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Nurse Practitioners Seek Expansion in Scope of Practice

With the looming implementation of healthcare reform slated to usher in millions of newly insured patients in January 2014, the challenge of a continuing primary care shortage has yet again come to the forefront of healthcare debates. One of the proposed stopgaps to combat this shortage is to expand the ability of midlevel providers, e.g., nurse practitioners (NP), to practice free of physician oversight.[i] A 2010 Institute of Medicine report regarding the future of nursing practice recommended that scope of practice barriers be removed for Advanced Practice Registered Nurses (APRN),[ii] along with recommendations to expand; standardize; and, streamline nursing education and integration in healthcare delivery.[iii]

As of 2013, NPs have the ability to provide a full range of medical care to patients without physician oversight in 17 states and Washington D.C. Other states require collaborative agreements between NPs and physicians to provide certain aspects of care (21 states), while others restrict care under supervision or delegation of a physician (12 states).[iv] In some of these states, a legislative war still wages between NPs and medical associations regarding a nurse practitioner's ability to practice medicine autonomously.

Even more restricted than NP practice authority is NP prescriptive authority, specifically with regard to controlled substances.[v] Reimbursement eligibility and rates also vary greatly by state, and by insurance carrier.[vi] One of the challenges facing NPs is that many insurers still won't accept, or restricts, acceptance of NPs into credentialed networks as primary care providers. In response to this, the American Nurses Association (ANA) wrote a letter to the Centers for Medicare and Medicaid Services (CMS) on July 17, 2013, proposing that any qualified health plan (QHP) under the new health exchanges must include at least 10% of the overall number of independently practicing APRNs in its network area.[vii] However, in the August 30, 2013 edition of the Federal Register, CMS responded that while the regulations regarding QHP provider inclusion would not be changed, it would continue to assess the topic.[viii]

On the other side of the debate, physician groups and medical associations often cite the training and educational differences between physicians and NPs when arguing why autonomous NP practice isn't feasible or safe. A family physician requires 11 years of education (from undergraduate education through residency) in comparison to the 5.5 to 7 years required for an NP to achieve certification to practice. In addition, the former spends a total of over 20,000 hours compared to an average of 4,000 or so hours in academic and clinical study towards degree completion.[ix] Medical associations, while opponents of autonomous NP practice, do support NP participating in team-based care models led by physicians.[x]

One of the reasons for the renewed attention to expansion of NP and APRN scope of practice, in addition to the aging crop of baby boomers, is the looming implementation of healthcare reform measures regarding health exchanges and consumer insurance. The coming reform implementation will cause a boom in consumers with healthcare insurance, further stressing overburdened and understaffed primary care practitioners, and exacerbating consumer challenges regarding access to care.[xi] Legislators are also interested in what kind of cost impact primary care practices led by autonomous NPs will have on a healthcare system bent on reducing overall cost of care. What both sides agree on, however is that more research is needed to address the questions surrounding cost, clinical impact, and contribution of autonomous NP practice to a healthcare system in reform.

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[i] "Nurse Practitioners Seek Right to Treat Patients on Their Own", by Melinda Beck, Wall Street Journal, August 14, 2013, online.wsj.com/article/SB10001424127887323455104579013193992224008.html (Accessed September 14, 2013)
[ii] "The Future of Nursing: Leading Change, Advancing Health", by the Institute of Medicine, 2010, p. 1
[iii] *Ibid*, Institute of Medicine, 2010, p. 1-6
[iv] "2013 Nurse Practitioner State Practice Environment", by the American Association of Nurse Practitioners, 2013
[v] *Ibid*, National Governors Association, December 2012, p. 9
[vi] *Ibid*, National Governors Association, December 2012, p. 10
[vii] Letter to Marilyn Tavenner, "Re: Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards. 78 Fed Reg. 37032 (June 19, 2013)", by Marla Weston, American Nurses Association, July 17, 2013, p. 2-4
[viii] "Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals: Final Rule", by Centers for Medicare and Medicaid Services, Federal Register, Vol. 78, No. 169, p. 54121
[ix] "Education and Training: Family Physicians and Nurse Practitioners", by American Academy of Family Physicians, p. 2

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[x] "Nurse Practitioners Try New Tack to Expand Foothold in Primary Care", by Julie Appleby, Kaiser Health News, September 8, 2013, www.kaiserhealthnews.org/Stories/2013/September/09/nurse-primary-care-slowed-by-insurer-credentialing.aspx?p=1 (Accessed September 14, 2013)

[xi] "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care", by the National Governors Association, December 2012, p. 1

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