BARRIERS TO NURSE PRACTITIONER FULL PRACTICE AUTHORITY (FPA): STATE OF THE SCIENCE

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ABSTRACT

Purpose: To explore the various barriers to full practice authority (FPA) of nurse practitioners (NP) in the United States, and to identify the specific legislative barriers to FPA.
Background: FPA for NPs is cited as a way to reduce the provider shortage in the U.S, increasing access to healthcare. However, the majority of states across the country restrict the NP ability to provide primary care. As of 2015, only 21 states offer NP's full practice authority.
Data Sources: A comprehensive literature search was conducted using data bases by PubMed, and MeSH, EBM Search, CINAHL, and Google Scholar. Thirty articles were chosen for synthesis.
Results: Several barriers impede the ability of NPs to practice autonomously including lack of formal business or marketing education, reduced reimbursement rates, and lack of recognition from public and other health professionals about their preparation. The most common barrier is restrictive legislation halting NP practice at the level of their full knowledge and preparation. No articles were found identifying specific barriers to implementing FPA legislation.
Implications: There is a gap in the literature identifying specific barriers to implementing successful legislation to remedy this problem. Understanding how NPs, NP organizations, legislators, and policy-makers are working to overcome these barriers and attain full practice authority in their respective states will help other states in their efforts to obtain similar legislation.
Keywords: Full practice authority, autonomous practice, independent practice, barriers, legislation, nurse practitioner, primary care, health policy, leadership, scope of practice

In many developed countries, there is a vast and increasing shortage of primary care providers to serve the population's healthcare needs. Over 65 million Americans live in primary care shortage areas, and adults across the nation are unable to promptly access primary care services (Bodenheimer & Pham, 2010). Population growth, an aging population, and an increase of individuals obtaining health insurance further add to the shortage of healthcare providers. Of those, population growth will call for the need for 33,000 additional physicians, and an additional 10,000 physicians will be required to address the health care needs of the aging population (Petterson et al., 2012). Secondary to the overhaul of the Affordable Care Act, an

additional 8,000 physicians are needed to address those with newly acquired access to health care (Petterson et al., 2012). Combined, the number of visits to a primary care provider is estimated to rise from 462 million visits in 2008 to 565 million visits in 2015 (Petterson et al., 2012).

This shortage of primary care providers is not only a US issue, but also a health concern in other developed countries including Canada and Australia (Carter, Owen-Williams & Della, 2015; MacLean et al., 2014). Furthermore, the physician shortage ranks Canada 26th out of 34 developed countries in terms of the physician-to-population ratio (Islam, 2014). In Australia, only 80% of the needed physicians to meet the healthcare demand of the country are currently practicing (Gorman & Brooks, 2009).

Internationally, nurse practitioners have been identified as providing an answer to this critical health care shortage. Many nurse practitioner organizations including the American Association for Nurse Practitioners and Canadian Nurses Association support autonomous practice for NPs. NPs armed with what is referred to as *FULL PRACTICE AUTHORITY* (FPA) are being touted as the ultimate solution to the shortage of primary care providers (PCPs), thereby improving access to health care (Cronenwett et al., 2011). FPA is the legal ability for nurse practitioners to practice to the full extent of their education and training. In the U.S., only 21 states and the District of Colombia allow FPA for nurse practitioners (American Association of Nurse Practitioners [AANP], 2015). Reduced practice is offered to nurse practitioners in 17 states, and 12 states only allow restricted practice (AANP, 2015).

Physician oversight is the main factor separating the various types of legislation across state lines (Gilman & Koslov, 2014). Some states require physicians to be involved in the following activities: reviewing a certain percentage of the charts of patients who are cared for by a nurse practitioner, and restrict the ability for the nurse practitioner to prescribe narcotics, and/or require a written collaborative agreement for doing these activities (Gilman & Koslov, 2014). Other states limit the physical distance between the nurse practitioner's primary office and the supervising physician, thereby reducing access to populations needing care in rural areas (Gilman & Koslov, 2014).

Legislative restrictions across the nation currently impede nurse practitioners' ability to practice to the full extent of their education and training, thereby reducing access to health care for the community. However, there is no data suggesting that greater legislative restrictions on nurse practitioners provide safer and better care than states offering Full Practice Authority (FPA; see Fairman, Rowe, Hassmiller & Shalala, 2011). Currently, there are over 250,000 nurse practitioners in the U. S. (Gilman & Koslov, 2014). If all of these nurse practitioners were allowed to treat patients under FPA legislation, the shortage of primary care providers would dramatically decrease, thereby providing a greater access to healthcare (Cronenwett et al., 2011).

Across the nation, legislation to remove these restrictive barriers on nurse practitioners is under state consideration. Disseminating knowledge about the barriers that prevent this legislation's implementation is essential to addressing the health care needs of this country.

Purpose

The purpose of this literature review is to explore the various barriers to Full Practice Authority (FPA) for nurse practitioners in the United States, including identification of the specific FPA legislative barriers.

Method of Literature Collection

Key Terms

A variety of key terms were utilized to search the various databases for literature identifying barriers to FPA. Table I contains a detailed list of the expanded search terms used.

TABLE I
Search Key Words

General	Expanded
Nurse Practitioner	Advanced practice nursing/nurse, APN, family nurse practitioner, FNP
Barrier	Barrier, challenges, restrictive
Full Practice Authority	Independent practice, autonomous practice, full practice, scope of practice
Legislation	Law, bill, senate bill, legislative bill, assembly bill, health policy
DNP	Doctor of nursing practice, practice doctorate, advanced practice

Databases Searched

A literature search was performed to identify all relevant and recent articles that addressed the topic. Database search engines used included OVID Medline, CINAHL, PubMed and Google Scholar. The search was not limited by discipline or type of research. Combining the results from PubMed and OVID Medline, the initial search returned 6896 articles. CINAHL returned 399 articles. The search was then narrowed by selecting articles that met the following inclusion criteria: published in the last five years, written in English, participants involved only

human subjects, and full text available was available. This search resulted in a total 830 articles. Using Google Scholar, the initial search returned 296,400 articles. The search was then limited to articles published in the past 5 years, returning 17,400 articles. Restricting the search to obtain the most recent articles, 816 articles published in the past fifteen months were retrieved.

The 816 articles were combined with the 830 articles from the initial search and duplicates were removed. Next, a review of the abstracts was performed using specific terms including *nurse practitioner* and *barrier*, *scope of practice*, *independent*, or *autonomous*. Finally, additional articles were retrieved from the reference list of the selected articles, resulting in a total of 30 articles included in this review. These selected articles were based on relevance to Full Practice Authority (FPA) based on a review of the abstract, published within the past seven years, and full-text availability.

Barriers to Full Practice Authority

Removing practice barriers is an essential step to improving access to care (Gutchell, Idzik & Lazear, 2014). This section will identify and discuss the various barriers identified in the literature, including conflict between the nursing and medical roles, lack of shared standards for practice among states, legal and financial barriers, lack of role recognition, lack of formal business knowledge or training, and various public policy issues. The authors of the articles selected for inclusion in this review specifically mentioned these barriers.

Conflict Between Nursing and Medical Roles

Conflict between nursing and medical roles is an underlying barrier identified repeatedly in the literature. There is growing tension between advanced practice nurses and physicians regarding the actual role of the nurse practitioner (Plager & Conger, 2007). Many specific nursing values (e.g., holistic, patient-centered and health-focused care) must be maintained in the nurse practitioner role (Bryant-Lukosius, DiCenso, Browne & Pinelli, 2004). Naylor and Kurtzman (2010) went beyond and described the nurse practitioner role to provide high-value primary care. To further clarify the role of nurse practitioners in primary care, the Institute of Medicine released the IOM Report on Future of Nursing in 2011 (IOM, 2011).

However, tension is evident in the American Medical Association response to the IOM stating that "Nurses are critical to the health care team, but there is no substitute for education and training" (Patchin, 2014, p.1). This type of statement and behaviors aimed at controlling practice and compensation continue to be a significant barrier to FPA for nurse practitioners.

Financial Barriers

Financial concerns are also a significant barrier to autonomous practice for nurse practitioners. Startup costs often deter nurse practitioners from practicing independently. Some nurse practitioners spend more than $50,000 in startup costs (Dubois, Green & Aertker, 2013). Personnel salaries, taxes, office utilities and lease payments also contribute to the high cost of running an autonomous practice. In states where FPA is not offered, a collaborative agreement with a physician must be in place. Many physicians charge a fee for this agreement, which adds to the cost of the practice (Dubois, Green & Aertker, 2013).

The cost of obtaining and maintaining required malpractice insurance is another financial barrier. According to the Nurses Service Organization website, the leading malpractice insurance provider in the U.S., the cost of malpractice insurance varies by state. Malpractice insurance may be required by law to maintain a nurse practitioner license; this varies by state. For example, NRS 632.238 of the Nevada Nurse Practice Act requires nurse practitioners to maintain malpractice insurance. This was a new requirement resulting from AB170 signed into law in 2013 (Scott, 2014).

Lack of Role Recognition

Public and professionals alike lack understanding regarding nurse practitioners' roles in the practice setting. There is ample literature defining the roles of nurse practitioners and their contributions to the healthcare system, yet a lack of role clarity persists (Lowe, Plummer, O'Brien & Boyd, 2012). From an inter-professional standpoint, there is a "blurring" of professional boundaries between physician and nurse practitioners (Lowe, Plummer, O'Brien & Boyd, 2012, p.681). Furthermore, diagnosing and prescribing medications may be understood by some as a role unique to physicians. Others describe these functions as representative of traditional nursing practice, and necessary to provide holistic care (Weiland, 2008). In addition, organizations may not understand nurse practitioners' roles causing confusion (Keating, Thompson & Lee, 2010).

Lack of Formal Business Knowledge and Training

Practice management issues were identified as another barrier to autonomous practice. To practice independently, nurse practitioners must know how to manage a business, including an understanding of obtaining business licenses, managing personnel, customer service, and marketing. In one study, 52% of nurse practitioner respondents who practiced independently in Florida (a restricted practice state) had no previous marketing training (Dubois, Green & Aertker, 2013). In addition, of the 20 states represented in the study, 57 % of respondents lacked

a marketing plan, 48 % did not have any customer service training, and only 48% had formulated a business plan (Dubois, Green & Aertker, 2013).

Public Policy Issues

Public policy issues were the most frequently mentioned barrier to autonomous practice of nurse practitioners, and were identified in every article included in this review. According to Gutchell, Idzik, and Lazear (2014), to remove the practice barriers for NPs, health policy must be changed to allow Full Practice Authority (FPA). Limited scope of practice, limited prescriptive authority, limited clinical privileges, reduced reimbursement rates, certification, and credentialing will be discussed in this section.

Limited Scope of Practice

Another public policy barrier to FPA is State Nurse Practice Acts restricting nurse practitioners from practicing to the full extent of their knowledge and training. Nurse Practice Acts give the authority to an organization, usually the Board of Nursing, to regulate and enforce the law involving nursing practice (Russell, 2012). These laws govern the clinical roles of nurse practitioners, determine the range of services they can provide, and describe the extent to which they can practice independent of physician oversight (Yee, Boukus, Cross & Samuel, 2013).

Currently, the Nurse Practice Acts in 29 US States restrict nurse practitioners from practicing to the full extent of their educational preparation. One common limitation is the requirement for collaborative agreements with physicians. This requirement is part of the Nurse Practice Act in all 29 states with restrictive or reduced practice for NPs (AANP, 2015). Some Nurse Practice Acts limit nurse practitioners' activities in regard to prescribing specific classes of medications, or to refer patients to physical or occupational therapy, or to sign various types of documents such as death certificates, worker's compensation forms, or disability insurance forms.

Limited Prescriptive Authority

Another aspect by which the Nurse Practice Acts vary from state to state pertains to the prescriptive restrictions imposed on nurse practitioners in particular geographical jurisdictions. Many state Nurse Practice Acts require a collaborative agreement with a physician in order for nurse practitioners to prescribe, whereas other states require the nurse practitioner to practice a specific number of hours prior to prescribing specific classes of drugs. For example, Nevada, which is a Full Practice Authority (FPA) state, requires nurse practitioners to practice for two years or 2,000 hours prior to attaining the privilege to independently prescribe Schedule II controlled substances (Nevada State Board of Nursing, 2014).

Limited Clinical Privileges

A third policy barrier pertains to organizational or institutional regulations. Some hospitals may have policies that disallow clinical privileges to nurse practitioners (Summers, 2012). Without clinical privileges in a hospital, nurse practitioners cannot continue to treat their patients who are admitted (Summers, 2012). Affording nurse practitioners clinical privileges is supported by the Institute of Medicine (IOM, 2011).

Reduced Reimbursement Rates

Another barrier to autonomous practice is the limited or reduced reimbursement rates from insurance companies for services provided by a nurse practitioner. In 1997, a Bill was signed into law providing direct reimbursement for nurse practitioners providing services covered under Medicare Part B (AANP, 2013). This legislation provided 85% reimbursement of the fee schedule for physicians (AANP, 2013). Despite this legislation, in many states, physicians continue to strive to ensure that exclusionary language is present to prevent reimbursement to non-physician providers (Kuntz, 2011). However, this reimbursement discrepancy has been refuted by the Medicare Payment Advisory Commission (Naylor & Kurtzman, 2010).

Insurance companies, including Medicare and Medicaid, use billing (CPT) codes that are based on the medical model (Miller, Snyder, Lindeke, 2005). This practice is disadvantageous for nurse practitioners because they are not allowed to bill for non-medical modalities common to their nursing model of practice (Miller, Snyder, Lindeke, 2005).

Lack of Shared Standards for Practice Among States

The Institute of Medicine (IOM) maintains that the uncoordinated system of state regulations, including lack of standardization of Nurse Practice Acts, one of the most significant barriers to nurse practitioners' autonomous practice (IOM, 2011; see also Naylor & Kurtzman, 2010). To address this issue, *The Consensus Model for Advanced Practice Registered Nurse Regulation* suggests implementing a single nurse practitioner license covering all states (Naylor & Kurtzman, 2010).

Certification

Inconsistent requirements for certification are also a barrier to Full Practice Authority (FPA). Across the country, each state has varying requirements for licensure to practice as a nurse practitioner. Currently, all states require the completion of a formal, masters-level nurse practitioner program and national certification (AANP, 2015). The only exception is the state of

California. Currently, California does not require national certification for licensure if they are a graduate from an accredited school from within that state (AANP, 2015).

Credentialing

A final public policy barrier mentioned in the literature is the inability for nurse practitioners to obtain credentialing. Credentialing is a process performed by a healthcare organization for analyzing a health providers' qualifications (Summers, 2012). Health care organization credentialing of nurse practitioners provides the possibility for them to have a set of patients assigned to their care (Plager & Conger, 2007). However, many managed care organizations choose not to credential nurse practitioners as primary care providers, thereby limiting their ability to be reimbursed by private insurers (Hansen-Turton et al., 2013). Furthermore, many states do not have "any willing provider" laws in place, thereby limiting the nurse practitioners right to be included on provider panels (Plager & Conger, 2007).

Gaps in the Literature

Policy restrictions to FPA for nurse practitioners caused by public policy were the most identified barriers in the literature. However, only one article actually discussed those barriers and why FPA legislation is not enacted as often as it is introduced to the legislature. In a qualitative study by Duncan and Sheppard (2015), eight specific legislative barriers were identified. Using a multiple case study format to interview a nurse practitioner activist, nursing leader, community nurse practitioner, and a state legislator who were actively involved in advancing full practice authority legislation in Nevada, the authors found specific barriers to the success of the FPA legislation (Duncan & Sheppard, 2015). These barriers included a lack of a clear vision, lack of physician support, inability to address stakeholders, lack of a strong coalition with leadership and legislative experiences, lack of vital resources, lack of role recognition and community support, poor relationships with community and regulatory organizations, and social media (Duncan & Sheppard, 2015).

Some of the other articles retrieved in the review did include information about how to improve the likelihood of legislation being signed into law, but the authors did not explain specific legislative barriers. For example, MacDonald et al. (2012) discussed the importance of forming strong alliances when introducing legislation (MacDonald et al., 2012). In addition, meeting with legislators personally, accessing the media, and improving public awareness were also cited as ways to improve the success of legislation passing (MacDonald et al., 2012; Demarco & Schneider, 2000).

FPA was signed into law in Nevada in June 2013, and insight on the process of introducing and successfully implementing FPA in this state was provided (VanBeuge &

Walker, 2014). Advice on how to prepare for introducing legislation was provided by citing five key steps: set priorities, secure a legislative champion, acquire a representative on the ground, seek external support and guidance with national organizations, and form a working group of NP leadership (VanBeuge & Walker, 2014). Additional "lessons learned" included staying on message, ensuring communication, keeping sight of the main objective, expecting the unexpected, and keeping updated on the opposition's point of view and talking points (VanBeuge & Walker, 2014). Although some can be inferred, there is no direct mention of specific legislative barriers to FPA legislation.

Summary

Overall, there are multiple barriers to FPA for nurse practitioners. The conflict between the medical and nursing roles, the lack of nurse practitioner role recognition, financial challenges, and a lack of business knowledge were some of the barriers discussed. However, barriers to FPA caused by policy limitations were the most frequently mentioned. Altogether, these barriers are multi-faceted and require additional literature support to overcome. More research is needed to identify specific legislative barriers to FPA legislation. Qualitative studies involving key informants in the states who have recently passed FPA legislation is needed to provide insight for other states, provinces and regions seeking FPA legislation for nurse practitioners.

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