proximal states to provide care and contribute to decreasing care shortages (NCSBN, n.d.). Further, the AANP supports HR 2713.S.2418 ICAN Act to remove barriers to NPs' ability to provide care to Medicare and Medicaid programs. This bill would allow NPs to care for Medicare patients with cardiac and pulmonary conditions and diabetes (NCSBN, n.d.).

Appendices C, D, and E summarize recommendations for the comparison states reviewed in this project. Recommendations for California and Texas are legislation to expand SOP regulations to FPA and adopt the Consensus Model. The policy briefs provide evidence of FPA's benefits. FPA increases access to primary care services, correlates with improved health outcomes, and lowers healthcare costs (Friedberg et al., 2010; Ying et al., 2018). Benefits to the states include lessening PCP shortages in HPSA, which face tremendous demand for primary care (Ying et al., 2018). Expansion of state SOP to FPA for NPs can improve the health and wellness of many vulnerable residents (Ying et al., 2018).

This policy analysis worked to identify the practice problem, complete a policy analysis, and create policy briefs for dissemination to stakeholders. Limitations to the project include sole reliance on written materials without consultation with nursing organization representatives, the

state boards of nursing for comparison states, or other key stakeholders. Additional limitations include the scope of the problem, including the complexity of policy change, the limited nature of the effectiveness of policy briefs, and the lack of tools for implementing FPA in the target states. Finally, the policy briefs advocated for policy change in the comparison states by highlighting evidence-based recommendations aligned with the AANP, the Consensus Model, and the ANA.

Dissemination

The dissemination of evidence-based projects should encourage the implementation of practice changes, particularly those that aim to improve population health. An integral part of a doctoral program, dissemination is necessary to translate available knowledge. Dissemination via a policy brief was submitted to the legislative bodies, professional organizations, and the state boards of nursing to contribute to further progress towards FPA for nurse practitioners in the Southwestern states, with eventual progression to implementation of the Consensus Model for APRN Regulation.

The manuscript was uploaded to the Scholarship and Open Access Repository (SOAR@USA) at the University of St. Augustine for Health Sciences (USAHS). Submittal of the project manuscript to this repository provides academic and professional nursing communities access to scholarly projects. The dissemination plan also included a poster presentation at USAHS. Submittal of the manuscript to *The Journal for Nurse Practitioners* allows for greater dissemination to key stakeholders and encourages nursing professional advocacy.

Conclusion

This project focused on developing an EBP policy recommendation for FPA in the Southwestern states, presenting it to NP organizations to contribute towards FPA and eventual Consensus Model implementation, improving access to care and patient outcomes, and allowing for standardized practice. The project established the practice problem of PCP

shortages and inconsistency in NP practice regulations. The CDC's Policy Analytical Framework and the JHEBP led the policy review and recommendation and were critical to its success.

A study of the works generated from a comprehensive literature review identified common themes consistent throughout the evidence. Evidence consistently shows that NP-provided primary care is safe and efficient and improves patient outcomes and satisfaction. Primary care services are associated with positive health outcomes and disease prevention and are, therefore, essential. NPs play a vital role in increasing access to primary care when practicing at their highest level of education. States with fewer practice restrictions have more NPs providing essential primary care, bridging the gap in access to care, especially in rural and underprivileged areas. Research shows NPs improve care quality and can contribute considerably to healthcare equity in the United States (NASEM, 2021).

Dissemination to NP organizations was executed via policy briefs towards policy restructuring and an indirect contribution to improved patient and population outcomes. Removing barriers to NP practice via policy change to FPA throughout the Southwest is necessary for maximum contribution towards problem resolution.

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Table 1

State Nurse Practitioner Scope of Practice

State	Collaborative Agreement	Prescriptive Agreement	Physical Therapy Orders	Disabled Parking Permits	Sign Do Not Resuscitate Orders	Sign POLST	Sign Death Certificates
Arizona	No	No	Yes	Yes	Yes	No standard state POLST documents	Yes
California	Yes	Yes	Yes	Yes	No	Yes	No
Texas	Yes	Yes	Yes	Yes	No	Program in Development	Yes

Appendix A

Evidence Table

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison (Definitions should include any specific research tools used along with reliability & validity.)	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Jeongyoung Park, Xinxin Han, & Pittman, P. (2020). Does expanded state scope of practice for nurse practitioners and physician assistants increase primary care utilization in community health centers? *Journal of the American Association of Nurse Practitioners, 32*(6), 447–460. https://doi.org/10.1097/JXX.0000000000000263	Level III A	Difference-in-differences approach using the Uniform Data System for 739 CHCs from 2009 to 2015	Models included patient, CHC, and market-level. Time-varying covariates. Clustered standard errors at the CHC level to account for heterogeneity. All statistical analyses were performed using Stata 13.	n/a	The hypothesis was that relaxing supervision requirements for NPs or PAs would increase the visits to NPs or PAs by eliminating unnecessary delays in care.	Independent practice and prescriptive authority for NPs resulted in statistically significant increases in NP visits and decreases in PA and PCP visits. Implications for practice: As the NP and PA workforce continues to grow and as SOP laws continue to be reduced, it is essential to advance evidence on how to deploy these staff most efficiently.
Mack, R. (2018). Increasing access to health care by implementing a consensus model for advanced practice registered nurse	Level V B	n/a	n/a	n/a	n/a	All supporting entities, APRNs, and educational programs must continue working toward promoting and implementing the Consensus Model for APRN regulation across the US.

practice. *The Journal for Nurse Practitioners, 14*(5), 419–424. https://doi.org/10.1016/j.nurpra.2018.02.008						This model eliminates practice barriers and expands healthcare access for patients in all areas, primarily rural and underserved communities. APRNs manage patients' overall care, including ordering and interpreting diagnostic tests, diagnosing and treating acute and chronic conditions, and prescribing treatments and medications. APRNs are well-positioned for health promotion and prevention. Eliminating practice barriers will further aid in improving patients' health across the US.
Poghosyan, L., Stein, J. H., Liu, J., Spetz, J., Osakwe, Z. T., & Martsolf, G. (2022). State-level scope of practice regulations for nurse practitioners impact work environments: Six state investigation. *Research in Nursing & Health, 45*(5), 516.	Level III A	1244 NPs in six states with variable SOP regulations	Cross-sectional survey design. Descriptive statistics for practice-level NP demo-graphic characteristics and practice attributes. Calculated practice-level mean scores on each NP-PCOCQ subscale at each level of state SOP. Aggregated independent variables to the practice level; examined the significance of bivariate relationships between SOP and each practice-level NP-PCOCQ subscale score using two-way analysis of	n/a	n/a	This study was the first on a large scale to assess the impact of state-level SOP policies on NP work environments within organizations. NPs practicing in primary care in states with less restrictive SOPs are more likely to have favorable work environments that support NPs' ability to deliver high-quality, safe care. Policymakers should remove state-level restrictions on NPs, and practice administrators should improve NP work environments to promote high-quality patient care.

			variance tests—ordinary least squares multiple linear regression models. Beta weights and 95% confidence intervals (CIs) showed the strength and direction of the relationships.			
Rajan, S. S., Akeroyd, J. M., Ahmed, S. T., Ramsey, D. J., Ballantyne, C. M., Petersen, L. A., & Virani, S. S. (2021). Health care costs associated with primary care physicians versus nurse practitioners and physician assistants. *Journal of the American Association of Nurse Practitioners, 33*(11), 967–974. https://doi.org/10.1097/JXX.0000000000000555	Level III A	A cohort of adult patients with diabetes or CVD receiving outpatient care at the VA in the United States. 953,887 in the diabetes cohort and 1,142,092 in the CVD cohort.	The study descriptively examined the characteristics of patients assigned to a physician versus an NP/PA for both diabetes and CVD cohorts. The cost variable distributions, Wooldridge R-square test comparing non-nested models, and aBox–Cox specification test. Regression analyses for total costs, inpatient, outpatient, and pharmacy components of both VA and total costs.	n/a	n/a	This study's findings suggest that NPs reduce patient costs, improve access, and ensure efficient provision of high-quality care.
Smith, S., Buchanan, H., & Cloutier, R. (2019). Political framing: A strategy	Level V A	n/a	n/a	n/a	Political frame: units of	Modification of policy is a necessary component of the legislative process. Outdated licensure laws have caused disordered patient access. The evolution

for issue analysis. *The Journal for Nurse Practitioners, 15*(10), 760–763. https://doi.org/10.1016/j.nurpra.2019.10.001					policy research analysis, packaged ideas, or a central organizing idea. Framing creates understanding and shared language to influence human decision-making in the policy process.	of the profession will necessitate future changes. Using reframing principles will serve the NP community throughout transitions. The "Model for Health Policy Making in the United States.", intended to describe federal systems, can also be applied to state, county, and local government policy-making processes. As a cyclical process, modifications occur when existing policy consequences feed into agenda setting, and the legislative process begins again.

Ying X., Kannan, V., Greener, E., Smith, J. A., Brasch, J., Johnson, B. A., & Spetz, J. (2018). Full scope-of-practice regulation Is associated with higher supply of nurse practitioners in rural and primary care health professional shortage counties. *Journal of Nursing Regulation, 8*(4), 5–13. https://doi.org/10.1016/S2155-8256(17)30176-X	Level III Grade A	Integrated county-level national data set from 2009 to 2013.	Descriptive statistics for county population demographics and providers. Hierarchical mixed-effects model. The residual maximum likelihood estimation method specified intercept and time as random effects with an unstructured covariance structure. We included an interaction term between the type of SOP regulation and year to test for a potential moderation effect of SOP regulation. All statistical tests were two-sided, with a significance level set at the nominal .05 level. Analyses were performed using SAS version 9.4.	n/a	n/a	Considering exacerbating primary care physician shortages in areas of socioeconomically disadvantaged individuals, the availability of NPs in these populations is vital to strategies for expanding access to care in these underserved areas. This study indicates that expanding state SOP regulation can increase NP supply in rural and primary care HPSA counties. Such information is critical to strategically guide state regulatory policy on NP practice within the broader healthcare provider workforce trend.
Zaletel, C. L., Madura, B., Miyamasu Metzel, J., & Lancas-	Level III Grade A		Results were reported using the Revised Standards for Quality Improvement	n/a	n/a	Healthcare leaders should leverage the abilities of NPs to meet organizational goals, benchmarks, and patient needs.

ter, R. J. (2022). Optimizing the productivity and placement of nurse practitioners and physician assistants in outpatient primary care sites. *Journal of the American Association of Nurse Practitioners, 34*(8), 1022–1032. https://doi.org/10.1097/JXX.0000000000000733			Reporting Excellence framework. After forming a QI team, gap analysis and action plans were developed and implemented.			Nurse practitioner leaders should focus on benchmarking performance and analyzing barriers to optimization. These efforts are most beneficial when multidisciplinary.

Legend: advanced practice registered nurse (APRN), cardiovascular disease (CVD), community health center (CHC), health professional shortage areas (HPSA), nurse practitioner (NP), nurse practitioner primary care organizational climate questionnaire (NP-PCOCQ), physician's assistant (PA), scope of practice (SOP), quality improvement (QI), veteran's affairs (VA)

Appendix B

Summary of Systematic Reviews

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
Abraham, C. M., Norful, A. A., Stone, P. W., & Poghosyan, L. (2019). Cost-Effectiveness of advanced practice nurses compared to physician-led care for chronic diseases: A systematic review. *Nursing Economic$, 37*(6), 293–305	Level 1 A	What is the cost-effectiveness of chronic disease care management delivered by NPs compared to physicians?	A comprehensive search of PubMed, Cumulative Index to Nursing and Allied Health Literature, Embase, EconLit, Cost Effective Analysis registry, Cochrane Library, Ovid Medline, university Nursing Economic$ November/December 2019 | Volume 37 Number 6 295 library catalog, and ProQuest	Studies were excluded if samples were limited to only students instead of practicing NPs and physicians able to charge for chronic disease care services; samples not focused solely on NP-led care; acute care settings; patients under 18 years of age; no reported costs for chronic disease care or reported costs unrelated; no comparison of cost of care provided by NPs and physicians or costs for co-management of patients; and editorials, news briefs, or commentaries.	The reported chronic disease care costs provided by the physician or NP in each study were documented in an Excel spreadsheet. Common categories were identified across studies, and two large categories were created.	Findings indicate that NPs are cost-effective providers of medication management. Mixed results were noted for laboratory testing and diagnostic procedures. Most studies support NPs as cost-effective providers for patient care visits. Results indicate that primary care practices that used more NPs in care delivery had lower labor costs per patient visit than those with minimal NP use.	Globally, NPs are more commonly managing chronic disease care for adult patients and are critical members of healthcare teams. Many studies have demonstrated that NPs are cost-effective providers. An inclusive conclusion from international studies is mixed. Future research with consistent and clearly defined measures for service costs is needed to improve understanding of NPs' potential in reducing the high cost of healthcare services.

Appendix C

Policy Brief for Legislative Bodies

Policy Brief

November 2024 Legislative Bodies

Full Practice Authority for Nurse Practitioners in the Southwestern United States

Executive Summary

The United States is experiencing a primary care physician shortage projected to increase in the coming years (Malayala et al., 2021). NPs are critical to increasing access to primary care (Thompson, 2019). However, to be an effective solution, NPs nationwide must be empowered to practice at the highest level of their education and training. FPA allows NPs to work under the exclusive licensing authority of the state board of nursing without physician oversight (American Academy of Nurse Practitioners [AANP], 2023a). States requiring oversight and restricted practice are associated with higher disease burdens and care costs, geographic disparities in health care, and lower national health ranking (AANP, 2023a). States with FPA have more primary care NPs, benefiting healthcare systems, patients, and society by increasing care availability and decreasing costs. Removal of restrictive licensing can increase access while maintaining quality and reducing costs (Jeongyoun et al., 2022). Increased access will decrease preventable conditions, hospitalizations, and emergency visits, improving patient health, treatment outcomes, and healthcare costs (Rajan et al., 2021). Research has reliably demonstrated that NPs improve the quality of care for patients, especially with chronic disease, and the care provided by NPs can be a considerable contributor toward healthcare equity in the United States (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021). This policy brief advocates for expanding practice autonomy for NPs in the Southwestern states, calling for extensive reform of advanced practice regulations to improve population health outcomes, lessen health disparities, alleviate healthcare shortages, increase access to care, increase affordability, and create a more efficient and responsive healthcare system.

Introduction

NPs are highly educated health professionals trained to provide a wide range of primary care and specialized services. SOP laws governing NP practice are variable across the Southwestern states, resulting in inconsistencies and practice barriers (AANP, 2023a). Antiquated SOP restrictions prevent NPs from practicing at their highest level of education, resulting in limited patient choice, lack of access to primary care services, increased healthcare costs, and decreased patient satisfaction (Myers et al., 2020). This policy brief addresses the importance of policy change to remove restrictive practice legislation and the adaptation of FPA for NPs in the Southwest states.

Barriers to Practice

NPs in restricted practice states experience mandated physician supervision, restricted prescribing rights for medication and medical equipment, and limits to services provided at skilled nursing facilities (Mack, 2018). These restrictions decrease providers' patient care time and increase cost burdens. NP reimbursement rates are also lower than physicians' (Myers et al., 2020). NPs are subject to signature restrictions preventing the signing of Do Not-Resuscitate orders, POLST, and death certificates (AANP, 2023b). There is a lack of consensus due to varying SOP regulations from state to state. Due to varying regulations, the APRN Consensus Work Group and the NCSBN APRN Advisory Committee formed the Consensus Model in 2008 to work towards standardizing APRN education, licensure, accreditation, and certification. Implementing this model could allow for state-to-state practice mobility and increase patient access to NP-led care (Mack, 2018).

Endorsements

The following organizations endorse Full Practice Authority for NPs: the AANP, the American Nurses Association (ANA), The National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, and the National Governors Association (NGA).

Recommendation for FPA in the Southwestern states

Evidence shows that states with restrictive practice regulations for NPs have higher disease burdens and care costs, geographic disparities, and lower national health ranking (AANP, 2023b). Eliminating antiquated SOP practice barriers can have a significant positive impact on reducing healthcare disparities, improving access to care, reducing primary care shortages, and increasing health equity throughout the nation, especially among rural communities or underserved areas where FPA is associated with increased equity and lessened health disparities (Okpala, 2021). FPA will decrease healthcare costs by eliminating duplicate billing resulting from physician oversight of NP practice, unnecessary repetitive orders, and office visits (AANP, n.d). FPA for NPs allows patients full access to NP services and protects patient choice to see the provider they desire (AANP, n.d.). Legislative bodies are encouraged to reevaluate restrictive SOP regulations and transition to FPA for NPs in the Southwest states.

Policy Brief

2024

Policy Recommendations

- **The AANP recommendations for legislation:** The AANP supports the ICAN Act, which would remove practice barriers and provide comprehensive patient care by allowing NPs to perform duties previously limited to physicians due to payor restrictions (AANP, n.d.). The ICAN Act, or bill HR 8812, was introduced to the House of Representatives in 2022 and would allow a nurse practitioner to fulfill documentation requirements for Medicare coverage of special shoes for diabetic individuals, supervise Medicare cardiac, intensive cardiac, and pulmonary rehabilitation programs; and certify inpatient hospital services under Medicare and Medicaid (ICAN ACT, 2022). Expanded APRN scope of practice is a significant way to help amend current and future care access limitations. The AANP also supports the implementation of The Consensus Model for APRNs, and adoption of the NCSBN Model Practice Act (AANP, n.d).

- **The Federal Trade Commission Recommends:** Expanded APRN scope of practice is good for competition and consumers (Federal Trade Commission [FTC], 2014). Compulsory physician supervision and collaborative practice agreements likely impede provider competition, resulting in decreased access to care, lower care quality, higher costs, and limited innovation in care delivery. Due to these issues, the Federal Trade Commission recommends that state legislators review requirements carefully. Noting that the FTC agrees with most expert health policy organizations' support for expanded APRN SOP as a vital component of the nation's strategy to fill primary care gaps (FTC, 2014).

- **National Academies of Sciences, Engineering, and Medicine**: The 2021 report, The Future of Nursing 2020-203: Charting a Path to Achieve Health Equity, calls for the elimination of SOP restrictions for NPs to increase access to high-quality healthcare services for those with complex needs; thereby improving health equity. Additionally, it is noted that NPs should be practicing to the full extent of their education and training.

- **The National Council of State Boards of Nursing Consensus Model (2008) recommends**: The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education was developed in 2008 to provide a uniform model for APRN regulation. The Consensus Model would parallel state NP laws and facilitate a pathway to an APRN Compact, allowing NPs to practice in multiple states. Removing scope of practice barriers for NPs would reduce primary care shortages, improve access to care, and improve patient satisfaction.

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Appendix D

Policy Brief for Professional Organizations

Policy Brief

November 2024 **Professional Organizations**

Full Practice Authority for Nurse Practitioners in the Southwestern United States

Executive Summary

The United States is experiencing a primary care provider (PCP) shortage projected to increase in the coming years (Malayala et al., 2021). Nurse practitioners (NPs) are critical to increasing access to primary care (Thompson, 2019). However, to be an effective solution, NPs nationwide must be empowered to practice at the highest level of their education and training. Full practice authority (FPA) allows NPs to work under the exclusive licensing authority of the state board of nursing without physician oversight (American Academy of Nurse Practitioners [AANP], 2023a). States requiring oversight and restricted practice are associated with higher disease burdens and care costs, geographic disparities in health care, and lower national health ranking. States with FPA have more primary care NPs, benefiting healthcare systems, patients, and society by increasing care availability and decreasing costs (AANP, 2023a). Removal of restrictive licensing can increase access while maintaining quality and reducing costs (Jeongyoun et al., 2022). Increased access will decrease preventable conditions, hospitalizations, and emergency visits, improving patient health, treatment outcomes, and healthcare costs (Rajan et al., 2021). Research has reliably demonstrated that NPs improve the quality of care for patients, especially with chronic disease, and the care provided by NPs can be a considerable contributor toward healthcare equity in the United States (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021). This policy brief advocates for expanding practice autonomy for NPs in the Southwestern states, calling for extensive reform of advanced practice regulations to improve population health outcomes, lessen health disparities, alleviate healthcare shortages, increase access to care, increase affordability, and create a more efficient and responsive healthcare system.

Introduction

Endorsements from professional organizations are valuable to advocacy efforts as nursing organizations are critical platforms to influence policy changes that benefit patient populations (Chiu et al., 2021). Additionally, policy advocacy efforts from nursing organizations often garner less scrutiny and are potent influencers in shaping policy processes and outcomes (Chiu et al., 2021). NPs are highly educated health professionals trained to provide a wide range of primary care and specialized services. SOP laws governing NP practice are variable across the Southwestern states, resulting in inconsistencies and practice barriers (AANP, 2023a). Antiquated SOP restrictions prevent NPs from practicing at their highest level of education and abilities, resulting in limited patient choice, lack of access to primary care services, increased healthcare costs, and decreased patient satisfaction (Myers et al., 2020). This policy brief advocates for FPA for NPs in the Southwest states and encourages continued support from valuable professional nursing organizations.

Barriers to Practice

In states requiring physician supervision, NPs experience restricted prescribing rights for medication and medical equipment and limitations to services at skilled nursing facilities. Additionally, reimbursement rates are lower for NPs than physicians (Myers et al., 2020; Mack, 2018). There is also a lack of consensus and license portability due to varying state SOP regulations.

Endorsements

The following organizations endorse Full Practice Authority for NPs: the AANP, the American Nurses Association (ANA), The National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, and the National Governors Association (NGA).

Recommendations

Evidence shows that states with restrictive practice regulations for NPs have higher disease burdens and care costs, geographic disparities in health care, and lower national health ranking (AANP, 2023a). Eliminating antiquated SOP practice barriers can have a significant positive impact on reducing healthcare disparities, improving access to care, reducing primary care shortages, and increasing health equity throughout the nation, especially among rural communities and underserved areas where FPA is associated with increased equity and lessened health disparities (Okpala, 2021). FPA will decrease healthcare costs by eliminating duplicate billing resulting from physician oversight of NP practice, unnecessary repetitive orders, and office visits (AANP, n.d). FPA for NPs allows patients full access to NP services and protects patient choice to see the provider they desire (AANP, n.d.). Legislative bodies are encouraged to reevaluate restrictive SOP regulations and transition to FPA for NPs in the Southwest states.

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Policy Recommendations

- **The AANP recommendations for legislation:** The AANP supports the ICAN Act, which would remove practice barriers and provide comprehensive patient care by allowing NPs to perform duties previously limited to physicians due to payor restrictions (AANP, n.d.). The ICAN Act, or bill HR 8812, was introduced to the House of Representatives in 2022 and would allow a nurse practitioner to fulfill documentation requirements for Medicare coverage of special shoes for diabetic individuals, supervise Medicare cardiac, intensive cardiac, and pulmonary rehabilitation programs; and certify inpatient hospital services under Medicare and Medicaid (ICAN Act, 2022). Expanded APRN scope of practice is a significant way to help amend current and future care access limitations. The AANP also supports the implementation of The Consensus Model for APRNs, and adoption of the NCSBN Model Practice Act (AANP, n.d).

- **The Federal Trade Commission Recommends:** Expanded APRN scope of practice is good for competition and consumers (Federal Trade Commission [FTC], 2014). Compulsory physician supervision and collaborative practice agreements likely impede provider competition, resulting in decreased access to care, lower care quality, higher costs, and limited innovation in care delivery. Due to these issues, the Federal Trade Commission recommends that state legislators review requirements carefully. Noting that the FTC agrees with most expert health policy organizations' support for expanded APRN SOP as a vital component of the nation's strategy to fill primary care gaps (FTC, 2014).

- **National Academies of Sciences, Engineering, and Medicine**: The 2021 report, The Future of Nursing 2020-203: Charting a Path to Achieve Health Equity, calls for the elimination of SOP restrictions for NPs to increase access to high-quality healthcare services for those with complex needs; thereby improving health equity. Additionally, it is noted that NPs should be practicing to the full extent of their education and training.

- **The National Council of State Boards of Nursing Consensus Model (2008) recommends**: The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education was developed in 2008 to provide a uniform model for APRN regulation. The Consensus Model would parallel state NP laws and facilitate a pathway to an APRN Compact, allowing NPs to practice in multiple states. Removing scope of practice barriers for NPs would reduce primary care shortages, improve access to care, and improve patient satisfaction.

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Appendix E

Policy Brief for State Boards of Nursing

Policy Brief

November 2024 **State Boards of Nursing**

Full Practice Authority for Nurse Practitioners in the Southwestern United States

Executive Summary

The United States is experiencing a primary care provider (PCP) shortage projected to increase in the coming years (Malayala et al., 2021). Nurse practitioners (NPs) are critical to increasing access to primary care (Thompson, 2019). However, to be an effective solution, NPs nationwide must be empowered to practice at the highest level of their education and training. Full practice authority (FPA) allows NPs to work under the exclusive licensing authority of the state board of nursing without physician oversight (American Academy of Nurse Practitioners [AANP], 2023a). States requiring oversight and restricted practice are associated with higher disease burdens and care costs, geographic disparities in health care, and lower national health ranking. States with FPA have more primary care NPs, benefiting healthcare systems, patients, and society by increasing care availability and decreasing costs (AANP, 2023a). Removal of restrictive licensing can increase access while maintaining quality and reducing costs (Jeongyoun et al., 2022). Increased access will decrease preventable conditions, hospitalizations, and emergency visits, improving patient health, treatment outcomes, and healthcare costs (Rajan et al., 2021). Research has reliably demonstrated that NPs improve the quality of care for patients, especially with chronic disease, and the care provided by NPs can be a considerable contributor toward healthcare equity in the United States (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021). This policy brief advocates for expanding practice autonomy for NPs in the Southwestern states, calling for extensive reform of advanced practice regulations to improve population health outcomes, lessen health disparities, alleviate healthcare shortages, increase access to care, increase affordability, and create a more efficient and responsive healthcare system.

Introduction

A PCP shortage in the United States is predicted to worsen (Malayala et al., 2021). Health inequities intensify the lack of access to care, resulting in more significant societal health inequities and population-specific variations in wellness outcomes, notably in marginalized groups (Shahidullah et al., 2023). The evidence consistently shows that NPs are critical to increasing access to care when able to practice at their highest level of education (AANP, 2023a; Thompson, 2019). However, barriers to FPA include federal regulations, APRN practice authority by state, transition to practice regulations by state, and economic challenges (Klienpell et al., 2023).

State nurse practice acts that include FPA for NPs allow for better utilization of the full scope of NP services that can lessen gaps in access to care and decrease health inequities (Moore et al., 2020). As the world continues to face challenges, such as the Coronavirus, updated nurse practice acts allowing FPA are imperative. Policy growth involves creating solutions for problems and includes analysis, synthesis, and evaluation of evidence and the recommendations of stakeholders. Stakeholders include NPs, NP organizations, state boards of nursing, legislators, and patients (Moore et al., 2020). This policy brief informs on the benefits afforded to patients in states with FPA for NPs and advocates for the modernization of state practice acts in the target Southwestern states to FPA for NPs.

Endorsements

The following organizations endorse Full Practice Authority for NPs: the AANP, the American Nurses Association (ANA), The National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, and the National Governors Association (NGA)

Recommendations

Evidence shows that states with restrictive practice regulations for NPs have higher disease burdens and care costs, geographic disparities in health care, and lower national health ranking (AANP, 2023a). Eliminating antiquated SOP practice barriers can have a significant positive impact on reducing healthcare disparities, improving access to care, reducing primary care shortages, and increasing health equity throughout the nation, especially among rural communities or underserved areas where FPA is associated with increased equity and lessened health disparities (Okpala, 2021). FPA will decrease healthcare costs by eliminating duplicate billing resulting from physician oversight of NP practice, unnecessary repetitive orders, and office visits (AANP, n.d). FPA for NPs allows patients full access to NP services and protects patient choice to see the provider they desire (AANP, n.d.). Legislative bodies are encouraged to reevaluate restrictive SOP regulations and transition to FPA for NPs in the Southwest states.

Policy Brief

2024

Policy Recommendations

- **The AANP recommendations for legislation:** The AANP supports the ICAN Act, which would remove practice barriers and provide comprehensive patient care by allowing NPs to perform duties previously limited to physicians due to payor restrictions (AANP, n.d.). The ICAN Act, or bill HR 8812, was introduced to the House of Representatives in 2022 and would allow an NP to fulfill documentation requirements for Medicare coverage of special shoes for diabetic individuals, supervise Medicare cardiac, intensive cardiac, and pulmonary rehabilitation programs; and certify inpatient hospital services under Medicare and Medicaid (ICAN Act, 2022). Expanded APRN scope of practice is a significant way to help amend current and future care access limitations. The AANP also supports the implementation of The Consensus Model for APRNs, and adoption of the NCSBN Model Practice Act (AANP, n.d).

- **The Federal Trade Commission Recommends** Expanded APRN scope of practice is good for competition and consumers (Federal Trade Commission [FTC], 2014). Compulsory physician supervision and collaborative practice agreements likely impede provider competition, resulting in decreased access to care, lower care quality, higher costs, and limited innovation in care delivery. Due to these issues, the Federal Trade Commission (FTC) recommends that state legislators review requirements carefully. Noting that the FTC agrees with most expert health policy organizations' support for expanded APRN SOP as a vital component of the nation's strategy to fill primary care gaps (FTC, 2014).

- **National Academies of Sciences, Engineering, and Medicine**, The 2021 report, The Future of Nursing 2020-203: Charting a Path to Achieve Health Equity, calls for the elimination of SOP restrictions for NPs to increase access to high-quality healthcare services for those with complex needs; thereby improving health equity. Additionally, it is noted that NPs should be practicing to the full extent of their education and training.

- **The National Council of State Boards of Nursing Consensus Model (2008) recommends**. The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education was developed in 2008 to provide a uniform model for APRN regulation. The Consensus Model would parallel state NP laws and facilitate a pathway to an APRN Compact, allowing NPs to practice in multiple states. Removing scope of practice barriers for NPs would reduce primary care shortages, improve access to care, and improve patient satisfaction

State specific Barriers to Practice Resuting from SOP Restrictions:

In states requiring physician supervision, NPs experience restricted prescribing rights for medication and medical equipment and limitations to services at skilled nursing facilities. These restrictions decrease providers' time to provide patient care and increase the cost burdens on NPs and patients (Mack, 2018). NP reimbursement rates are lower than physicians' (Myers et al., 2020). NPs are subject to signature restrictions preventing the signing of Do Not- Resuscitate orders, POLST, and death certificates (AANP, 2023b). SOP regulations vary from state to state, creating a lack of consensus. Due to varying regulations, the APRN Consensus Work Group and the NCSNB APRN Advisory Committee formed the Consensus Model in 2008 to work towards standardizing APRN education and licensure, accreditation, and certification (Mack, 2018). Implementing this model could allow for state-to-state practice mobility and increase patient access to NP-led care (Mack, 2018).

Texas: New legislation has been presented regarding SOP changes in TX; currently, NP licensure is restricted by the requirement of physician delegation and supervision (AANP, 2023b). According to TX code 301.152, NPs must maintain written agreements with physicians throughout their careers. NPs must keep a prescriptive authority agreement with a physician but are limited to specific settings and diagnoses on Schedule II medication. NPs can refer to physical therapy, approve disabled parking permits, and sign death certificates. However, they are not authorized to sign Do Not Resuscitate orders. A POLST program is being developed for the state of TX (AANP, 2023b)

California: In 2020, Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) was signed into law, creating two new categories of NPs (California Board of Registered Nursing [CABON], n.d.). The first category, a 103 NP, works under the provisions of BPC Section 2837.103 in a group setting with at least one physician focused on the NP's certification. The second category, 104 NPs, may work outside a group setting in their certified focus population or open an independent practice. These new categories do not significantly extend the current NP SOP but allow additional practice authority (CABON, n.d.). The traditional NP role remains, and there is no requirement to transition to a new category. NPs can refer to PT, approve disabled parking permits, and sign POLST forms. However, they cannot sign Do Not Resuscitate orders or death certificates (AANP, 2023a). Although CA has seemingly made progress, there has been no substantial expansion to NP SOP, and practice restrictions remain.

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