University of St Augustine for Health Sciences
SOAR @ USA

Student Scholarly Projects

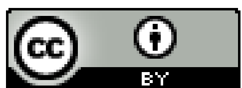
Student Research

Fall 11-29-2023

Full Practice Authority: Policy Review and Recommendation for Regional Nurse Practitioner Practice in the Southeastern Region of the United States

Tambra Ratledge
University of St. Augustine for Health Sciences

DOI: https://doi.org/10.46409/sr.IBVO8398



This work is licensed under a Creative Commons Attribution 4.0 License.

Follow this and additional works at: https://soar.usa.edu/scholprojects

Part of the Family Practice Nursing Commons

Recommended Citation

Ratledge, T. (2023). *Full Practice Authority: Policy Review and Recommendation for Regional Nurse Practitioner Practice in the Southeastern Region of the United States.* [Doctoral project, University of St Augustine for Health Sciences]. SOAR @ USA: Student Scholarly Projects Collection. https://doi.org/10.46409/sr.IBVO8398

This Scholarly Project is brought to you for free and open access by the Student Research at SOAR @ USA. It has been accepted for inclusion in Student Scholarly Projects by an authorized administrator of SOAR @ USA. For more information, please contact soar@usa.edu.

Full Practice Authority: Policy Review and Recommendation for Regional Nurse Practitioner Practice in the Southeastern Region of the United States

Tambra Ratledge, MSN, APRN, FNP-C

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

This Manuscript Partially Fullfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

Mary Brann, DNP, RN

Ahnnya A. Slaughter, DNP, RN, CNS-BC

Approved: November 29, 2023

DocuSign Envelope ID: 0CC9B135-0F9C-4E67-9B7A-397A8EB3E751

University of St. Augustine for Health Sciences
DNP Scholarly Project
Signature Form

Student Last Name: Ratledge	**First Name:** Tambra	**Middle Initial:**
E-mail: T.ratledge@usa.edu		
Title of DNP Project: Full Practice Authority: Policy Review and Recommendation for Regional Nurse Practitioner Practice in the Southeastern Region of the United States		

My signature confirms I have reviewed and approved this final written DNP Scholarly Project.
DocuSign electronic signature or wet signature required.

Type Name in Blue Box Below	Signature	Date
DNP Project Primary Faculty: Dr. Mary Brann	DocuSigned by: Dr. Mary Brann 45484A3BA15C450...	11/27/2023
DNP Project Preceptor: Dr. Ahnnya A. Slaughter	DocuSigned by: [signature] 6A39819101444D6...	11/29/2023
DNP Project Preceptor:		

Abstract

This policy analysis examines the limited practice authority for advanced practice registered nurses (APRN) in the Southeastern United States, focusing on Tennessee while drawing comparisons to Georgia and Alabama. The PICO question that guided this policy analysis is: For advanced practice registered nurses within the southeast region of the United States (P), how does the development of a comprehensive policy recommendation for full practice authority (I), compared to existing reduced or restricted practice authority in the southeast region of the United States (C) affect access to care as endorsed by literature (O)? The literature suggests that despite being equipped with the education, accreditation, certification, and licensure, APRNs in the Southeastern states still have regulatory and nonregulatory barriers to practice, impeding their ability to provide access to care, especially in rural and underserved communities. Moreover, the literature strongly advocates adopting evidence-based recommendations by the American Association of Nurse Practitioners, the Consensus Model, and The Academy of Medicine to modernize the outdated regulatory and nonregulatory barriers impeding APRNs. A policy brief is also proposed to engage stakeholders in advocating for these evidence-based recommendations and securing APRNs' full practice authority. Eliminating these barriers allows APRNs to work to their full ability, resulting in enhanced healthcare access, improved quality, reduced healthcare disparities, and potentially lowered healthcare costs.

Full Practice Authority: Policy Review and Recommendation for Regional Nurse Practitioner Practice in the Southeastern Region of the United States

Advanced practice registered nurses (APRNs) are essential in providing high-quality care for millions of Americans. However, APRNs in the Southeastern region have reduced or restricted scope of practice based on regulatory and non-regulatory restrictions. These scope of practice restrictions limit APRNs from treating patients to the full extent of their education, accreditation, certification, and licensure (Kleinpell et al., 2022). It is predicted that by 2034, the United States will have a shortage of physicians estimated to be between 37,800 and 124,000 (Association of American Medical Colleges [AAMC], 2021). APRNs can fill the gaps in the physician shortage; however, regulatory and non-regulatory barriers continue to limit their scope of practice. This scholarly project has two primary aims. The first is to analyze the current knowledge gap related to barriers to full practice authority (FPA) in the Southeastern region. The second is to suggest evidence-based policy recommendations with a policy brief for APRNs to have full practice authority in the Southeastern region of the United States.

Significance of the Practice Problem

As of 2022, 355,000 APRNs were licensed to practice in the United States, with a predicted growth of 46% by 2031 (American Association of Nurse Practitioners [AANP], 2022b; 2023a). APRNs provide comprehensive, patient-centered care to more than one billion patients annually in nationwide primary and specialty care settings (AANP, 2022b). Although education for APRNs is uniform across the nation, their scope of practice depends upon regulatory and non-regulatory barriers at the state and national levels (Kleinpell et al., 2022). Regulatory and non-regulatory barriers impede aspects of patient care by reducing access to high-quality care, delaying needed care, limiting choices of providers for patients, diminishing efficiency and timeliness of results, and adding costs to healthcare systems (Schorn et al., 2022).

Regulatory Practice Restrictions

Regulatory barriers arise from federal and state laws, regulations, statutes, and various public policies, encompassing mandates and executive orders (Schorn et al., 2022). An example of a federal regulatory barrier is limitations from the Centers for Medicare and Medicaid Services that APRNs can provide, such as care in skilled nursing facilities and long-term care facilities. Some regulatory barriers are at the state level. APRN practice authority is one of the most significant state regulatory barriers (Schorn et al., 2022). In the reduced scope of practice states, APRNs must collaborate with or work under the supervision of a physician and are limited in at least one of the four domains of practice (evaluation, diagnosis, ordering and interpreting diagnostic tests, and initiating and managing treatments). Within states considered restricted practice, there are strict collaborative or supervisory requirements, and APRNs face restrictions in two or more of the four practice domains (Schorn et al., 2022).

Other regulatory barriers involve prescribing schedule II medications, which the collaborating or supervisory physician determines, and there is a restriction on prescribing medications for telehealth appointments that occur out of state (Schorn et al., 2022). APRNs can also be limited at the state level by the Board of Medicine and the Board of Pharmacy (Bosse et al., 2017). Pharmacies will only fill medication prescriptions if they are from a consulting physician, and many physicians do not send consults or recommendations directly to APRNs (Schorn et al., 2022). These restrictions limit the services APRNs can provide, certain medications that can be prescribed, the inability to bill for services, and a decreased reimbursement rate. In addition, these barriers cause gaps or delays in care and deter APRNs from working in reduced and restricted practice states in the Southeastern region (Bosse et al., 2017).

Bosse et al. (2017) stated that the Affordable Care Act does not define APRNs as primary care providers. This restrictive definition also contributes to barriers to variable reimbursement policies. In some states, APRN signatures are insufficient for birth and death

certificates, family medical leave forms, handicap placards, employment and school physicals, disability forms, and informed consent (Schorn et al., 2022).

Non-regulatory Practice Restrictions

Non-regulatory barriers arise from the policies and practices of organizations and institutions, resistance from physicians, and cultural norms (Schorn et al., 2022). Organizational barriers include policy restrictions, inadequate comprehension or acknowledgment of the APRN role, poor collegiality with physicians and administrators, absence of hospital privileges, issues with provider credentialing, restricted admitting and staffing privileges, and issues related to insurance and reimbursement (Kleinpell et al., 2022; Schorn et al., 2022). Furthermore, electronic health records (EHRs) fail to document care provided by APRNs, and numerous prescriptions and hospital admissions require a physician co-signature, resulting in care delays, restricted patient communication, challenges in delivering adequate follow-up care, and limited provider choices (Kleinpell et al., 2022; Schirle et al., 2020). Reduced and restricted states often come with costly collaborative agreements ranging from $6,000 to $50,000 annually (Schorn et al., 2022). These barriers create APRNs' lack of autonomy and independent practice (Schorn et al., 2022).

In the United States, particularly in the country's Southeastern region, access to healthcare remains a substantial concern, with APRNs having reduced or restricted practice authority depending on the state (America’s Health Rankings, 2022). The Southeast region is characterized by persistent disparities in health outcomes, marked by increased rates of chronic diseases, infant mortality, premature mortality, and decreased life expectancy (America’s Health Rankings, 2022). Patients such as seniors, low-income, and LGBTQ communities are more likely not to seek preventative care, which worsens their health and increases costs and mortality (Bosse et al., 2017). Limiting APRNs' scope of practice impacts these patients as it decreases or delays their care. These barriers cause a substantial challenge for APRNs to fully

utilize their education, accreditation, certification, and licensure, which causes persistent avoidable disparities in healthcare (National Academy of Medicine, 2021).

Further compounding the state of healthcare in the South is the shortage of primary care providers, which is expected to worsen in the coming years (Association of American Medical Colleges, 2021). Lack of FPA increases the provider shortage issues. According to a federal government report in 2018, there were 7,181 healthcare provider shortage areas, with 84 million Americans with inadequate primary care access and 66% living in rural areas without access to care (Buerhaus, 2018). Medicare enrollment is expected to increase from 54 to 80 million applicants by 2030, with baby boomers aging into Medicare. By 2030, it is estimated that there will be up to 49,300 fewer primary care physicians. APRNs have the ability and are well-positioned to address the need for increased shortages in rural and urban areas of the country, such as in the Southeast region of the United States (Buerhaus, 2018). However, many APRNs do not practice in reduced or restricted areas due to the regulatory and non-regulatory barriers to their scope of practice (Hudspeth & Klein, 2019; Schorn et al., 2022). With the predicted physician shortage and the size of the population with inadequate access to care increasing and impacting 80.6 million Americans, there needs to be FPA nationwide (National Academy of Medicine, 2021).

Purpose of the Policy Project

Full practice authority is vital for every state to eliminate unnecessary, inefficient barriers to APRN practice that can improve access to care and meet the needs of patients and communities to enhance their quality of care (Schorn et al., 2022). Restrictive states account for forty percent fewer primary care APRNs and patients without access to care (National Academy of Medicine, 2021). Out of 791 counties, one-third were designated as high physician shortage areas and were more likely to be rural in the country's southeast region (National Academy of Medicine, 2021). The population of interest includes APRNs with reduced or restricted practice.

The setting comprises the southeast region of the United States, including Tennessee as the focus, and comparing it to Georgia and Alabama. In addition, the CDC's POLARIS framework model was used to develop a policy evaluation of the Southeastern states, comparing the APRN role, scope of practice, barriers to practice, and recommendations for FPA. The intervention includes a policy brief with evidence-based recommendations for FPA. This scholarly policy analysis project aimed to determine the barriers for APRNs in the southeast region of the United States and provide comprehensive policy recommendations for FPA to improve access to healthcare, as they have the most restrictive scope of practice regulations across the nation (National Academy of Medicine, 2021). The policy recommendations seek to remove barriers to allow APRNs to improve access to care and decrease healthcare disparities in the Southeast region.

Project Objectives

The objectives of this scholarly policy analysis have been defined using the SMART format (specific, measurable, attainable, realistic, and timed).

1. The project manager (PM) will identify current gaps in knowledge regarding FPA using evidence-based literature by the end of week 12 of the project proposal development period.
2. The PM will develop a policy evaluation through an evidence-informed assessment using the CDC POLARIS model by the end of week 15 of the project proposal development period.
3. The PM will develop three policy briefs with recommendations for full practice authority by week 12 of NUR7803 to send to legislative bodies, professional organizations, and state boards of nursing.

Policy Problem Statement

Regulatory and non-regulatory barriers stand in the way of nurse practitioners practicing to their full extent. This project evaluated current policy recommendations related to the scope

of practice restrictions in southeast states compared to having FPA. A policy analysis with recommended changes to support FPA is the purpose of this scholarly project.

Population: APRNs working in the southeast region of the United States, including Tennessee, Georgia, and Alabama.

Intervention: The intervention will develop a comprehensive policy recommendation for FPA in the southeast region of the United States.

Comparison: Existing practice in the southeast region is either reduced or restricted, requires a collaborative or supervisory physician agreement, and limits the APRNs' scope of practice.

Outcome: Determine the current gaps in FPA, how they impact care access, and the best policy recommendations for change.

Utility of Policy Review

Policy reviews rely on evidence-based research to improve outcomes. This policy review provided a comprehensive analysis of the existing state of practice authority for APRNs within the Southeast region of the United States. The review assessed the existing policies and regulations that govern APRNs and proposed evidence-based policy recommendations to improve access to care. Informed decisions can be made from the evidence through evaluation, analysis, and revisions of current policies to remove reduced and restricted practice authority for APRNs in the southeast states. It will require effective communication with key stakeholders and translation of the data into the best evidence-based recommendations to ensure barriers to practice are removed.

The engagement of key stakeholders is essential for the buy-in and success of the implementation of evidence-based policy recommendations. The stakeholders for this policy review include the patients, APRNs, legislators, boards of nursing, and critical supportive organizations that stand behind APRNs for FPA. According to the American Association for Nurse Practitioners (2023a), there was a 20% jump in Americans living in areas of primary care shortage, which leaves 99 million Americans without primary care access. By removing

legislative and organizational barriers, access to essential healthcare services can be improved and positively impact millions of Americans.

Developing evidence-based policy recommendations that can be passed will positively impact nurses working as APRNs. Removing barriers can give APRNs a way to provide efficient patient care. In addition, removing barriers can eliminate physician supervision and collaboration and delays to patient care. This policy analysis can assist legislators in gaining a comprehensive perspective and modernizing outdated legislation. APRNs have been delivering high-quality care for many years. Barriers are included in this policy analysis and were used to identify the best evidence-based policy recommendations for FPA.

Analytical Framework

The Centers for Disease Control and Prevention's Policy Analytical Framework guided this project. The framework systematically focuses on three concepts: identifying the issue, determining policy solutions, and developing adoption strategies to improve health outcomes (Centers for Disease Control and Prevention [CDC], 2021). The framework has five domains: identifying the problem, policy analysis, strategy, policy development, policy enactment, and policy implementation with stakeholders, essential education, and evaluation strategies considered throughout the process. The problem identified is that APRNs have reduced or restricted practice authority in the southeast region of the United States. The next step involved reviewing and analyzing the literature on the topic and determining the best policy recommendations. Lastly, the best evidence-based policy recommendations were used for three policy briefs to adopt strategies for adopting FPA.

To enhance the project's effectiveness, the John Hopkins evidence-based practice for nurses and healthcare professionals model (JHNEBP) also guided this project. The JHNEBP is another framework used for clinical decision-making through practice, evidence, and translation (Dang et al., 2022). Along with the CDC's analytical framework, the JHNEBP assessed the problem as evidenced by the PICO question. In addition, it appraised the literature supporting

the solution to the problem. It also translated the evidence and guided the development of recommendations and policy briefs, as evidenced by disseminating findings.

Evidence Search Strategy, Results, and Evaluation

After identifying the first step of the analytical framework, the problem, the next step of reviewing and analyzing the literature can follow. The following section will provide information detailing how the literature search was conducted, how the supporting articles were reviewed, and the strength and quality of the evidence in the articles, which will be detailed to support policy recommendations for FPA. Again, the PICO question guided the search criteria.

Search Strategy

An electronic search was conducted. The University of St. Augustine (USA) library and PubMed were the primary sources for the literature search. MeSH terms used in the search included *nurse practitioner* and *full practice authority barriers*. These terms were combined in the USA search and used with Boolean operators for PubMed searches. An additional search with USA was performed using the smart text searching tool using an article from a grey literature search on Google. The article was written by Michelle Buck (2021) titled "*An update on the Consensus Model for APRN regulation: More than a decade of progress*." From the retrieved articles from USA and PubMed, additional articles were also obtained from the reference selection of the selected articles.

After the initial search through the USA library, 16,445 articles were yielded. Next, filters were applied to narrow down the search. The advanced search option used additional filters: *academic journals, English language, 2018-2023, USA, United States,* and *peer-reviewed* articles, which narrowed it down to 353. The second USA search using the smart text option yielded 1,092 articles. Filters for the smart text option included *full text, peer-reviewed, academic journals, 2018-2023, English, USA, United States, Tennessee, Georgia,* and *Southeastern U.S.* To narrow down the articles further, subject filters were applied: *nurse practitioners, advanced practice nursing, nursing practice,* and *professional role*, which resulted

in 91 remaining articles. The PubMed search yielded 41 articles before applying the filters of five years and the English language. The inclusion criteria included articles on barriers to FPA for APRNs and evidence to support implementing FPA and its impact on healthcare and populations. Exclusion criteria included articles not focused on APRNs, not in the English language, and studies conducted outside the United States.

Results

The PubMed database search yielded 41 articles. The filters applied were five years and the English language, which left 22 articles. Each of the 22 articles was evaluated using the abstract. Exclusion criteria included articles irrelevant to the scope of practice of APRNs or not solely focused on APRNs. Studies not conducted in the United States were not considered, leaving two articles remaining.

The USA database search included the Cumulative Index to Nursing and Allied Health Literature (CINHAL) Complete, PubMed, Science Direct, Sport Discuss, Supplemental Index, and Academic Search Index. The inclusion criteria for the first USA search included *peer-reviewed* research, *2018-2023, academic journals, USA, United States, full text, abstract*, and *English*. The inclusion criteria left 353 articles. Next, a subject filter was applied to narrow the articles and contained *nurse practitioners, advanced practice registered nurses,* and *advanced practice registered nursing*. This approach left 41 articles to be screened. Between the two USA searches and the PubMed search, there were 11 articles.

Finally, five additional articles were retrieved from the references of the 11 selected articles, resulting in 16 sources. Each article was based on a review of the abstract and full-text availability. Each article selected supported the PICO question and discussed the scope of practice, barriers to practice, or practice recommendations for APRN full practice authority. Four additional sources from organizations were chosen to support the PICO. Two were from the American Association for Nurse Practitioners (AANP), the National Academy of Medicine, and

the American Association of Medical Colleges. The final count of sources was 20. The results' summarization is visualized using the PRISMA diagram in Figure 1.

Evaluation

The JHEBP model was used to evaluate the literature (Table 1). The model helps determine the strength of the evidence and familiar themes to guide this project's practice recommendations (Dang et al., 2022). Out of the 20 articles, there was one Level I, one Level II, seven Level III, three Level IV, and eight Level V (Appendix A). One systematic review was a Level II, and the other was a Level I (Appendix B). One systematic review was considered Grade A because it had strong evidence, and the second was Grade B with moderate evidence (Dang et al., 2022). Based on the JHNEBP model, one of the systematic reviews had clear aims and objectives with reasonable, consistent recommendations; however, more research was needed to indicate the benefits of the studies (Dang et al., 2022; Fraser & Melillo, 2018). Four of the non-systematic research articles had Quality B ratings based on the grading criteria as they were consistent or reasonably consistent with literature and recommendations (Dang et al., 2022). The remaining fourteen non-systematic research articles were Quality C ratings as they did not provide sufficient evidence but gave relevant information or provided statistical facts (Dang et al., 2022). Overall, based on the JHNEBP model, the level of evidence gathered could be stronger. However, the quality of content in the articles provided reliable and credible expert information for APRNs, barriers to achieving FPA, and recommendations for FPA.

Critical Appraisal of the Evidence with Themes

The synthesis of the literature review included 20 articles that were related to the PICO question (Appendix and B). Of the 20 studies, two were systematic reviews (Fraser & Melillo, 2018; Schirle et al., 2018); five were from healthcare organizations (AANP, 2022b; 2023a; AAMC, 2021; Haney, 2023; National Academy of Medicine, 2021); one health policy review (Hudspeth & Klein, 2019); six literature research (Buerhaus, 2018; Chattopadhyay & Zangaro, 2019; Poghosyan et al., 2022; Shakya & Plemmons, 2020; Smith, 2021; Zwilling & Fiandt,

2020); one policy position statement (Bosse et al., 2017); one quantitative descriptive study (Kleinpell et al., 2022); one retrospective descriptive health policy analysis (Brom et al., 2018); one multi-method qualitative and quantitative study (Schorn et al., 2022); one qualitative study (Myers et al., 2022), and one economic impact analysis (Myers et al., 2020).

During the evaluation of the literature, several themes were identified. The identified themes include APRNs' role, the scope of practice, barriers to practice, the physician shortage, the ability to work to their full extent, and access to care.

Theme 1: APRN's Role

A key theme is the role of APRNs. APRN roles include certified midwives (CNMs), certified registered nurse anesthetists (CRNAs), certified nurse practitioners (CNPs), and clinical nurse specialists (CNS) (Haney, 2023; Kleinpell et al., 2022; Myers et al., 2022; Schirle et al., 2018; Schorn et al., 2022). The CNP role includes specialties such as family, adult-geriatric, women's health, and pediatrics (Zwilling & Fiandt, 2020). Chattopadhyay and Zangaro (2019) included the specialty of psychiatry. APRNs are trained to diagnose, educate, treat, refer, and prescribe, focusing on health promotion and disease prevention (AANP, 2022b; Smith, 2021; Zwilling & Fiandt, 2020).

Theme 2: Scope of Practice

State boards of nursing regulate the scope of practice laws and govern the skills, procedures, and services APRNs can perform under state law. Education, accreditation, certification, and licensure are standards that APRNs retain across the nation. Yet, variations in the scope of practice among each state place barriers on APRNs (Schirle et al., 2018; Schorn et al., 2022; Smith, 2021). Schirle et al. (2018) also stated that it can vary among institutions. These rules determine the scope of services APRNs can deliver and the extent of the services APRNs are allowed to practice without a collaborating or supervisory physician. Depending on the state, the scope of practice can be full, reduced, or restricted practice (Buerhaus, 2018;

Kleinpell et al., 2022; Myers et al., 2020; Myers et al., 2022; Schorn et al., 2022; Shakya & Plemmons, 2020; Zwilling & Fiandt, 2020).

Haney (2023) stated that the AANP definition for FPA is "the authorization of nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments including prescribing medications." Full practice authority means that APRNs practice in the four domains of evaluation, diagnosis, ordering and interpreting diagnostics, and initiation and management of treatments (Schorn et al., 2022). Reduced practice requires a collaborative agreement with a physician so that the APRN can provide patient care, or it limits the setting or scope of practice in one or more of the domains of practice (Brom et al., 2018). In restricted practice, the state practice and licensure laws restrict APRNs from engaging in at least one domain of practice (Buerhaus, 2018). State scope of practice laws limit the APRNs' ability regarding prescription authority, chart reviews, who can and cannot be a collaborating physician, and how many miles the collaborating or supervisory physician must be from the APRN (Buerhaus, 2018). In addition, these rules require a career-long agreement with another healthcare provider with supervision, delegation, or team management (Buerhaus, 2018).

Theme 3: Barriers to Practice

Barriers are the driving factors limiting FPA. These barriers come from state, federal, and organizational restrictions. One barrier to full practice authority is the recognition of APRNs and the language used to describe APRNs. Bosse et al. (2017) stated that the Affordable Care Act failed to define APRNs as primary care physicians. Brom et al. (2018) indicated that the language needs to say FPA instead of independent and autonomous. Schirle et al. (2018) stated that there needs to be more professional recognition, electronic health records do not capture APRN care, and APRNs are often not listed as providers.

Collaborative and supervisory agreements are significant barriers. Bosse et al. (2017) also stated that mandatory collaboration and physician transition periods increase the cost of

care, cause gaps in care, and deter APRNs from working in reduced or restricted states. Supervision or collaborative agreements create added expenses and delays in care, waiting for physicians to communicate or sign off charts or referrals (Myers et al., 2022). Shakya and Plemmons (2020) indicated that with state restrictions, patients have difficulty scheduling appointments, have long wait times, have high healthcare costs, and have higher administrative costs for physician practices. Smith (2021) stated that the varying state-level regulations generate administrative burdens and increased healthcare costs. Poghosyan et al. (2022) stated that supervision and collaborative agreements can create unnecessary roadblocks, such as extra time and effort for physician oversight and decreased access to care in rural and underserved areas.

APRNs' barriers can come from institutions and may overlap state and federal barriers. Some barriers include hospital credentialing and granting privileges to APRNs (Kleinpell et al., 2022). Other barriers include organizational policies, inability to prescribe, physician co-signature requirements, and third-party and federal policy reimbursements at lower rates than physicians (Kleinpell et al., 2022; Schirle et al., 2018). The Centers for Medicare & Medicaid Services (CMS) prohibits APRNs from performing common tasks such as admission evaluations and monthly assessments of patients in skilled nursing facilities (Buerhaus, 2018). Additional barriers include the inability to perform home health approvals or retrieve lab results because they are only provided to the collaborating or supervisory physician (Kleinpell et al., 2022). Physicians must sign durable medical equipment, pre- and post-assessments, birth or death certificates, referrals, and disability forms (Kleinpell et al., 2022). Barriers include needing supervision for procedures, physicians repeating exams, and the inability to order patient therapy (Kleinpell et al., 2022). Lastly, barriers are created due to the opposition of physician-led organizations. These physician-led organizations oppose FPA and rally against APRNs, saying patient safety or quality of care is a concern (Myers et al., 2022).

Theme 4: Physician Shortage

The physician shortage is essential to address in recommendations for FPA. Poghosyan et al. (2022) stated that primary care shortages do not consider expanding the APRN scope of practice, further worsening these shortages and reducing the accessibility of healthcare services. Fraser and Melillo (2018) estimated that the physician shortage would be 20,400 by 2020. According to Shakya and Plemmons (2020), there is a projected physician shortage of 100,000 by 2030. Another prediction is that there will be 37,800 and 124,000 physician shortages in primary and specialty care by 2034 (AAMC, 2021). Poghosyan et al. (2022) stated that the aging population and the demand for increased primary care will rise by nearly 20% in the next ten years. Brom et al. (2018) indicated that the Affordable Care Act increased the demand for providers with an increased aging population, leading to a physician shortage. Chattopadhyay and Zangaro (2019) further discussed that the expected shortage would target rural and underserved populations.

Theme 5: APRNs' Ability to Work to Their Full Extent

Buerhaus (2018) stated that by 2030, 61% of the healthcare workforce will be APRNs. Much of the literature searched recommended APRNs work to their full extent of education, accreditation, certification, and licensure (Brom et al., 2018; Chattopadhyay & Zangaro, 2019; Hudspeth & Klein, 2019; Kleinpell et al., 2022; Myers et al., 2020; Schirle et al., 2018; Shakya & Plemmons, 2020; Smith, 2021). There is national support from the National Council of State Boards of Nursing (NCSBN), the National Academy of Medicine, the Robert Wood Johnson Foundation, the National Governors Association (NGA), and the Federal Trade Commission (Brom et al., 2018). Similar sentiments were listed in an article by Zwilling and Fiandt (2020) indicating that the National Academy of Medicine and the NCSBN support the removal of barriers to APRN scope of practice. Myers et al. (2020) also stated that the NGA, Federal Trade Commission, and the National Academy of Medicine support FPA.

Theme 6: Access to Care

Having access to care is a significant component of gaining FPA. The American Association of Nurse Practitioners (2023) stated that an estimated 100 million Americans live in primary care shortage areas, which continues to rise. They further stated that 99 million people lack adequate primary care access and found that nearly 50% of patients waited longer than one month, and 25% waited more than two months for an appointment within 12 months (AANP, 2023a). Shakya and Plemmons (2020) indicated that states with restrictive practice may lose APRNs to states with FPA, furthering the need for access to care in rural and underserved areas such as in the Southeastern region of the United States. Smith (2021) indicated that APRNs can meet the physician shortage demand while increasing access in rural and underserved areas. Poghosyan et al. (2022) stated that APRNs represent one in four providers that care for vulnerable racial minorities and rural communities. Brom et al. (2018) stated that more APRNs practicing in restricted or reduced practice states may work in these rural or vulnerable areas. APRNs have been shown to provide care in health professional shortage areas such as rural and underserved populations (Buerhaus, 2018). Zwilling and Fiandt (2020) stated that FPA can increase access to care by having APRNs work in rural and underserved areas.

Policy Review Recommendation Statement

Based upon the evidence identified through a comprehensive literature review, developing policy changes that reflect the modernization of the scope of practices, removing regulatory and non-regulatory barriers, and engaging stakeholders is imperative to advocate for full practice authority for the Southeast regions of Tennessee, Alabama, and Georgia. Aligned with the recurring themes and the strength of the evidence, the literature strongly emphasizes that the APRN scope of practice needs to be updated (Schorn et al., 2022). Removing barriers enables APRNs to work to their full extent, helps with the physician shortage, improves care access, enhances healthcare services, and advances equality in patient health (Schorn et al., 2022). Removing barriers and expanding the scope of practice for APRNs in the Southeast

region could facilitate the establishment of nurse-managed health centers and retail clinics, offering increased access to patients and potentially lowering the costs of primary care services (Chattopadhyay & Zangaro, 2019). Removing the barriers could also reduce patient visits and lower care costs since services would not need to be billed under physicians due to collaborative and practice agreements (Chattopadhyay & Zangaro, 2019). The political climate to remove barriers needs careful planning to address legislative action for policy change.

These policy change recommendations answer the PICOT question: For advanced practice registered nurses within the southeast region of the United States (P), how does the development of a comprehensive policy recommendation for full practice authority (I), compared to existing reduced or restricted practice authority in the southeast region of the United States (C) affect access to care as endorsed by literature (O)? The recommendations support a definitive path forward to enhance healthcare access and outcomes in the Southeastern regions of Tennessee, Georgia, and Alabama.

Policy Analysis and Evaluation Plan

The process of evaluating recommendations for FPA from the synthesized literature was guided using the CDC's POLARIS analytical framework to identify potential policy recommendations and to choose the most effective and efficient policies to achieve full practice authority (CDC, 2021). The literature emphasized a need for regulatory changes and legislative actions to move APRNs to practice to the full extent of their education, accreditation, certification, and licensure with recommendations from AANP, The Consensus Model, and The National Academy of Medicine. The policy change recommendations are essential to modernizing the scope of practices and to gaining FPA to improve access to care.

An essential aspect of the policy analysis was identifying stakeholders who would benefit from the policy changes (CDC, 2021). The stakeholders include APRNs, patients in the Southeastern region, physicians, professional healthcare organizations, and insurance companies. Stakeholders are critical as facilitators that support policy changes to influence

legislators to make decisions that enhance healthcare access, deliver high-quality, cost-effective care, and ultimately increase patient satisfaction (Zwilling & Fiandt, 2020). This policy analysis aimed to improve access to high-quality patient healthcare while reducing costs, outcomes, primary care shortages, and health disparities in the Southeastern region (Brom et al., 2018).

Problem Identification

The problem was defined as APRNs with limited practice authority in the Southeast region, which impedes access to care and worsens disparities in healthcare.

Policy Analysis

The policy analysis examined three Southeastern states selected based upon their restrictive and reduced scope of practice. A state comparison table for this policy review represents each state's APRN workforce, current nurse practice acts, health professional shortage areas, health rankings, and current state and federal recommendations (see Appendix C). AANP state and federal policy recommendations, the Consensus Model, and the National Academy of Medicine were selected as the best-evidence recommendations for FPA.

Strategy and Policy Development

This policy analysis assessed six themes: APRN role, scope of practice, barriers to practice, physician shortage, ability to work to the full extent of their education and certification, and access to care. The policy recommendations were examined to ensure that each theme was addressed to inform legislators and state boards of nursing of the need for full practice authority policy changes. This policy analysis was based on evidence synthesis and involved developing an evidence-informed policy brief that aligned with the project objectives and supported the desired policy changes (CDC, 2021). The policy briefs reflect a thorough analysis and highlight the barriers in Tennessee, Georgia, and Alabama (see Appendix D, E, F). Policy options recommended from the literature are feasible to adopt FPA.

Policy Enactment

The recommendations are politically feasible as they are a no-cost solution and highlight the intended purpose of the policy analysis. Policy briefs were utilized, and the recommendations were effectively presented to pertinent stakeholders of each state to ensure successful policy enactment and to gain support. The evidence-based recommendations provided stakeholders with a clear understanding of the potential benefits of allowing APRNs to practice to the full extent of their education, accreditation, certification, and licensure.

Policy Implementation

The project manager used the policy briefs to advocate and educate for policy change and collaborate with policymakers and stakeholders to support APRN FPA. The policy briefs guided the implementation phase to transition from the current state into the proposed new state. Facilitators of the recommendations are key stakeholders that can help push for FPA. Possible barriers that may arise include a lack of support for policy changes and strong opposition from physician groups.

Tennessee

Tennessee, considered one of the most restricted states for APRN scope of practice, is predominantly rural, with 17,684 APRNs (Haney, 2023; Myers et al., 2022). According to America's Health Rankings (2022), Tennessee ranks 44th overall. Numerous counties are considered primary health professional shortage areas (HPSAs), and face substantial health disparities and constraints to healthcare accessibility (Myers et al., 2022; Rural Health Information Hub, 2022). APRNs in the state are regulated by the Tennessee Board of Nursing (Haney, 2023).

Barriers to practice include restrictive practice regulations, which necessitate a lifelong commitment to a supervisory physician (AANP, 2022b). Tennessee has prescriptive authority requirements, which include restrictions from prescribing Schedule II-IV medications (Haney, 2023). APRNs must possess a Board of Nursing-issued fitness certificate and have filed a notice to prescribe with the board. The APRN must also have a copy of the formulary that

describes the drugs to be prescribed or get approval from their supervising physician (AANP, 2022a; Haney, 2023). Other barriers include unequal reimbursement for APRNs, opposition from physician organizations, prescriptive authority constraints, unnecessary supervision requirements, and the inability to sign DNRs/death certifications or join medical staff (AANP, 2022a; Haney, 2023; Myers et al., 2022). The barriers lead to reduced access to care, expenses from collaborative regulations, and hinder efficient patient care (Haney, 2023; Myers et al., 2022). APRN reimbursement is mandated for APRNs by private insurance, but there are challenges because only some organizations credential or accept APRNs into their networks (Haney, 2023). For example, Blue Cross/Blue Shield (BC/BS) generally credentials APRNs and offers full reimbursement for primary care CNPs, CNMs, and CRNAs under TennCare. However, similar acceptance varies among other MCOs in the TennCare program (Haney, 2023).

Granting FPA could enhance access to distressed Tennessee rural counties and improve access to underserved communities (Myers et al., 2022). Granting FPA could offer economic benefits, too, potentially generating close to $1 billion in total output and creating over 7,696 jobs between 2017-2025 (Myers et al., 2022).

Georgia

Georgia is also a restricted practice state, with 17,917 APRNs working (AANP, 2022a; Haney, 2023). Like Tennessee, Georgia also has numerous counties considered HPSAs. According to America's Health Rankings (2022), Georgia is ranked 36th overall. Georgia's regulatory agency is the Board of Nursing (AANP, 2022a). Prescriptive authority is jointly regulated by the Board of Nursing and the Board of Medicine (Haney, 2023). APRNs with prescriptive authority must submit a Nurse Protocol Agreement that follows the rules and is approved by the Board of Medicine (Haney, 2023).

There are many barriers to practice. APRNs cannot prescribe schedule II substances (AANP, 2022a). APRNs cannot sign parking permits, DNRs, or POLST forms (AANP, 2022a).

Supervisory agreements state that the delegating physician should periodically review patient records, evaluations, and exams under certain circumstances (Haney, 2023). Some private insurers are not legally required to reimburse APRNs, and there are no statute mandates for third-party reimbursements. Rates vary; CNPs and CRNAs receive 90% of the physician's rate, while CNMs are reimbursed at 100% of the physician's rate (Haney, 2023).

The current policies create barriers to practice, including a wide provider gap. Nine Georgia counties do not have any providers (Denson & Timmons, 2022). Since it is a restricted state, fewer APRNs work in Georgia counties, which decreases access to care for many Georgia rural patients. Granting APRNs FPA would enhance healthcare outcomes and correlate with improved economic well-being for these underserved populations (Denson & Timmons, 2022).

Alabama

Alabama is a reduced practice state with 8,481 APRNs (AANP, 2022a; Haney, 2023). Alabama, too, has numerous HPSAs. According to America's Health Rankings (2022), Alabama is 46th overall. APRNs are regulated by the Board of Nursing and the Board of Medical Examiners (AANP, 2022a). Alabama APRNs are required to have a life-long collaborative agreement with a physician. However, if the collaborative agreement gets dissolved, the APRNs will be recognized as registered nurses even though they have the required education and national certification (Hart et al., 2020).

For prescriptive authority, according to the rules of the Board of Medical Examiners, APRNs can prescribe Schedule III, IV, and V drugs and, under limited situations, can prescribe Schedule II drugs (Haney, 2023). CNPs and CNMs are required to hold a Qualified Alabama Controlled Substances Registration Certificate. The Alabama Medicaid Program enrolls and reimburses CNPs. In addition, Blue Cross and Blue Shield will reimburse CNPs and CNMs at 70% of the physician's rate (Haney, 2023).

Some perceive Alabama's collaborative and prescriptive agreements as potentially insufficient in protecting public interests because the restrictions increase healthcare expenses and add an anti-competitive component (Hart et al., 2020). Granting FPA would increase healthcare accessibility by 76% and result in more than $729 million in savings over 10 years (Hart et al., 2020; Hayes et al., 2023).

Policy Discussion and Recommendations

The policy analysis aimed to advocate for the implementation of FPA. The recommendations were based on a comprehensive literature review and consistent with the six key themes with evidence from reputable sources, including the American Association of Nurse Practitioners (n.d; 2022c), the Consensus Model (National Council of State Boards of Nursing [NCSBN], 2008), and the Academy of Medicine (2021).

The evidence suggests that effective communication strategies are critical for advocating full practice authority. First, organizations must collaborate with nurse leaders to support change (Myers et al., 2022). Next, APRNs should collaborate with stakeholders (patients, legislators, and healthcare organizations) and tailor the communication to their needs (Kleinpell et al., 2022). Addressing institutional barriers should be a priority for each recommendation. Institutional barriers include issues surrounding hospital admitting privileges, organizational bylaws, provider credentialing protocols, and the integration of APRN care into electronic medical records (Schirle et al., 2020). Lastly, advocacy efforts should include endorsements from credible organizations as they significantly influence legislation decisions favoring FPA.

The AANP (n.d.; 2022c) strongly advocates that achieving FPA requires policy changes to remove barriers. AANP highlights state and federal legislative policy priorities that eliminate barriers. The AANP (n.d.) recommends H.R. 2713/S. 2418 ICAN Act to remove the outdated federal barriers to care under the Medicare and Medicaid programs: 1) authorizing APRNs to order cardiac and pulmonary rehabilitation services for Medicare patients, 2) enabling APRNs to provide a full range of diabetes care and their needs for therapeutic shoes, and 3) allowing

APRNs to certify disabilities and oversee treatment for injured federal employees under the Federal Employees' Compensation Act. AANP (2022c) recommends the removal of state barriers: 1) modernizing state licensure laws, 2) removing outdated policies so that APRNs have signature authority within their scope of practice, and 3) utilizing provider-inclusive and provider-neutral language.

The Consensus Model suggests that states establish uniformity in APRN roles, encompassing licensure, accreditation, certification, and education (NCSBN, 2008). The Consensus Model states that to move towards full practice authority, restricted and reduced states should 1) eliminate practice restrictions that lack evidence-based support or deter APRNs from delivering safe and effective care, including removing collaborating and supervisory agreements, 2) establish uniformity in education and certification requirements, requiring that APRNs complete graduate-level education programs specific to their role and attain national certification in their specialties, 3) remove unnecessary prescribing barriers and granting APRNs authority to prescribe medications per their education, certification, and state regulations, 4) highlight the importance of regulatory consistency across states to enhance APRN mobility and improve access to care, and 5) implement global signature authority to grant APRNs the ability to sign comprehensive patient care forms (Bosse et al., 2017; NCSBN, 2008). Evidence shows that states adopting the Consensus Model have successfully eliminated practice barriers with enhanced healthcare access, particularly in rural and underserved regions (Mack, 2018).

The National Academy of Medicine's (2021) *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* emphasizes that stakeholders are key to implementing policy changes. The National Academy of Medicine (2021) recommends 1) modernizing the APRN scope of practice and removing outdated regulations and language, 2) including payment equality, 3) removing barriers from federal and state agencies and other private employing agencies that prevent APRNs from addressing social needs and social determinants of health. The removal of barriers includes regulatory constraints, public and private funding limitations,

restrictive policies and procedures, and various legal, professional, and commercial barriers. Additionally, efforts should be made to enhance healthcare accessibility, quality, and overall value (National Academy of Medicine, 2021).

In Tennessee, the recommendations should highlight the advantages of granting FPA. The emphasis should be placed on how it benefits patients, communities, and the state while decreasing health disparities and inefficiencies in healthcare (Kleinpell et al., 2023). There should also be importance on the impact of FPA cost-effectiveness and the economic benefits of better health and healthcare within communities. The recommendations for Georgia should follow the same theme as Tennessee. Georgia leaders recommend removing barriers that limit the APRNs' ability to work to their full extent (Denson & Timmons, 2022). Recommendations for Alabama include acknowledging APRNs as valuable healthcare providers operating independently without obligatory collaboration with physicians (Hart et al., 2020). Alabama leaders also recommend transitioning to a licensure process based on the APRN's education and national certification, as opposed to certification dependent on physician collaboration (Hart et al., 2020). Lastly, The Alabama Board of Medical Examiners should be removed from regulating NP practice within Alabama (Hart et al., 2020). Each state details that despite education, accreditation, certification, and licensure, barriers and practice limitations remain that restrict and reduce practice for APRNs and cause an ongoing shortage of healthcare access. Evidence shows that patients who receive care from APRNs experience fewer emergency room visits, decreased hospital stays, and lower medication costs (Mack, 2018). These outcomes would benefit each state.

The benefits of FPA are impactful. The AANP (2023b) stated that 1) FPA creates access to care because states with FPA are more likely to have APRNs working in rural and underserved areas, 2) streamlines care and removes delays in care from outdated regulations, 3) decreases costs by avoiding duplicated services and billing costs with outdated physician

oversight, 4) reduces repetitive orders, office visits, and care services, 5) allows patients to have provider choice and removes anti-competitive licensing restrictions.

The Consensus Model impacts APRN regulation, which 1) can give clarity to consumers about APRN roles, 2) employers can gain a clear understanding of APRNs' qualifications and scope of practice, 3) APRNs can meet licensure requirements and maintain consistency in practice no matter where they are located, 4) ensures future APRNs have the proper accredited education and proper training, 5) boards of nursing can trust the competences of APRNs licensed in other states, and 6) legislators can demonstrate accountability to constituents with the adoption of the regulatory model that prioritizes public protection (National Council of State Boards of Nursing [NCSBN], n.d.).

Other advantages of granting FPA to APRNs include decreasing non-emergent emergency services, reduced hospitalizations, expanded healthcare utilization, and overall cost savings in healthcare, including preventative care (Bosse et al., 2017). Consequently, patients tend to experience higher satisfaction (Schorn et al., 2022). Increasing the presence of APRNs in areas with high demand can also contribute to reduced overall state healthcare expenditure (Chattopadhyay & Zangaro, 2019). Granting FPA could reduce the amount of outpatient Medicaid claims by 10% and increase Medicaid patient care by 8% without increasing costs (Denson & Timmons, 2022). The workforce of providers could increase by 60% in provider shortage areas and improve access to care. Granting FPA could also increase patient-reported mental health and reduce mental health-related mortality (Denson & Timmons, 2022).

This policy analysis objectives aimed to identify current gaps in knowledge, develop a policy evaluation, and produce policy briefs to advocate for FPA. The first objective was achieved by conducting a comprehensive literature review highlighting the existing knowledge gaps and identifying barriers restricting FPA. The second objective was achieved with the policy analysis, as it successfully highlighted the need for policy changes to support FPA by providing evidence-based recommendations consistent with the AANP, the Consensus Model, and the

National Academy of Medicine. Lastly, the policy briefs were developed to distribute to key stakeholders for each state, including legislative bodies, professional organizations, and state boards of nursing for Tennessee, Georgia, and Alabama, as part of the advocacy effort (see Appendices D, E, and F).

One limitation of this policy analysis was that it was exclusively based on electronically available written data. Although attempts were made to reach prominent stakeholders, state boards of nursing, and local state nurse practitioner associations, these efforts were unsuccessful, and recommendations for each state were not individualized. Additionally, the policy analysis primarily focused on identifying barriers and proposing policy recommendations, without delving into the practical implementation of FPA.

Dissemination

The policy analysis results were created as a scholarly project for a DNP student and were completed in a virtual setting. The results of this scholarly project were designed to provide evidence-based recommendations for granting FPA to APRNs in Tennessee, Georgia, and Alabama. The policy recommendations will be disseminated among APRN stakeholders. In addition, the PM shared the recommendations via policy briefs with professional organizations such as the American Association of Nurse Practitioners and the American Nurses Credentialing Center. The policy briefs will be distributed to organizations that endorse full practice authority and state legislators to garner support.

The final DNP scholarly project has been uploaded and archived in the University of St. Augustine for Health Sciences Scholarship and Open Access Repository (SOAR) to disseminate findings to students and faculty. A virtual poster presentation was submitted to disseminate the scholarly project to DNP students and faculty. Ideally, the disseminated findings will raise awareness among a broader range of stakeholders. The disseminated findings can also provide valuable insights to inform and engage communities in other states with reduced or restricted scopes of practice to move toward full practice authority.

Conclusion

This evidence-based scholarly project proposal addresses the need for full practice authority for APRNs in Tennessee, compared to Georgia and Alabama. Reduced and restricted states impede APRNs from working to their full scope of practice. This project's objectives were: 1) to identify, evaluate, analyze, and present the best evidence-based practice recommendations for the Southeastern region of the United States, specifically the states of Tennessee, Georgia, and Alabama, and 2) to develop policy briefs for FPA.

The literature synthesis effectively identified barriers, the relevance of full practice authority, and recommendations to achieve FPA. These findings focused on APRN roles, the scope of practice, barriers to practice, the physician shortage, access to care, and APRNs' ability to work to their full extent. The CDC's (2021) POLARIS framework guides the project's policy analysis to ensure the development of an effective policy brief. The recognition for reduced and restricted states to allow APRNs to work within their full scope of education, accreditation, certification, and licensure is needed. This project can have a significant impact on APRN practice. The removal of APRN practice barriers and the potential of the policy brief to reach appropriate stakeholders is a huge step in allowing millions of Americans to receive better access to care, especially in underserved and rural populations.

References

America's Health Rankings. (2022). *Health disparity report*. America's Health Rankings. https://www.americashealthrankings.org/learn/reports/2021-disparities-report

American Association of Nurse Practitioners. (n.d.). *Federal issue briefs: Informing NPs on health policy, sharing the NP perspective*. Retrieved October 25, 2023 from https://www.aanp.org/advocacy/federal

American Association of Nurse Practitioners. (2022a). *AANP state fact sheet*. https://www.aanp.org/advocacy/state/state-practice-environment/state-policy-fact-sheets

American Association of Nurse Practitioners. (2022b). *Nurse practitioner, No. 1 ranked health care job, reports increase in numbers*. https://www.aanp.org/news-feed/nurse-practitioner-no-1-ranked-health-care-job-reports-increase-in-numbers

American Association of Nurse Practitioners. (2022c). *2023 state policy priorities*. https://www.aanp.org/advocacy/state/state-policy-priorities

American Association of Nurse Practitioners. (2023a). *Five health care trends to watch in 2023*. https://www.aanp.org/news-feed/five-health-care-trends-to-watch-in-2023

American Association of Nurse Practitioners. (2023b). *Issues at a glance: Full practice authority*. https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

American Medical Association. (2023). *State law chart: Nurse practitioner practice authority* [PDF]. https://www.ama-assn.org/system/files/2020-02/ama-chart-np-practice-authority.pdf

Association of American Medical Colleges. (2021). *AAMC report reinforces mounting physician shortage*. https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage

Bosse, J., Simmonds, K., Hanson, C., Pulcini, J., Dunphy, L., Vanhook, P., & Poghosyan, L. (2017). Position statement: Full practice authority for advanced practice registered

nurses is necessary to transform primary care. *Nursing Outlook*, *65*(6), 761–765. https://doi.org/10.1016/j.outlook.2017.10.002

Brom, H. M., Salsberry, P. J., & Graham, M. C. (2018). Leveraging health care reform to accelerate nurse practitioner full practice authority. *Journal of the American Association of Nurse Practitioners*, *30*(3), 120–130. https://doi.org/10.1097/jxx.0000000000000023

Buerhaus, P. (2018). *Nurse Practitioners: A solution to America's primary care crisis*. American Enterprise Institute. https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf?x91208

Centers for Disease Control and Prevention. (2021). *The CDC policy process*. https://www.cdc.gov/policy/polaris/policyprocess/index.html

Chattopadhyay, S., & Zangaro, G. (2019). *The economic cost and impacts of scope of practice restrictions on nurse practitioners* [PDF]. https://www.vfp-apsi.ch/fileadmin/user_upload/Chattopadhyay_2019_Costs_NP_RestrictionsScopeOfPractice.pdf

Dang, D., Dearholt, S., Bissett, K., Ascenzi, J., & Whalen, M. (2022). *Johns Hopkins evidence-based practice for nurses and healthcare professionals: Model and guidelines* (4th ed.). Sigma Theta Tau International. https://www.hopkinsmedicine.org/evidence-based-practice/models-tools.html

Denson, C., & Timmons, E. (2022). *Addressing Georgia's healthcare disparities: The benefits of full practice authority for nurse practitioners and physician assistants*. Denson & Timmons. https://www.georgiapolicy.org/publications/addressing-georgias-healthcare-disparities-the-benefits-of-full-practice-authority-for-nurse-practitioners-and-physician-assistants/

Fraser, M. A., & Melillo, C. (2018). Expanding the scope of practice of APRNs: A systematic review of the cost analyses used. *Nursing Economics*, *36*(1), 23–28. https://0b30egz32-mp01-y-https-eds-s-ebscohost-com.prx-

usa.lirn.net/eds/detail/detail?vid=1%26sid=1d590fd1-359d-4c8c-be90-005a91ebdf61%40redis&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsgcl.529490139&db=edsgao

Haney, B. (2023). 35th annual APRN legislative update: Updates to APRN practice authority in the United States. *The Nurse Practitioner*, *48*(1), 20–47. https://doi.org/10.1097/01.npr.0000903012.03553.a4

Hart, L., Ferguson, R., & Amiri, A. (2020). Full scope of practice for Alabama nurse practitioners: Act now. *The Journal for Nurse Practitioners*, *16*(2), 100–104. https://doi.org/10.1016/j.nurpra.2019.10.016

Hayes, W., Baker, N. R., Benson, P., & O'Keefe, L. C. (2023). The state of advanced practice registered nursing in Alabama. *Journal of Nursing Regulation*, *13*(4), 44–53. https://doi.org/10.1016/s2155-8256(23)00030-3

Hudspeth, R. S., & Klein, T. A. (2019). Understanding nurse practitioner scope of practice: Regulatory, practice, and employment perspectives now and for the future. *Journal of the American Association of Nurse Practitioners*, *31*(8), 468–473. https://doi.org/10.1097/JXX.0000000000000268

Kleinpell, R., Myers, C. R., Likes, W., & Schorn, M. N. (2022). Breaking down institutional barriers to advanced practice registered nurse practice. *Nursing Administration Quarterly*, *46*(2), 137–143. https://doi.org/10.1097/naq.0000000000000518

Morris, G. (2023). How the improving care and access to nurses (I CAN) act impacts nurses. *NurseJournal*. https://nursejournal.org/articles/the-improving-care-and-access-to-nurses-act-impact/

Myers, C. R., Chang, C., Mirvis, D., & Stansberry, T. (2020). The macroeconomic benefits of Tennessee APRNs having full practice authority. *Nursing Outlook*, *68*(2), 155–161. https://doi.org/10.1016/j.outlook.2019.09.003

Myers, C. R., Muñoz, L. R., Stansberry, T., Schorn, M., Kleinpell, R., & Likes, W. (2022). COVID-19 effects on practice: Perspectives of Tennessee APRNs. *Nursing Forum*, *57*(4), 593–602. https://doi.org/10.1111/nuf.12711

National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF]. National Academies Press. https://doi.org/10.17226/25982

National Council of State Boards of Nursing. (n.d.). *APRN campaign for consensus: Moving toward uniformity in state laws*. https://www.ncsbn.org/nursing-regulation/practice/aprn/campaign-for-consensus.page

National Council of State Boards of Nursing. (2008). *Consensus Model for APRN regulation: Licensure, accreditation, certification & education*. https://ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

Poghosyan, L., Pulcini, J., Chan, G. K., Dunphy, L., Martsolf, G. R., Greco, K., Todd, B. A., Brown, S. C., Fitzgerald, M., McMenamin, A. L., & Solari-Twadell, P. (2022). State responses to COVID-19: Potential benefits of continuing full practice authority for primary care nurse practitioners. *Nursing Outlook*, *70*(1), 28–35. https://doi.org/10.1016/j.outlook.2021.07.012

Rural Health Information Hub. (2022). *Map of health professional shortage areas: Primary care, by county, 2022*. https://www.ruralhealthinfo.org/charts/5

Schirle, L., Norful, A. A., Rudner, N., & Poghosyan, L. (2018). Organizational facilitators and barriers to optimal APRN practice: An integrative review. *Health Care Management Review*, *45*(4), 311–320. https://doi.org/10.1097/hmr.0000000000000229

Schorn, M. N., Myers, C., Barroso, J., Hande, K., Hudson, T., Kim, J., & Kleinpell, R. (2022). Results of a national survey: Ongoing barriers to APRN practice in the United States. *Policy, Politics, & Nursing Practice*, *23*(2), 118–129. https://doi.org/10.1177/15271544221076524

Shakya, S., & Plemmons, A. (2020). Does scope of practice affect mobility of nurse practitioners serving Medicare beneficiaries? *Journal of Labor Research*, *41*(4), 421–434. https://doi.org/10.1007/s12122-020-09308-1

Smith, L. B. (2021). The effect of nurse practitioner scope of practice laws on primary care delivery. *Health Economics*, *31*(1), 21–41. https://doi.org/10.1002/hec.4438

Zwilling, J. G., & Fiandt, K. (2020). Where are we now? Practice-level utilization of nurse practitioners in comparison with state-level regulations. *Journal of the American Association of Nurse Practitioners*, *32*(6), 429–437. https://doi.org/10.1097/jxx.0000000000000270

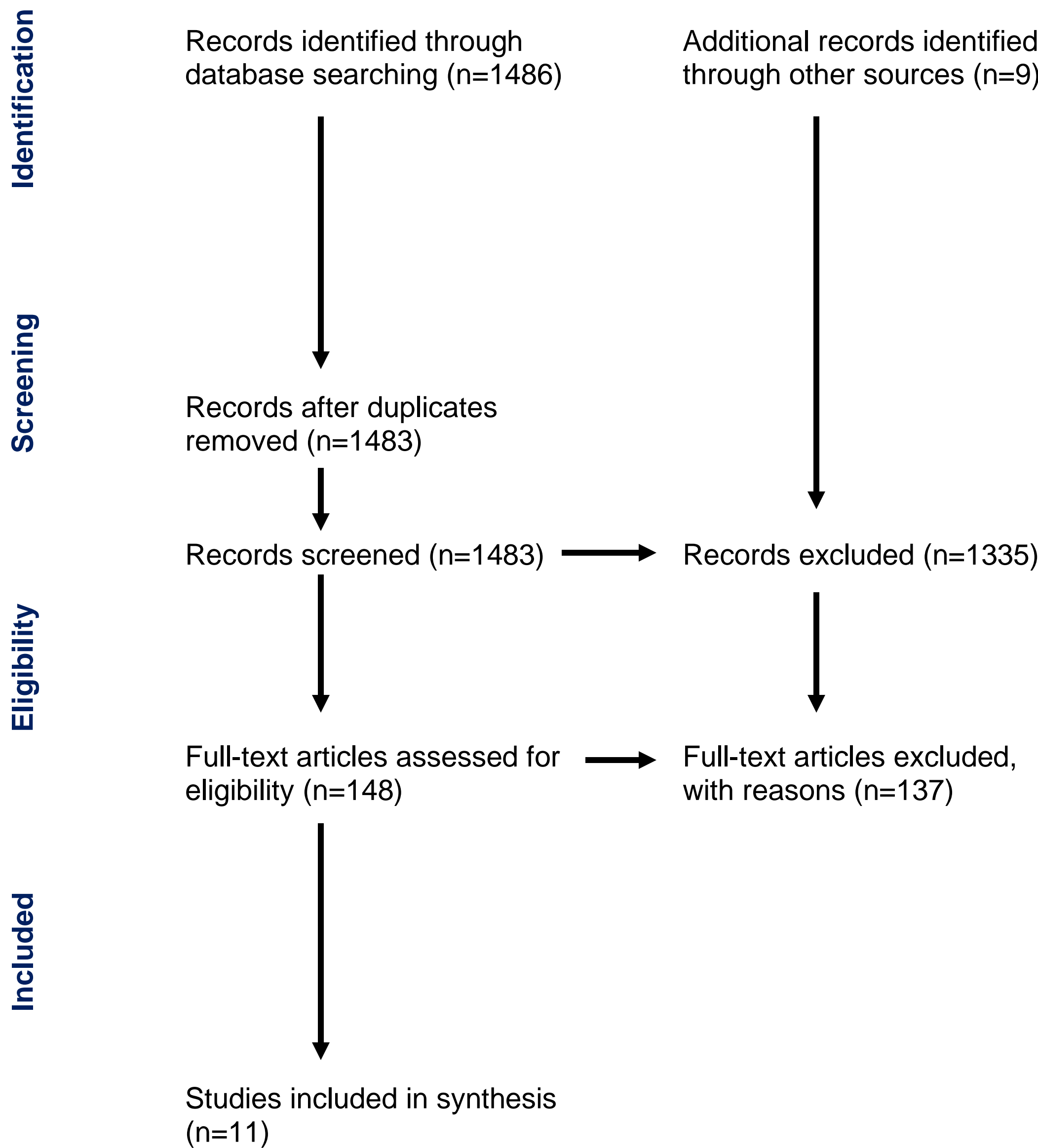
Table 1

Johns Hopkins Nursing Evidence-Based Practice: Evidence Level and Quality Guide

Evidence Levels	Quality Grades
Level I Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis	A – High Quality
Level II Quasi-experimental study Systematic review of a combination of RCTs and quasiexperimental, or quasi-experimental studies only, with or without meta-analysis	B – Good Quality
Level III Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis Qualitative study or systematic review with or without a metasynthesis	C – Low Quality
Level IV Opinion of respected authorities and/or nationally recognized expert committees/consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels	
Level V Based on experiential and non-research evidence Includes: • Literature reviews • Quality improvement, program or financial evaluation • Case reports • Opinion of nationally recognized experts(s) based on experiential evidence	

Figure 1

PRISMA Flowchart



Note. Prisma flow chart diagram from “Preferred Reporting Items for Systematic Reviews and Meta-analyses: The PRISMA Statement,” by D. Moher, A. Liberati, J. Tetzlaff, & D.G. Altman, 2009, *Annals of Internal Medicine*, *151*(4), p.267 (http://dx.doi.org/10.7326/0003-4819-151-4-200908180-00135). Copyright 2009 by The American College of Physicians.

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Kleinpell et al., (2022)	Level IV Quality B					Barriers to practice for APRNs are at the state and federal levels. Key barriers include the inability to do hospital admits, restriction for home health approval, inability to sign durable medical equipment, and inability to sign DNR. The APRN Consensus Model is recommended to help with APRN roles for licensure, accreditation, certification, and education.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
American Association of Nurse Practitioners, (2022b)	Level IV Quality C					Statistics on how many APRNs are practicing and how they are prepared to close the gap in healthcare.
Schorn et al., (2022)	A multi-method qualitative and quantitative study Level III Quality C	Over 7,467 APRNS in all 50 states.	An electronic 20-item descriptive survey was conducted to assess barriers to practice.		Regulatory and non-regulatory barriers were identified.	Barriers exist in FPA, reduced and restricted states. Most participants were from the Southern region. Barriers included licensure or administrative issues, APRN signature insufficiency, therapy restrictions, prescribing, collegiality, reimbursement, telehealth, and physician-only procedure restrictions. Recommendations were included in the study. The Consensus Model and the recommendations from National Academy of Medicine are listed for regulatory and non-regulatory barriers.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Bosse et al., (2017)	Level V Quality C					APRNs' lack of full practice authority results from state and local barriers. Recommendation s for FPA are based on the National Academy of MedicineFI Acad.
Schirle et al., (2018)	Level II Quality B			An institutional theory guided this review. The Whittemore and Knafl integrative review guided the literature review.	A literature search was conducted on organizatio nal facilitators and barriers to optimal APRN practice.	The focus of this article was the barriers to practice which included policy restrictions, collegiality, physician opposition, lack of understanding of the APRN role, and lack of recognition. The review helps guide recommendations for APRN to achieve FPA.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Chattopadhyay & Zangaro, (2019)	Level III Quality B		Data were obtained from the Area Health Resources Files from over 60 different sources. A three-stage least squares (3SLS) framework was used to determine savings for restricted and reduced practice states.		The data indicate that Medicare cost savings could be achieved at the county, state, and national levels.	By lifting the scope of practice restrictions, $2.19 billion would be saved in annual Medicare costs for restricted-practice states and $1.07 billion in reduced-practice states. The full expansion of APRN scope of practice could be $44.5 billion nationally.
Buerhaus, (2018)	Level V Quality C					NPs are more likely to work in rural areas, are more likely to serve poor and vulnerable Americans, and their services cost less. APRNs provide primary care of equal or better quality than MDs.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Hudspeth & Klein, (2019)	Level V Quality C					APRNs are ready to meet the primary care shortage. Barriers to practice include regulatory barriers. Rules and policies at state levels still exist. Scope of practice needs clarified. The APRN Consensus Model and the Future of Nursing will help guide APRN scope of practice to meet the demands of the physician shortage.
National Academy of Medicine, (2021)	Level III Quality C					This lists important implications to practice and has the potential to make a significant impact on access to care. Chapter three focuses on APRNs and how they can help meet the needs for social

Citation	**Design, Level** **Quality Grade**	**Sample** **Sample size**	**Intervention** **Comparison**	**Theoretical** **Foundation**	**Outcome** **Definition**	**Usefulness** **Results** **Key Findings**
						determinants of health. Yet, state-level regulations limit their scope of practice. If all states removed scope of practice barriers, there would be a 70% reduction in primary care shortage areas and a 65% reduction in rural areas. Not allowing APRNs to practice to their full extent causes significant gaps in patient care access.
American Association of Nurse Practitioners, (2023)	Level III Quality C					Indicates five trends for APRNs. There is a growing demand for APRNs with continued growth into 2031. Ninety-nine million Americans live in primary care shortage areas, and APRNs are ready to close the gap.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Fraser & Melillo, (2018)	Level I Quality A	5 published cost analyses studies were used		Welfare Economics Theory		Discusses physician shortage and how APRNs can fulfill the gap. State laws restrict scope of practice preventing necessary care. APRNs can provide high-quality care with positive outcomes, proper diagnoses, and can maintain quality of care. States could see 810 million dollars in savings if APRNS could have FPA
Haney, (2023)	Level V Quality C					Research indicates states that have FPA rank highest in the nation for healthcare access.

Citation	**Design, Level** **Quality Grade**	**Sample** **Sample size**	**Intervention** **Comparison**	**Theoretical** **Foundation**	**Outcome** **Definition**	**Usefulness** **Results** **Key Findings**
Poghosyan et al., (2022)	Level V Quality B					This study indicates that APRN full scope of practice improves access and quality of care, leading to better outcomes for patients. It recommends changes to support full practice authority as a long-term plan to address inequities and deficiencies.
Brom et al., (2018)	Retrospective descriptive design Level V Quality C	Data was taken from all 50 states and the District of Columbia.	Full practice, reduce, and restricted practice states were compared by looking at the scope of practice change, the Affordable Care Act, party affiliation, and interest groups.	Regulatory theory	There was a two-fold increase in 8 stated that adopted full practice authority. Seven states adopted Medicaid expansion. Affordable Care Act, provider	This study looked at the scope of practice legislation for APRNs from 2011-2016. It suggests doing an analysis of states that failed with legislation because it would help understand state-level dynamics that influence legislation.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
					shortages, and rural health care issues were arguments for favor of FPA.	This information isuseful for reduced or restricted states wanting to adopt FPA and is impactful for recommendations.
Myers et al., (2020)	Economic impact analysis Level V Grade C	Data for 2015-2017 for state and local economy for TN APRNs	Implan software and TN board of nursing's demographic information system was assessed to estimate the direct, indirect, and induced economic impact for APRNs if they were to gain FPA		The data was used to determine TN APRNs being granted FPA and the economic impact. Results of the study indicated the economic impacts of granting FPA to FT and PT TN APRNS is estimated to be $8.63 billion and 69,263	This study is useful for the project as it indicates barriers for FPA. It indicates APRNS are highly educated and trained. It discusses language pertaining to MD supervision, rules, and regulations for prescriptive authority, and how granting FPA could help mitigate recruitment and retention in rural areas. Granting FPA can decrease mortality,

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
					jobs between 2007 and 2025.	lower hospital readmission rates, and significantly decrease annual beneficiary Medicare expenditures.
Myers et al., (2022)	Qualitative study Level V Quality C	Fifteen TN APRNs	Web-based survey opened from June 1 to September 23, 2020, that included questions regarding the pandemic impact on practice, practice barriers, and executive order impact on practice.		The surveys indicated that the pandemic caused major changes in care delivery, patient volume and mix, and needs of patients, and resources available.	Barriers were lifted for two months. The survey shows that telehealth allowed for alleviation of transportation issues, supervisory requirements caused increase time and money, having to get with collaborative physicians led to delays in care and reduced access to care due to waiting on paperwork requirements and signatures.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
						Regulatory barriers interfere with access and quality of care. TN has longstanding unmet healthcare needs. TN did not meet core measures with chronic conditions, premature death, and smoking. APRNs should organize to advocate for FPA and emphasis should be placed on economic benefits.
Zwilling & Fiandt, (2020)	Level III Quality C					Identification of components of practice utilization were investigated. The study identified rural areas had less APRNs per capita.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Smith, (2021)	Level III Quality C					This research article indicates by 2025, APRNs will represent more than one quarter of all primary care providers and are able to meet the demands for increased access to care in rural and underserved areas. Studies show that relaxed scope of practice laws can improve population health and access to care. Patient satisfaction is higher among patients treated by APRNs. Political resistance remains in southern states.

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Shakya & Plemmons, (2020)	Level III Quality C	Data from 2013-2017	National Provider Identifiers from Part D prescriber public use file data identified nurse's practice locations from 2013 to 2017	Regression framework	The study indicated that APRNs prefer to practice in states with FPA or they are more likely to move to states with FPA.	This study indicates a relationship with FPA and APRNs movement across states. APRNs were less likely to move if in a state with FPA. The study shows APRNs prefer to have autonomy in practice.

Legend: full practice authority (FPA), nurse practitioners (NPs), advanced practice registered nurses (APRNs), National Academies of Sciences, Engineering, and Medicine (National Academy of Medicine)

Appendix B

Summary of Systematic Reviews (SR)

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
Schirle et al., (2018)	Quality B	To determine organizational facilitators and barriers of APRNs and make recommendations for APRN utilization	CINAHL, PubMed, PsychInfo were used and yielded 366 studies. Keywords: advanced practice registered nurse, practice environment, integrative review, organizational culture, organizational climate, nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist. 31 articles were left after inclusion and	Inclusion criteria: peer-reviewed research, English language, all publication years, studies in all countries, and if it investigated the practice environment of APRNs. Exclusion criteria: no relevance to APRNs, studies that did not investigate organizational factors that affected APRN practice environment	Appraisal tools used: For quantitative studies, the National Institutes of Health National Heart, Lung, and Blood Institute, Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies. Qualitative Studies used the Johanna Briggs Institute Critical Appraisal Checklist for Qualitative Research.	Studies indicated autonomy/independent practice and positive physician/APRN relationships were facilitators to optimal practice environments. Policy restrictions on practice, poor relationships with physicians, lack of understanding of APRN role were barriers.	This study is useful for policy analysis as it relates to barriers in place for APRNs. This study recommends future studies to identify internal policies to practice barriers. Organizational policy reform is recommended to help efforts to promote a positive environment for APRNs.

Citation	Quality Grade	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/ Implications
			exclusion criteria.				
Fraser & Melillo, (2018).	Quality A	To determine cost analyses if there was expansion of APRN scope of practice in primary care	OneSearch, Medline, and Google were used and revealed 288 peer-reviewed articles or government publications. Keywords searched: cost, scope of practice, nurse, or APRN in the abstract or title. After exclusion criteria, six articles remained.	Inclusion criteria: 1985-2015 and cost, scope of practice, nurse, or APRN. The exclusion criteria included no or little discussion of cost analysis methodology, studies outside of the United States, not focused on nurse practitioners, not focused on primary care, and not available in full text.	Review of literature looked at costs, salaries, billing, healthcare costs, multiplier effects, costs not included in the analysis, and fees for services included in the six analysis articles	Although there were different calculations of the cost analyses, the studies indicated that expanding the scope of practice for APRNs could decrease costs associated with healthcare.	Studies to employ a more rigorous methodology are recommended to look at the cost benefits of patients. There could be $810 million in savings if APRNs were allowed FPA.

Legend: nurse practitioners (NPs), advanced practice registered nurses (APRNs), Practice-level utilization (PLU)

Appendix C

Current State Analysis and New Policy Recommendations

	Tennessee	Georgia	Alabama	New Policy Recommendations
APRN Roles	CNPs, CNMs, CRNAs, CNS	CNPs, CNMs, CRNAs, CNS	CNPs, CNMs, CRNAs, CNS	CNPs, CNMs, CRNAs, CNS
Workforce	17,684 APRNs	17,917 APRNs	8,481 APRNs	Increase workforce to provide more patients access to care
Regulatory Structure	Restricted Practice	Restricted Practice	Reduced Practice	Full Practice Authority
Health Professional Shortage Areas	84 counties 8 counties partial	141 counties 15 counties partial	42 counties 25 counties partial	No HPSAs to increase access to care
America's Health Rankings	44th overall	36th overall	46th overall	Policy Advocacy, preventative and affordable care, addressing health disparities and social determinants of health, patient education, and resources
Contributing Health Factors	Multiple chronic conditions, high premature death, and smoking	High premature death, high levels of air pollution, and high uninsured rate	High premature death, multiple chronic conditions, and low supply of mental healthcare providers	Full Practice Authority, Expanded Scope of practice to reach more communities and increase access to care, mental health integration, interprofessional collaboration
Licensure Requirements	RN License, a graduate degree in APRN role, National Certification	RN License, a graduate degree in APRN role, National Certification	RN License, a graduate degree in APRN role, National Certification	RN License, a graduate degree in APRN role, National Certification
Regulatory Body	The Board of Nursing	The Board of Nursing	The Board of Nursing and the Board of Medical Examiners	Uniformity with the Regulatory Body

	Tennessee	Georgia	Alabama	New Policy Recommendations
Prescriptive Authority	Restrictions from prescribing Schedule II-IV medications	Prohibited from prescribing Schedule II medications	Allowed to prescribe Schedule III, IV, and V medications and under limited situations, Schedule II medications	Uniformity with no prescriptive restrictions
Supervision Requirements	Required to have supervision under a physician	Physician delegation or supervision	Required to have a career-long regulated collaborative agreement with a physician. If dissolved, then they are considered registered nurses despite their education and certification	Uniformity with no supervision requirements
Parking Permit Signature Recognition	Allowed	Allowed	Allowed	APRNs have the authority to certify disability for parking placards
DNR Signature Recognition	Not allowed	Not allowed, unless delegated by Georgia Code	Not allowed	Uniformity with DNR signature recognition
Death Certificate Signature Recognition	Not allowed	Allowed with delegation by a physician	Allowed	Uniformity with death certificate signature recognition
State Policy Advocacy	-Modernize State Licensure Laws -Streamline Care Delivery With NP Signature Recognition -Promoting the adoption and enforcement of insurance regulations that facilitate direct credentialing and reimbursement for NPs, while also ensuring that reimbursement rates support long-term	-Modernize State Licensure Laws -Streamline Care Delivery With NP Signature Recognition -Promoting the adoption and enforcement of insurance regulations that facilitate direct credentialing and reimbursement for NPs, while also ensuring that reimbursement rates support long-term	-Modernize State Licensure Laws -Streamline Care Delivery With NP Signature Recognition -Promoting the adoption and enforcement of insurance regulations that facilitate direct credentialing and reimbursement for NPs, while also ensuring that reimbursement rates support long-term	Grant Full practice and prescription authority

	Tennessee	**Georgia**	**Alabama**	**New Policy Recommendations**
	practice sustainability, and including NPs in network directories. -Eliminate restriction on the ability to prescribe controlled substances.	practice sustainability, and including NPs in network directories. -Eliminate restriction on the ability to prescribe controlled substances.	practice sustainability, and including NPs in network directories. -Eliminate restriction on the ability to prescribe controlled substances.	Grant Full practice and prescription authority
National Policy Advocacy	- H.R. 2713/S.2418 to remove outdated federal regulations within the Medicaid and Medicare systems -Maintain Medicare telehealth waivers - Increase funding for nursing education programs. - Improve the assignment of NP patients to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)	- H.R. 2713/S.2418 to remove outdated federal regulations within the Medicaid and Medicare systems -Maintain Medicare telehealth waivers - Increase funding for nursing education programs. - Improve the assignment of NP patients to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)	- H.R. 2713/S.2418 to remove outdated federal regulations within the Medicaid and Medicare systems -Maintain Medicare telehealth waivers - Increase funding for nursing education programs. - Improve the assignment of NP patients to Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACOs)	- Approval of H.R. 2713/S.2418 removes outdated barriers that Medicare/Medicaid place on APRNs and their patients, including the ability to order cardiac and pulmonary rehabilitation, ability to order therapeutic shoes in diabetes cases, ensure full participation in the beneficiary attribution process for the Medicare Shared Savings Program, make referrals for medical nutrition therapy, establish and assess patients' home infusion care plans, validate and revalidate terminal illnesses for hospice eligibility, conduct mandatory examinations in skilled nursing facilities, oversee hospitalized patients' care by APRNs, and manage outpatient clinic services for Medicaid patients.

	Tennessee	**Georgia**	**Alabama**	**New Policy Recommendations**
				-Permanent implementation of telehealth waivers - Maintain existing APRN education and training initiatives, enhance diversity within the workforce, and allocate resources for APRN clinical training programs

(AANP, n.d.; , 2022a; 2023b; America's Health Rankings, 2022.; Haney, 2023; Morris, 2023; National Academy of Medicine, 2021; Rural Health Information Hub, 2022)

Appendix D

Tennessee Policy Brief

Policy Brief

2023

Full Practice Authority for Tennessee Advanced Practice Registered Nurses

Executive Summary

Tennessee is a predominantly rural area with 84 counties designated as primary health professional shortage areas and eight as partial health professional shortage areas (America's Health Rankings, 2022). Tennessee faces substantial health disparities and constraints to healthcare accessibility. The state ranks 44th in America's Health Rankings, and its 17,684 Advanced Practice Registered Nurses (APRNs) can play a pivotal role in addressing these challenges (America's Health Rankings, 2022; Haney, 2023). However, Tennessee APRNs face restrictive regulatory and non-regulatory barriers that hinder their ability to provide quality care, reduce access to healthcare services, and create inefficiencies in patient care. This policy brief calls for a comprehensive reform of APRN regulations to improve access to care, reduce disparities, and address the growing demand for providers.

Introduction

As part of the Southeast region, Tennessee is marked by rural areas, primary health professional shortage areas, and persistent health disparities (America's Health Rankings, 2022). Despite having many APRNs, Tennessee has one of the nation's most restrictive practice authorities (Myers et al., 2022). Despite national standards for nursing, state laws and legislative bodies that govern APRNs vary across states (American Association of Nurse Practitioners [AANP], 2023). This inconsistency is evident in barriers, including licensing and administrative restrictions, limitations on treatment options, mandatory physician authorizations, prescribing restrictions, varying reimbursement practices, and challenges related to telehealth (Schorn et al., 2022). These outdated restrictions prevent APRNs from practicing to the full scope of their education, accreditation, certification, and licensure. The opposition from physician organizations further exacerbates the challenges (Myers et al., 2022). These barriers create higher healthcare costs, reduced access to care, and inefficient care (AANP, 2023). The barriers undermine the state's efforts to address the healthcare disparities, preventing APRNs from providing comprehensive care, particularly in rural and underserved areas. This policy brief highlights the pressing need for modernization of policies to remove these barriers and maximize the potential of APRNs to improve healthcare accessibility and quality of care to the population and state of Tennessee.

Endorsements

Full Practice Authority is endorsed by the National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, the National Governors Association (NGA), the American Association of Nurse Practitioners (AANP), the American Nurses Association (ANA), and the Robert Wood Johnson Foundation (Brom et al., 2018).

Barriers to practice

- Limiting APRNs' scope of practice impacts patients as it decreases or delays care and limits access to care (AANP, 2023).
- APRNs cannot prescribe medications categorized under Schedules II-IV unless they have received specific authorization from the formulary or have obtained approval after consulting with the supervising physician before the initial prescription is issued. APRNs also must adhere to the limitations on supplying Schedule II and III opioids (American Association of Nurse Practitioners [AANP], 2022a).
- Low reimbursement rates (Myers et al., 2022).
- Signature restrictions prevent APRNs from signing Do-Not-Resuscitate orders, needed durable medical equipment, and death certificates (AANP, 2022a).
- Collaborative/supervisory requirements increase care costs, cause delays in care, restrict patient follow-up care, limit provider choices, and cost up to $24,000 annually (Myers et al., 2022).
- Electronic health records (EHRs) fail to document APRN care (Schirle et al., 2018).

Recommendations to move toward full practice authority

There is no evidence to support APRNs do not provide safe and high-quality care. Therefore, enacting legislation that modernizes and removes outdated scope of practice barriers and creates uniformity in reimbursement policies for Tennessee APRNs is an essential step toward improving healthcare access, reducing disparities, and addressing the healthcare needs of the state's population, especially in distressed rural counties and underserved communities (American Association of Nurse Practitioners [AANP], n.d.; National Council of State Boards of Nursing [NCSBN], 2008). Addressing the recommendations proposed in this policy brief will lead to a more effective, efficient, and equitable healthcare system in Tennessee. Tennessee can reduce healthcare disparities, increase access to care, and meet the growing demand for healthcare providers (National Academy of Medicine, 2021). Tennessee must embrace these changes to improve the health and well-being of its residents.

Policy Brief

2023

Policy Recommendations

1. **The AANP (n.d.) recommends federal legislation**: the H.R. 2713/S. 2418 ICAN Act to remove outdated Medicare and Medicaid barriers. The ICAN Act authorizes APRNs to order cardiac and pulmonary rehabilitation services for Medicare patients, enables APRNs to provide a full range of diabetes care and their needs for therapeutic shoes, and allows APRNs to certify disabilities and oversee treatment for injured federal employees under the Federal Employees' Compensation Act (AANP, n.d.).

2. **The AANP (2022b) recommends state legislation**: For Tennessee to modernize state licensure laws, remove outdated policies so APRNs have signature authority within their scope of practice, and utilize provider-inclusive and provider-neutral language.

3. **The National Council of State Boards of Nursing (2008) Consensus Model recommends:**

    - **Eliminating Practice Restrictions:** Remove practice restrictions that lack evidence-based support or deter APRNs from delivering safe and effective care, including removing collaborating and supervisory agreements.
    - **Establishing uniformity in education and certification requirements**: To ensure APRNs complete graduate-level education programs specific to their role and attain national certification in their specialties.
    - **Establish uniformity in Prescription Authority**: Removing unnecessary prescribing barriers and granting APRNs authority to prescribe medications per their education, certification, and state regulations.
    - **Regulatory Consistency**: Highlighting the importance of regulatory consistency across states to enhance APRN mobility and improve access to care.
    - **Global Signature**: Implement a global signature to grant APRNs the ability to sign comprehensive patient care forms.

4. **The National Academy of Medicine (2021) recommends:**

    - **Modernize Scope of Practice:** Remove outdated regulations and language that hinder APRNs' ability to provide comprehensive care.
    - **Payment Equality**: Ensure payment equality and acknowledge APRN role in the healthcare system.
    - **Address Social Determinants of Health**: Remove barriers from federal and state agencies and other private employing agencies that prevent APRNs from addressing social needs and social determinants of health.

Benefits of FPA

- **Enhanced Access to Rural and Underserved Areas:** Patients can receive timely and comprehensive care (AANP, 2022b).
- **Economic Benefits:** Could generate $1 billion in total output and create over 7,696 jobs between 2017-2025 (Myers et al., 2022).
- **Streamlined Care:** Eliminates delays caused by outdated regulations, and patients can receive efficient and prompt care (AANP, 2022b).
- **Cost Reduction:** Decreases costs by avoiding duplicated services and billing costs with outdated physician oversight. Reduces repetitive orders, office visits, and care services (AANP, 2022b).
- **Patient Choice:** Allows patients to choose their healthcare provider and removes anti-competitive licensing restrictions (AANP, 2022b).
- **Decreased Non-Emergent Services and Hospitalizations**: APRNs can provide proactive and preventative care (Bosse et al., 2017).
- **Increased Patient Satisfaction:** Patients can have direct access to their provider and build strong patient-provider relationships (Smith, 2021).
- **Decreased State Healthcare Expenditure:** Care becomes more efficient, preventative, and cost-effective (Zwilling & Fiandt, 2020).
- **Reduced Medicaid Claims:** Potential to reduce Medicaid claims by 10% and increase Medicaid patient care by 8% without increasing costs (Denson & Timmons, 2022).
- **Increased Provider Workforce:** FPA expands the provider workforce in areas facing shortages of healthcare professionals. APRNs can fill the gaps in healthcare delivery (Denson & Timmons, 2022).
- **Expanded Healthcare Utilization:** Ensures patients receive the care they need when they need it (AANP, 2022b).

Policy Brief

2023

References

America's Health Rankings. (n.d.). *Health disparity report.* America's Health Rankings. https://www.americashealthrankings.org/learn/reports/2021-disparities-report

American Association of Nurse Practitioners. (n.d.). *Federal issue briefs: Informing NPs on health policy, sharing the NP perspective*. Retrieved October 25, 2023, from https://www.aanp.org/advocacy/federal

American Association of Nurse Practitioners. (2022a). *AANP state fact sheet.* https://www.aanp.org/advocacy/state/state-practice-environment/state-policy-fact-sheets

American Association of Nurse Practitioners. (2022b). *2023 state policy priorities.* https://www.aanp.org/advocacy/state/state-policy-priorities

American Association of Nurse Practitioners. (2023). *Issues at a glance: Full practice authority.* https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

Bosse, J., Simmonds, K., Hanson, C., Pulcini, J., Dunphy, L., Vanhook, P., & Poghosyan, L. (2017). Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care. *Nursing Outlook, 65*(6), 761–765. https://doi.org/10.1016/j.outlook.2017.10.002

Brom, H. M., Salsberry, P. J., & Graham, M. C. (2018). Leveraging health care reform to accelerate nurse practitioner full practice authority. *Journal of the American Association of Nurse Practitioners, 30*(3), 120–130. https://doi.org/10.1097/jxx.0000000000000023

Denson, C., & Timmons, E. (2022). *Addressing Georgia's healthcare disparities: The benefits of full practice authority for nurse practitioners and physician assistants.* Denson & Timmons. https://www.georgiapolicy.org/publications/addressing-georgias-healthcare-disparities-the-benefits-of-full-practice-authority-for-nurse-practitioners-and-physician-assistants/

Haney, B. (2023). 35th annual APRN legislative update: Updates to APRN practice authority in the United States. *The Nurse Practitioner, 48*(1), 20–47. https://doi.org/10.1097/01.npr.0000903012.03553.a4

Myers, C. R., Muñoz, L. R., Stansberry, T., Schorn, M., Kleinpell, R., & Likes, W. (2022). COVID-19 effects on practice: Perspectives of Tennessee APRNs. *Nursing Forum, 57*(4), 593–602. https://doi.org/10.1111/nuf.12711

National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF]. National Academies Press. https://doi.org/10.17226/25982

National Council of State Boards of Nursing. (2008). *Consensus Model for APRN regulation: Licensure, accreditation, certification & education.* https://ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

Schirle, L., Norful, A. A., Rudner, N., & Poghosyan, L. (2018). Organizational facilitators and barriers to optimal APRN practice: An integrative review. *Health Care Management Review, 45*(4), 311–320. https://doi.org/10.1097/hmr.0000000000000229

Schorn, M. N., Myers, C., Barroso, J., Hande, K., Hudson, T., Kim, J., & Kleinpell, R. (2022). Results of a national survey: Ongoing barriers to APRN practice in the United States. *Policy, Politics, & Nursing Practice, 23*(2), 118–129. https://doi.org/10.1177/15271544221076524

Smith, L. B. (2021). The effect of nurse practitioner scope of practice laws on primary care delivery. *Health Economics, 31*(1), 21–41. https://doi.org/10.1002/hec.4438

Zwilling, J. G., & Fiandt, K. (2020). Where are we now? Practice-level utilization of nurse practitioners in comparison with state-level regulations. *Journal of the American Association of Nurse Practitioners, 32*(6), 429–437. https://doi.org/10.1097/jxx.0000000000000270

Appendix E

Georgia Policy Brief

Policy Brief

2023

Full Practice Authority for Georgia Advanced Practice Registered Nurses

Executive Summary

Georgia is a predominantly rural area with 41 counties designated as health professional shortage areas and 15 partial health professional shortage areas (America's Health Rankings, 2022). Georgia faces substantial health disparities and constraints to healthcare accessibility. The state ranks 36th in America's Health Rankings, and its 17,917 Advanced Practice Registered Nurses (APRNs) can play a pivotal role in addressing these challenges (America's Health Rankings, 2022; Haney, 2023). However, APRNs face restrictive regulatory and non-regulatory barriers that hinder their ability to provide quality care, reduce access to healthcare services, and create inefficiencies in patient care. This policy brief calls for a comprehensive reform of APRN regulations to improve access to care, reduce disparities, and address the growing demand for providers.

Introduction

As part of the Southeast region, Georgia is marked by rural areas, primary health professional shortage areas, and persistent health disparities (America's Health Rankings, 2022). Despite having a substantial number of APRNs, Georgia is a restrictive scope of practice state (American Association of Nurse Practitioners [AANP], 2023). Despite national standards for nursing, state laws and legislative bodies that govern APRNs vary across states (AANP, 2023). This inconsistency is evident in barriers, including licensing and administrative restrictions, limitations on treatment options, mandatory physician authorizations, prescribing restrictions, varying reimbursement practices, and challenges related to telehealth (Schorn et al., 2022). These outdated restrictions prevent APRNs from practicing to the full scope of their education, accreditation, certification, and licensure. The opposition from physician organizations further exacerbates the challenges (Myers et al., 2022). These barriers create higher healthcare costs, reduced access to care, and inefficient care (AANP, 2023). The barriers undermine the state's efforts to address the healthcare disparities, preventing APRNs from providing comprehensive care, particularly in rural and underserved areas. This policy brief highlights the pressing need for modernization of policies to remove these barriers and maximize the potential of APRNs to improve healthcare accessibility and quality of care to the population and state of Georgia.

Endorsements

Full Practice Authority is endorsed by the National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, the National Governors Association (NGA), the American Association of Nurse Practitioners (AANP), the American Nurses Association (ANA), and the Robert Wood Johnson Foundation (Brom et al., 2018).

Barriers to practice

- Limiting APRNs' scope of practice impacts patients as it decreases or delays care and limits access to care (AANP, 2023).
- Inability to hold Schedule II controlled substance prescriptive authority and APRN must submit a nurse protocol agreement that follows the rules and is approved by the Board of Medicine (American Association of Nurse Practitioners [AANP], 2022).
- Low reimbursement rates (Myers et al., 2022).
- Signature restrictions prevent APRNs from signing Do-Not-Resuscitate orders, POLST, and death certificates only when delegated by a physician (AANP, 2022).
- Signature restrictions prevent APRNs from signing needed durable medical equipment (AANP, 2022).
- Collaborative/supervisory requirements limit APRN autonomy, cause delays in care, restrict patient follow-up care, limit provider choices, and cost the APRN between $6,000-$50,000 annually (Schorn et al., 2022).
- Electronic health records (EHRs) fail to document APRN care (Schirle et al., 2018).

Recommendations to move toward full practice authority

There is no evidence to support APRNs do not provide safe and high-quality care. Therefore, enacting legislation that modernizes and removes outdated scope of practice barriers and creates uniformity in reimbursement policies for Georgia APRNs is an essential step toward improving healthcare access, reducing disparities, and addressing the healthcare needs of the state's population, especially in distressed rural counties and underserved communities (AANP, n.d.; National Council of State Boards of Nursing [NCSBN], 2008). Addressing the recommendations proposed in this policy brief will lead to a more effective, efficient, and equitable healthcare system in Georgia. Georgia can reduce healthcare disparities, increase access to care, and meet the growing demand for healthcare providers (National Academy of Medicine, 2021). Georgias must embrace these changes to improve the health and well-being of its residents.

Policy Brief

2023

Policy Recommendations

1. **The AANP (n.d.) recommends federal legislation**: the H.R. 2713/S. 2418 ICAN Act to remove outdated Medicare and Medicaid barriers. The ICAN Act authorizes APRNs to order cardiac and pulmonary rehabilitation services for Medicare patients, enables APRNs to provide a full range of diabetes care and their needs for therapeutic shoes, and allows APRNs to certify disabilities and oversee treatment for injured federal employees under the Federal Employees' Compensation Act (AANP, n.d.).

2. **The AANP (2022b) recommends state legislation**: For Georgia to modernize state licensure laws, remove outdated policies so APRNs have signature authority within their scope of practice, and utilize provider-inclusive and provider-neutral language.

3. **The National Council of State Boards of Nursing (2008) Consensus Model recommends:**

   - **Eliminating Practice Restrictions:** Remove practice restrictions that lack evidence-based support or deter APRNs from delivering safe and effective care, including removing collaborating and supervisory agreements.
   - **Establishing uniformity in education and certification requirements**: To ensure APRNs complete graduate-level education programs specific to their role and attain national certification in their specialties.
   - **Establish uniformity in Prescription Authority**: Removing unnecessary prescribing barriers and granting APRNs authority to prescribe medications per their education, certification, and state regulations.
   - **Regulatory Consistency**: Highlighting the importance of regulatory consistency across states to enhance APRN mobility and improve access to care.
   - **Global Signature**: Implement a global signature to grant APRNs the ability to sign comprehensive patient care forms.

4. **The National Academy of Medicine (2021)**

   - **Modernize Scope of Practice:** Remove outdated regulations and language that hinder APRNs' ability to provide comprehensive care.
   - **Payment Equality**: Ensure payment equality and acknowledge APRN role in the healthcare system.
   - **Address Social Determinants of Health**: Remove barriers from federal and state agencies and other private employing agencies that prevent APRNs from addressing social needs and social determinants of health.

Benefits of FPA

- **Enhanced Access to Rural and Underserved Areas:** Patients can receive timely and comprehensive care (AANP, 2022b).
- **Streamlined Care:** Eliminates delays caused by outdated regulations, and patients can receive efficient and prompt care (AANP, 2022b).
- **Cost Reduction:** Decreases costs by avoiding duplicated services and billing costs with outdated physician oversight. Reduces repetitive orders, office visits, and care services (AANP, 2022b).
- **Patient Choice:** Allows patients to choose their healthcare provider and removes anti-competitive licensing restrictions (AANP, 2022b).
- **Decreased Non-Emergent Services and Hospitalizations**: APRNs can provide proactive and preventative care (Bosse et al., 2017).
- **Increased Patient Satisfaction:** Patients can have direct access to their provider and build strong patient-provider relationships (Smith, 2021).
- **Decreased State Healthcare Expenditure:** Care becomes more efficient, preventative, and cost-effective (Zwilling & Fiandt, 2020).
- **Reduced Medicaid Claims:** Potential to reduce Medicaid claims by 10% and increase Medicaid patient care by 8% without increasing costs (Denson & Timmons, 2022).
- **Increased Provider Workforce:** FPA expands the provider workforce in areas facing shortages of healthcare professionals. APRNs can fill the gaps in healthcare delivery (Denson & Timmons, 2022).
- **Expanded Healthcare Utilization:** Ensures patients receive the care they need when they need it (AANP, 2022b).

Policy Brief

2023

References

America's Health Rankings. (n.d.). *Health disparity report*. America's Health Rankings. https://www.americashealthrankings.org/learn/reports/2021-disparities-report

American Association of Nurse Practitioners. (n.d.). *Federal issue briefs: Informing NPs on health policy, sharing the NP perspective*. Retrieved October 25, 2023, from https://www.aanp.org/advocacy/federal

American Association of Nurse Practitioners. (2022a). *AANP state fact sheet*. https://www.aanp.org/advocacy/state/state-practice-environment/state-policy-fact-sheets

American Association of Nurse Practitioners. (2022b). *2023 state policy priorities*. https://www.aanp.org/advocacy/state/state-policy-priorities

American Association of Nurse Practitioners. (2023). *Issues at a glance: Full practice authority*. https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

Bosse, J., Simmonds, K., Hanson, C., Pulcini, J., Dunphy, L., Vanhook, P., & Poghosyan, L. (2017). Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care. *Nursing Outlook*, *65*(6), 761–765. https://doi.org/10.1016/j.outlook.2017.10.002

Brom, H. M., Salsberry, P. J., & Graham, M. C. (2018). Leveraging health care reform to accelerate nurse practitioner full practice authority. *Journal of the American Association of Nurse Practitioners*, *30*(3), 120–130. https://doi.org/10.1097/jxx.0000000000000023

Denson, C., & Timmons, E. (2022). *Addressing Georgia's healthcare disparities: The benefits of full practice authority for nurse practitioners and physician assistants*. Denson & Timmons. https://www.georgiapolicy.org/publications/addressing-georgias-healthcare-disparities-the-benefits-of-full-practice-authority-for-nurse-practitioners-and-physician-assistants/

Haney, B. (2023). 35th annual APRN legislative update: Updates to APRN practice authority in the United States. *The Nurse Practitioner*, *48*(1), 20–47. https://doi.org/10.1097/01.npr.0000903012.03553.a4

Myers, C. R., Muñoz, L. R., Stansberry, T., Schorn, M., Kleinpell, R., & Likes, W. (2022). COVID-19 effects on practice: Perspectives of Tennessee APRNs. *Nursing Forum*, *57*(4), 593–602. https://doi.org/10.1111/nuf.12711

National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF]. National Academies Press. https://doi.org/10.17226/25982

National Council of State Boards of Nursing. (2008). *Consensus Model for APRN regulation: Licensure, accreditation, certification & education.* https://ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

Schirle, L., Norful, A. A., Rudner, N., & Poghosyan, L. (2018). Organizational facilitators and barriers to optimal APRN practice: An integrative review. *Health Care Management Review*, *45*(4), 311–320. https://doi.org/10.1097/hmr.0000000000000229

Schorn, M. N., Myers, C., Barroso, J., Hande, K., Hudson, T., Kim, J., & Kleinpell, R. (2022). Results of a national survey: Ongoing barriers to APRN practice in the United States. *Policy, Politics, & Nursing Practice*, *23*(2), 118–129. https://doi.org/10.1177/15271544221076524

Smith, L. B. (2021). The effect of nurse practitioner scope of practice laws on primary care delivery. *Health Economics*, *31*(1), 21–41. https://doi.org/10.1002/hec.4438

Zwilling, J. G., & Fiandt, K. (2020). Where are we now? Practice-level utilization of nurse practitioners in comparison with state-level regulations. *Journal of the American Association of Nurse Practitioners*, *32*(6), 429–437. https://doi.org/10.1097/jxx.0000000000000270

Appendix F

Alabama Policy Brief

Policy Brief

2023

Full Practice Authority for Alabama Advanced Practice Registered Nurses

Executive Summary

Alabama is a predominantly rural area with 42 counties designated as health professional shortage areas and 25 partial health professional shortage areas (America's Health Rankings, 2022). Alabama faces substantial health disparities and constraints to healthcare accessibility. The state ranks 46th in America's Health Rankings, and its 8,481 Advanced Practice Registered Nurses (APRNs) can play a pivotal role in addressing these challenges (America's Health Rankings, 2022; Haney, 2023). However, APRNs face restrictive regulatory and non-regulatory barriers that hinder their ability to provide quality care, reducing access to healthcare services and inefficiencies in patient care. This policy brief calls for a comprehensive reform of APRN regulations to improve access to care, reduce disparities, and address the growing demand for providers.

Introduction

As part of the Southeast region, Alabama is marked by rural areas, primary health professional shortage areas, and persistent health disparities (America's Health Rankings, 2022). Despite having a substantial number of APRNs, Georgia is a restrictive scope of practice state (American Association of Nurse Practitioners [AANP], 2023). Despite national standards for nursing, state laws and legislative bodies that govern APRNs vary across states (AANP, 2023). This inconsistency is evident in barriers, including licensing and administrative restrictions, limitations on treatment options, mandatory physician authorizations, prescribing restrictions, varying reimbursement practices, and challenges related to telehealth (Schorn et al., 2022). These outdated restrictions prevent APRNs from practicing to the full scope of their education, accreditation, certification, and licensure. The opposition from physician organizations further exacerbates the challenges (Myers et al., 2022). These barriers create higher healthcare costs, reduced access to care, and inefficient care (AANP, 2023). The barriers undermine the state's efforts to address the healthcare disparities, preventing APRNs from providing comprehensive care, particularly in rural and underserved areas. This policy brief highlights the pressing need for modernization of policies to remove these barriers and maximize the potential of APRNs to improve healthcare accessibility and quality of care to the population and state of Alabama.

Endorsements

Full Practice Authority is endorsed by the National Council of State Boards of Nursing (NCSBN), the National Academies of Sciences, Engineering, and Medicine, the National Governors Association (NGA), the American Association of Nurse Practitioners (AANP), the American Nurses Association (ANA), and the Robert Wood Johnson Foundation (Brom et al., 2018).

Barriers to practice

- Limiting APRNs' scope of practice impacts patients as it decreases or delays care and limits access to care.
- Regulated by both the Board of Nursing and the Board of Medical Examiners.
- Restrictions apply to prescribing Schedule II drugs and must follow the rules of the Board of Medical Examiners.
- Signature restrictions prevent APRNs from signing Do-Not-Resuscitate orders.
- Signature restrictions prevent APRNs from signing needed durable medical equipment.
- Required to have a lifelong collaborative agreement, but if it is dissolved, the APRN is considered a registered nurse.
- Collaborative requirements limit APRN autonomy, cause delays in care, restrict patient follow-up care, limit provider choices, and cost the APRN between $6,000-$50,000 annually.
- Electronic health records (EHRs) fail to document APRN care.

Recommendations to move toward full practice authority

No evidence supports that APRNs do not provide safe and high-quality care. Therefore, Alabama should acknowledge APRNs as valuable healthcare providers operating independently without obligatory collaboration with physicians and eliminate the Alabama Board of Medical Examiners from overseeing APRN practice (Hart et al., 2022). There should also be a transition to a licensure process based on the APRN's education and national certification, as opposed to certification dependent on physician collaboration (Hart et al., 2022). Enacting legislation to modernize and remove outdated scope of practice barriers, including collaborative/supervisory agreements and restrictive prescriptive authority for Alabama APRNs, is essential (Hart et al., 2022). Full practice authority can improve healthcare access, reduce disparities, and address the healthcare needs of the state's population, especially in distressed rural counties and underserved communities (National Academy of Medicine, 2021). Addressing the recommendations proposed in this policy brief will lead to a more effective, efficient, and equitable healthcare system in Alabama. Alabama can reduce healthcare disparities, increase access to care, and meet the growing demand for healthcare providers. Alabama must embrace these changes to improve the health and well-being of its residents.

Policy Brief

2023

Policy Recommendations

1. **The AANP (n.d.) recommends federal legislation**: the H.R. 2713/S. 2418 ICAN Act to remove outdated Medicare and Medicaid barriers. The ICAN Act authorizes APRNs to order cardiac and pulmonary rehabilitation services for Medicare patients, enables APRNs to provide a full range of diabetes care and their needs for therapeutic shoes, and allows APRNs to certify disabilities and oversee treatment for injured federal employees under the Federal Employees' Compensation Act (AANP, n.d.).

2. **The AANP (2022b) recommends state legislation**: For Alabama to modernize state licensure laws, remove outdated policies so APRNs have signature authority within their scope of practice, and utilize provider-inclusive and provider-neutral language.

3. **The National Council of State Boards of Nursing (2008) Consensus Model recommends:**

   - **Eliminating Practice Restrictions:** Remove practice restrictions that lack evidence-based support or deter APRNs from delivering safe and effective care, including removing collaborating and supervisory agreements.
   - **Establishing uniformity in education and certification requirements**: To ensure APRNs complete graduate-level education programs specific to their role and attain national certification in their specialties.
   - **Establish uniformity in Prescription Authority**: Removing unnecessary prescribing barriers and granting APRNs authority to prescribe medications per their education, certification, and state regulations.
   - **Regulatory Consistency**: Highlighting the importance of regulatory consistency across states to enhance APRN mobility and improve access to care.
   - **Global Signature**: Implement a global signature to grant APRNs the ability to sign comprehensive patient care forms.

4. **The National Academy of Medicine (2021)**

   - **Modernize Scope of Practice:** Remove outdated regulations and language that hinder APRNs' ability to provide comprehensive care.
   - **Payment Equality**: Ensure payment equality and acknowledge APRN role in the healthcare system.
   - **Address Social Determinants of Health**: Remove barriers from federal and state agencies and other private employing agencies that prevent APRNs from addressing social needs and social determinants of health.

Benefits of FPA

- **Enhanced Access to Rural and Underserved Areas:** Patients can receive timely and comprehensive care (AANP, 2022b).
- **Streamlined Care:** Eliminates delays caused by outdated regulations, and patients can receive efficient and prompt care (AANP, 2022b).
- **Economic Benefits:** Result in more than $729 million in savings over ten years (Hart et al., 2020).
- **Cost Reduction:** Decreases costs by avoiding duplicated services and billing costs with outdated physician oversight. Reduces repetitive orders, office visits, and care services (AANP, 2022b).
- **Patient Choice:** Allows patients to choose their healthcare provider and removes anti-competitive licensing restrictions (AANP, 2022b).
- **Decreased Non-Emergent Services and Hospitalizations**: APRNs can provide proactive and preventative care (Bosse et al., 2017).
- **Increased Patient Satisfaction:** Patients can have direct access to their provider and build strong patient-provider relationships (Smith, 2021).
- **Decreased State Healthcare Expenditure:** Care becomes more efficient, preventative, and cost-effective (Zwilling & Fiandt, 2020).
- **Reduced Medicaid Claims:** Potential to reduce Medicaid claims by 10% and increase Medicaid patient care by 8% without increasing costs (Denson & Timmons, 2022).
- **Increased Provider Workforce:** FPA expands the provider workforce in areas facing shortages of healthcare professionals. APRNs can fill the gaps in healthcare delivery (Denson & Timmons, 2022).
- **Expanded Healthcare Utilization:** Ensures patients receive the care they need when they need it and healthcare access has the potential to increase in Alabama by 76% (AANP, 2022b; Hayes et al., 202).

Policy Brief

2023

References

America's Health Rankings. (n.d.). *Health disparity report*. America's Health Rankings. https://www.americashealthrankings.org/learn/reports/2021-disparities-report

American Association of Nurse Practitioners. (n.d.). *Federal issue briefs: Informing NPs on health policy, sharing the NP perspective*. Retrieved October 25, 2023, from https://www.aanp.org/advocacy/federal

American Association of Nurse Practitioners. (2022a). *AANP state fact sheet*. https://www.aanp.org/advocacy/state/state-practice-environment/state-policy-fact-sheets

American Association of Nurse Practitioners. (2022b). *2023 state policy priorities*. https://www.aanp.org/advocacy/state/state-policy-priorities

American Association of Nurse Practitioners. (2023). *Issues at a glance: Full practice authority*. https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

Bosse, J., Simmonds, K., Hanson, C., Pulcini, J., Dunphy, L., Vanhook, P., & Poghosyan, L. (2017). Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care. *Nursing Outlook*, *65*(6), 761–765. https://doi.org/10.1016/j.outlook.2017.10.002

Brom, H. M., Salsberry, P. J., & Graham, M. C. (2018). Leveraging health care reform to accelerate nurse practitioner full practice authority. *Journal of the American Association of Nurse Practitioners*, *30*(3), 120–130. https://doi.org/10.1097/jxx.0000000000000023

Denson, C., & Timmons, E. (2022). *Addressing Georgia's healthcare disparities: The benefits of full practice authority for nurse practitioners and physician assistants*. Denson & Timmons. https://www.georgiapolicy.org/publications/addressing-georgias-healthcare-disparities-the-benefits-of-full-practice-authority-for-nurse-practitioners-and-physician-assistants/

Haney, B. (2023). 35th annual APRN legislative update: Updates to APRN practice authority in the United States. *The Nurse Practitioner*, *48*(1), 20–47. https://doi.org/10.1097/01.npr.0000903012.03553.a4

Hart, L., Ferguson, R., & Amiri, A. (2020). Full scope of practice for Alabama nurse practitioners: Act now. *The Journal for Nurse Practitioners*, *16*(2), 100–104. https://doi.org/10.1016/j.nurpra.2019.10.016

Hayes, W., Baker, N. R., Benson, P., & O'Keefe, L. C. (2023). The state of advanced practice registered nursing in Alabama. *Journal of Nursing Regulation*, *13*(4), 44–53. https://doi.org/10.1016/s2155-8256(23)00030-3

Myers, C. R., Muñoz, L. R., Stansberry, T., Schorn, M., Kleinpell, R., & Likes, W. (2022). COVID-19 effects on practice: Perspectives of Tennessee APRNs. *Nursing Forum*, *57*(4), 593–602. https://doi.org/10.1111/nuf.12711

National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF]. National Academies Press. https://doi.org/10.17226/25982

National Council of State Boards of Nursing. (2008). *Consensus Model for APRN regulation: Licensure, accreditation, certification & education*. https://ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

Schirle, L., Norful, A. A., Rudner, N., & Poghosyan, L. (2018). Organizational facilitators and barriers to optimal APRN practice: An integrative review. *Health Care Management Review*, *45*(4), 311–320. https://doi.org/10.1097/hmr.0000000000000229

Schorn, M. N., Myers, C., Barroso, J., Hande, K., Hudson, T., Kim, J., & Kleinpell, R. (2022). Results of a national survey: Ongoing barriers to APRN practice in the United States. *Policy, Politics, & Nursing Practice*, *23*(2), 118–129. https://doi.org/10.1177/15271544221076524

Smith, L. B. (2021). The effect of nurse practitioner scope of practice laws on primary care delivery. *Health Economics*, *31*(1), 21–41. https://doi.org/10.1002/hec.4438

Zwilling, J. G., & Fiandt, K. (2020). Where are we now? Practice-level utilization of nurse practitioners in comparison with state-level regulations. *Journal of the American Association of Nurse Practitioners*, *32*(6), 429–437. https://doi.org/10.1097/jxx.0000000000000270