

Center to Champion Nursing in America

Access to Care and Advanced Practice Nurses *A Review of Southern U.S. Practice Laws*

Introduction

Consumers need greater access to high quality primary health care, especially in underserved settings in both urban and rural communities. Our nation is facing a severe shortage of primary care providers who can serve people of all ages and particularly those with multiple chronic conditions¹. Americans need a broad range of primary care services—from health promotion to assessment and treatment of health problems and providers who teach patients and families how to manage their daily lives to improve health and avoid worsening conditions.

Advanced practice registered nurses (APRNs), primarily nurse practitioners, can help fill this critical void, particularly in rural and underserved areas of the country. Nurse practitioners are registered nurses with advanced training in preventing, diagnosing, and treating illness. These professionals are licensed with prescriptive authority and educated to do what we need them to do—care for those who need primary, preventive, and chronic care.

In some states, despite the urgent need to expand access to primary care and preventive services, a number of barriers prevent the full deployment of nurses, in particular APRNs. State legislatures and governors should consider re-evaluating laws that prevent broader utilization of this valuable resource to meet citizens' needs.

This is one paper in a series of reports pertaining to scope of practice—or the range of services an APRN is skilled to provide—produced by the Center to Champion Nursing in America at AARP. This report includes a regional snapshot of the regulation of advanced nursing practice in southern states (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, TX, and VA) and its effect on consumers. It includes the following recommendations:

- State governments should re-assess their laws and rules governing APRNs.
- State laws should reflect that APRNs can practice independently; referrals to physicians are part of an APRN's daily practice, but physician supervision should not be mandated in state laws.
- State laws should allow APRNs full prescriptive authority so they can write prescriptions for all of their patients.
- State laws and rules should be updated so that the State Board of Nursing is the sole regulatory authority of all registered nurses—including APRNs.

APRNs: Evidence of Quality

Studies demonstrate that, for more than 40 years, APRNs have been delivering safe and effective health care to all populations, across settings, and in many specialties. In fact, research shows no difference in outcomes of primary care delivered by APRNs and physicians, including such outcomes as patient health status, number of prescriptions written, return visits requested, or referrals to other providers.² A recent review of the quality and effectiveness of care provided by APRNs from 1990 to 2008 found that APRNs provide as high a quality of care as physicians³.

Research continues to show the unique aspects of advanced practice nursing by validating that hospital care by APRNs can reduce the number of hospital days for patients,⁴ good news for payers as well as patients and their families. Nurse-led clinics are especially effective in secondary prevention⁵ or the care provided to patients who are striving to stay as healthy as possible while learning to live with one or more chronic diseases, such as diabetes or heart disease.

APRNs: Impact on Consumers

Access to high quality primary care, chronic care management, pain management, and women's health care increases quality of life for individuals and reduces health care costs for both consumers and businesses. Consumers count on APRNs to provide direct care and help them manage common health problems. Restrictions on APRN scope of practice threaten consumers' access to affordable, high quality health care, health care that enhances quality of life and keeps employees in the workplace, a benefit to economic security and business productivity.

In rural areas, access to care is an especially important issue for consumers because a shortage of primary care providers already exists. Physicians are less likely to live and practice in rural areas, whereas APRNs are more available in those settings.^{6,7}

Barriers to APRN Practice

APRNs are qualified to provide the basic health care that consumers need. However, APRNs are often prevented from providing the skilled clinical care in which they are trained, preventing Americans from accessing the primary care, chronic care management and other services that they need and deserve, resulting in poorer health outcomes.

Some states, particularly Southern states, have established elaborate rules to oversee these graduate-level educated professionals. Simply put, we are over-regulating a highly skilled and educated professional workforce that costs tax payers money, limits consumer access and choice and puts undue time restraints on professional nurses and physicians.

Regulatory barriers tend to fall into three categories: required physician supervision or collaboration, restrictions on prescriptive authority, and duplicative regulatory structures. Physician supervision means that the physician has some degree of responsibility for the APRN's care; collaboration means a mutually agreed upon relationship between an APRN and a physician (and in some southern states the collaborating doctor can be a dentist). Prescriptive

authority is the ability to write prescriptions. Regulatory boards protect the public by ensuring that only qualified individuals are licensed to practice. In many southern states, both the board of nursing and the board of medicine regulate APRN practice.

Advanced Nursing Practice in the Southern States

The southern states have among them 111 colleges and universities educating APRNs requiring a bachelor's degree for entrance and conferring master's degrees to graduates. Some of the nation's best universities including the University of Alabama at Birmingham, Duke University, University of North Carolina at Chapel Hill, Vanderbilt University, the University of Texas Austin and Houston, and the University of Virginia, all ranked in the top 10 percent of graduate nursing schools by U.S. News and World Report⁸, have been educating these nursing professionals for decades. The return on investment that these states put toward the education of their APRNs would greatly increase by allowing these professionals to do the job they are prepared to do.

Nurse practice acts are the laws that define the scope of practice of nurses, according to their level of education. The scope of practice for registered nurses does not vary across the United States. For APRNs, however, nurse practitioner scope of practice varies widely⁹. The southern states restrict APRN practice through their state's nurse practice act and through interpretation and rule-making.

Physician Supervision of APRNs

In each of the southern states' nurse practice acts, APRNs are required to have some degree of physician involvement, ranging from a written collaborative agreement to on-site supervision.¹⁰ Table 1 details the type and degree of physician involvement in APRN practice in the southern states nurse practice acts. The law may describe the APRN as "under the direction of a licensed physician" (Arkansas), or the law may require that the method of supervision be specifically identified in the written protocol (Florida). In rural areas, APRNs have difficulty finding a collaborating physician, and if the physician charges the APRN a collaboration fee, this cost is passed on to patients.¹¹ Ultimately, whatever the degree of physician involvement, these restrictions on nursing practice mean that many people go without care because physicians are not available to provide the required but unnecessary oversight specified in the state laws and regulations.

Prescriptive Authority

Many state nurse practice acts restrict the prescriptive authority of APRNs, which results in a lack of access to health care for consumers. Some states only allow APRNs to prescribe drugs that are on a formulary, or list of approved drugs. This means that APRNs cannot prescribe any new drugs until the drug is added to their collaborative agreement.

Prescriptions for controlled substances, those drugs considered at risk of being abused, such as morphine, require additional authorization from the federal government. This means all health care professionals who prescribe controlled substances must register with the Drug Enforcement

Administration (DEA) and must follow state prescriptive authority laws. Therefore, APRNs who prescribe pain medication are already regulated by two levels of public policy oversight. To be required to collaborate with or be supervised by a physician is another redundancy that slows down the process of people having access to health care.

Nurse practice acts delineate which level of controlled substances that an APRN can prescribe. APRNs in forty-eight states and the District of Columbia can prescribe controlled substances. In two of the southern states, Alabama and Florida, APRNs cannot prescribe any controlled substances (see Table 1). In Arkansas, South Carolina, and Texas, APRNs cannot prescribe drugs such as liquid morphine or fentanyl patches for hospice patients. In Mississippi, the Board of Nursing requires a detailed letter from each APRN and collaborating physician describing the APRN's practice, including types of diseases treated, and may deny the APRN's authority to prescribe controlled substances.

Laws that prevent people from having access to health care providers who can provide them with medication, including pain medication, threaten their health and well-being. In turn, people are less productive in society and health care costs increase.

Duplicative Regulatory Structures

In Alabama, Georgia, Florida, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia, state legislatures require that two licensing boards, nursing and medicine (or extra committees thereof), oversee APRN practice. In addition to involving two boards in APRN regulation, these states still have laws that require APRNs be monitored by a physician.¹²

Typically, regulatory bodies provide oversight by responding to complaints brought against their practitioners. These complaints can originate from any interested person: consumers, nurses, physicians, hospitals, etc. Alabama, however, has added an extra step in this process by allowing the Board of Medicine to hire two full-time employees to proactively monitor physicians' offices that employ APRNs. In two years, these investigators filed 12 complaints and 10 were found to be of no merit, calling into question the cost effectiveness of this duplicative process.¹³

The National Council of State Boards of Nursing advocates licensure by Boards of Nursing only. APRN advisory committees of Boards of Nursing should oversee APRN practice in every state.¹⁴ This arrangement is a more practical oversight approach because it is nursing professionals who understand nursing, and it eliminates another example of inefficient redundancy.

Conclusions

For 40 years, the nursing profession has provided for the education, training and testing of APRNs. More importantly, since the inception of the level of advanced nursing practice in the early 1970s, APRNs' professional care has been studied by researchers in the fields of nursing, medicine, economics, and public policy, with papers published in top peer reviewed journals. All studies conclude that the APRN can deliver high quality primary care safely.¹⁵ Their primary care skills have been found to be equal to their colleagues in the medical profession. None of

these studies establishes a basis for requiring that physicians supervise APRNs. APRN skills are not the result of supervision, delegation, or collaboration. They are acquired through two nursing degrees (the undergraduate and the master's degree for the APRN license) along with supervised clinical training, and assessed by national accredited testing bodies in nursing (all the southern states require national certification). Once certified by the state, continuing education and experience add to skill development, just as is the case with other health care disciplines.

Laws and regulations for health care professionals exist to protect the public. However, requiring physician supervision of APRNs, preventing APRNs from practicing to their full range of expertise, and imposing redundant oversight actually diminishes public safety because it decreases the availability of primary care to those in need. Without such access, health outcomes diminish and costs rise. If states changed their laws to allow APRNs to practice to their fullest range of skills and expertise, without the extraneous supervision of physicians, and with regulatory oversight by boards of nursing, not only would the public's safety increase, and people's health improve, but costs to the payers of health care would decrease, including state governments, employers, and the federal government. Updating laws like this not only makes sense, it saves dollars.

Recommendations

To ensure all Americans have greater access to qualified health care professionals who can provide the primary care and chronic care management that will allow them to maintain a higher quality of life and remain active in their communities, as well as prevent unnecessary hospitalizations, we offer the following recommendations:

- All state governments should re-assess their laws governing APRNs.
- Nurse practice acts should reflect that APRNs can practice independently.
- Nurse practice acts should allow APRNs full prescriptive authority so that they can write prescriptions for all of their patients.
- Laws and rules should be updated so that the Board of Nursing is the sole regulatory authority of all registered nurses—including APRNs.

In addition to these recommendations that are based on the rationale described in this report, states can also consider offering “carrots” or “sticks” that would facilitate third party payers to reimburse APRNs for their clinical services. Reimbursement for APRN clinical services also would help to provide care that has so far been unmet. By doing so, health care consumers would live more productive lives and, ultimately, the costs for health care payers would be driven down.

Addendum

Table 1. Comparisons of Barriers to Access to Nurse Practitioner Care in Southern U.S. States¹⁶

State	Physician Involvement	Prescribing Restrictions	Additional Restrictions
Alabama	<ul style="list-style-type: none"> Required Collaborative Practice Agreement (CPA) and protocol with Alabama MD 	<ul style="list-style-type: none"> Restricted to formulary—cannot Rx any new drugs unless CPA revised. No controlled substances (CS) 	<ul style="list-style-type: none"> Can only order labs or x-rays as specified on protocol Cannot order physical therapy Can perform but cannot sign sports physicals Recent state Medicaid ruling NOT to list nurse practitioners (NPs) as primary care providers
Arkansas	<ul style="list-style-type: none"> Required CPA for prescribing 	<ul style="list-style-type: none"> CS restricted to III-V 	<ul style="list-style-type: none"> NPs have no legal right to be listed on provider panels as primary care providers
Florida	<ul style="list-style-type: none"> Supervision by a Florida MD or dentist Written protocol required 	<ul style="list-style-type: none"> No CS Written practice protocol—outlines generic and broad drug categories 	<ul style="list-style-type: none"> NPs who practice in specialty areas must have all consultations reviewed and co-signed by the supervising physician No NP reimbursement by HMOs
Georgia	<ul style="list-style-type: none"> Required Nurse Protocol Agreement that spells out what drugs, medical treatments, and diagnostic tests NP can order 	<ul style="list-style-type: none"> Protocol limits number of refills which may be ordered NPs may order CS II-V but physician must review and sign all records and patients must be examined by the delegating physician at least quarterly 	<ul style="list-style-type: none"> Radiographic image tests (CT, MRI) may be ordered in life-threatening situations Delegating physician required to review and sign 10 percent of all NP's medical records
Kentucky	<ul style="list-style-type: none"> Two required CPAs – one for non scheduled drugs and one for controlled substances 	<ul style="list-style-type: none"> CS II-V after one year of practice Schedule II limited to a 72 hour supply Valium, Xanax and Hydrocodone prescriptions limited to a two week supply with no refills 	<ul style="list-style-type: none"> NPs' hospital privileges limited as regulations specify that a physician has overall responsibility for each patient
Louisiana	<ul style="list-style-type: none"> Practice in collaboration with MD or dentist with written CPA and with detailed protocols 	<ul style="list-style-type: none"> Schedule II under certain circumstances No CS for treating chronic and intractable pain 	<ul style="list-style-type: none"> Detailed protocols are clinical practice guidelines that describe a specific sequence of orders to be followed in various clinical situations Requires physician examination when patient needs are outside of protocol
Mississippi	<ul style="list-style-type: none"> NPs must practice in a collaborative/consultative relationship with a physician. Board of Nursing must approve specific and detailed protocols/guidelines that APRN and MD develop Protocol must identify diagnoses within APRN's scope of practice 	<ul style="list-style-type: none"> For CS, the Board of Nursing requires a letter from NP and the collaborative/consultative physician outlining the NP's practice including population served and types of diseases treated Board of Nursing may approve any combination of Schedules II-V or may deny CS 	<ul style="list-style-type: none"> A detailed quality assurance program to evaluate NP prescribing practices is required

State	Physician Involvement	Prescribing Restrictions	Additional Restrictions
North Carolina	<ul style="list-style-type: none"> Board of Nursing and Board of Medicine must authorize "Approval to Practice" under a CPA requiring an MD to continually supervise and evaluate the APRN 	<ul style="list-style-type: none"> Included in the CPA—CS-II-V but limited to 30 days and no refills 	<ul style="list-style-type: none"> NP and supervising physician meet monthly during the first six months of practice and every six months thereafter Dated and signed minutes of these quality assurance meetings must be available for Nursing or Medical Board review
South Carolina	<ul style="list-style-type: none"> Supervision by an MD who delegates medical acts by protocols subject to Board of Nursing and Board of Medicine approval 	<ul style="list-style-type: none"> Prescriptions are limited to drugs for "common well-defined medical problems" included in protocols CS limited to III-V only 	<ul style="list-style-type: none"> Number of NPs supervised by physician or dentist is limited
Tennessee	<ul style="list-style-type: none"> Written guideline/protocol/formulary for prescribing only—with a supervising MD 	<ul style="list-style-type: none"> Physician shall "supervise, control, and be responsible" for NP's prescriptions. Certificate of Fitness to Prescribe required for NPs 	<ul style="list-style-type: none"> Physician must sign the NP's chart documentation for all patients prescribed a controlled drug
Texas	<ul style="list-style-type: none"> Delegation and supervision by MD with protocols agreed upon by APRN and MD 	<ul style="list-style-type: none"> Agreed upon protocols—CS-III-V, limited to 90 days 	<ul style="list-style-type: none"> NPs working in medically underserved areas must report daily to delegating physician and physician must review 10 percent of NP's charts NPs practicing in facilities may sign drug orders only for those patients for whom physicians have given their prior consent
Virginia	<ul style="list-style-type: none"> NPs practice under the medical direction and supervision of a licensed physician. Medical Practice Act regulations are promulgated jointly by the Board of Medicine and the Board of Nursing. 	<ul style="list-style-type: none"> A separate written practice agreement with the supervising MD—CS-II-V 	<ul style="list-style-type: none"> Number of NPs supervised by physician is limited to 4 Physician is required to regularly practice in setting where NP prescribes Physician required to conduct a random review of NP's charts NP cannot tell the public that NPs are able to practice independently – grounds for disciplinary action

Written by the Center to Champion Nursing in America
AARP Public Policy Institute
Center to Champion Nursing in America
601 E Street, NW, Washington, DC 20049
www.championnursing.org
202-434-3920
ppi@aarp.org
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¹ Cronenwett Linda and Victor Dzau. "Chairman's Summary of the Conference." In *Who Will Provide Primary Care and How Will They Be Trained?*, edited by B. Culliton. Durham, NC: Josiah Macy, Jr. Foundation, 2010. http://www.josiahmacyfoundation.org/documents/jmf_ChairSumConf_Jan2010.pdf (accessed March 16 2010).

² Horricks, Sue, Elizabeth Anderson, and Chris Salisbury. "Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors." *British Medical Journal*, 324 (2002): 819-823.

³ Newhouse, Robin, Julie Stanik-Hutt, Kathleen White, Meg Johantgen, George Zangaro, and Lou. Heindel. *An Assessment of the Safety, Quality, and Effectiveness of Care Provided by Advanced Practice Nurses*. Washington, DC: The TriCouncil for Nursing, 2010.

⁴ Lenz, Elizabeth R., Mary O'Neil Munding, Robert L. Kane, Sarah C. Hopkins, and Susan X. Lin. "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: Two-year Follow-up." *Medical Care Research and Review* 61 (2004): 332-351.

⁵ Raftery, James P., Guiqing L. Yao, Peter Murchie, Neil C. Campbell, and Lewis D Ritchie. "Cost Effectiveness of Nurse Led Secondary Prevention Clinics for Coronary Heart Disease in Primary Care." *British Medical Journal*, 330 (2005): 707-710.

⁶ Martin, Kenneth E. "Nurse Practitioners: A Comparison of Rural-Urban Practice Patterns and Willingness to Serve in Underserved Areas." *Journal of the American Academy of Nurse Practitioners* 17 (2000): 337-341.

⁷ Kaplan, Louise, Marie-Annette Brown, C. Holly Andrilla, and L. Gary Hart. "Rural-Urban Practice Patterns of Nurse Practitioners in Washington State." *The Journal for Nurse Practitioners* 5 (2009): 169-175.

⁸ *U.S. News & World Report*, "Nursing Ranked in 2007." <http://grad-schools.usnews.rankingsandreviews.com/best-graduate-schools/top-nursing-schools/rankings> (accessed March 2, 2010).

⁹ Hudspeth, Randall. "Finding Answers." *Advance for Nurse Practitioners*. <http://nurse-practitioners.advanceweb.com/Editorial/Content/Editorial.aspx?CTIID=2698&RPID=34&RPID=13> (accessed March 16, 2010).

¹⁰ Pearson, Linda. "The Pearson Report." *The American Journal for Nurse Practitioners* 13 (2009): 8-82.

¹¹ Schrand, Susan. "State-mandated collaboration for nurse practitioners." *Virtual Mentor*, January 2010. <http://virtualmentor.ama-assn.org/2010/01/oped2-1001.html>. (accessed March 2, 2010).

¹² Pearson, Linda. "The Pearson Report."

¹³ Interview with Joseph Decker, Executive Director, Alabama State Nurses Association, Montgomery, AL, on October 5, 2009 and January 29, 2010 by telephone.

¹⁴ National Council of State Boards of Nursing. *Consensus Model for APRN Regulation*, July 7, 2008. https://www.ncsbn.org/7_23_08_Consensus_APRN_Final.pdf (accessed March 2, 2010).

¹⁵ Newhouse, Robin, Julie Stanik-Hutt, Kathleen White, Meg Johantgen, George Zangaro, and Lou. Heindel. *An Assessment of the Safety, Quality, and Effectiveness of Care Provided by Advanced Practice Nurses*. Washington, DC: The TriCouncil for Nursing, 2010.

¹⁶ Pearson, Linda. *The Pearson Report*. (2010) <http://www.pearsonreport.com/> (accessed March 18, 2010).