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Understanding nurse practitioner scope of practice: Regulatory, practice, and employment perspectives now and for the future

Randall S. Hudspeth, PhD, MBA, MS, APRN-CNP, FRE, FAANP[1] & Tracy A. Klein, PhD, ARNP-CNP, FRE, FAANP, FAAN (Assistant Professor, Principal Consultant)[2]

ABSTRACT

The nurse practitioner (NP) role has existed for 50 years. During the past 10 years, a national effort to use NPs to the full extent of their education based on the 2008 Consensus Model for Advanced Practice Registered Nurse Regulation and the 2010 Institute of Medicine Report on the Future of Nursing continues to result in variable scopes of practice (SOP) between states. Subsequently, NPs have a lack of clarity on SOP because it relates to population foci and practice setting. Review and analysis of state-based statutes and rules with the current literature focused on NP SOP, including documents by the National Council of State Boards of Nursing, was conducted. Clarification and understanding of SOP is essential for safe practice and optimum access to care. Inconsistent SOP regulation continues to exist between states, and NPs can be in employment situations that place them in a position to possibly breech their SOP. Although practice is not setting specific, NP licensure is based on NP education and certification that is competency based within population foci, and credentialing by employers should align with these parameters. Continuing to work toward a more common NP SOP between states and achievement of full practice authority means periodic reassessment of NP education and practice models. Practice mobility is essential for continued advancement of the NP profession and increased access to care by the public.

Keywords: NP scope of practice; nurse practice acts; practice authority; regulation; rules; statutes.

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Introduction

This article presents a historical basis of nurse practitioner (NP) scope of practice (SOP) modifications over the past 40 years, and further discusses how SOP is managed from regulatory, practice, and employment perspectives. The authors discuss factors such as workforce maldistribution, provider access, perceived SOP encroachment, and other factors that have impacted changing NP SOP to be in line with the national goal of full practice authority for all NPs.

In general, NPs continue to be identified as an essential solution to providing health care in the United States and are hired and credentialed in multiple clinic settings to diagnose and treat a broad spectrum of conditions. Continued NP growth as a profession has been driven by a major emphasis on the need for more primary care providers (Pohl, Thomas, Bigley & Kapanos, 2018). Also, NPs are well suited to meet the increasing shortages of primary care providers in both rural and urban areas resulting in part from provider retirements, workforce maldistribution, and the focus and interest of physicians and other provider groups in practicing outside of primary care (United States Department of Health and Human Services, 2016; National Residency Match Program, 2018).

To respond to this national need and to positively impact access to care for many Americans, policy experts for the past four decades have supported changes to restrictive state-based SOP (Westat, 2015). Policy and regulatory changes have been nationally driven to support full practice authority based on recommendations of the 2010 Institute of Medicine report on the Future of Nursing (Institute of Medicine, 2011) and the 2008 National Consensus Model for Advanced Practice Registered Nurses (APRN) Regulation: Licensure, Accreditation, Certification and Education (APRN Joint Dialogue Group Report, 2008). In 2017, President Trump issued an executive order to direct federal agency analysis of how choice and competition in the health care market can be facilitated to both provide greater access to care and reduce regulatory barriers (Exec. Order 13813, 2017). The

[1]*RSHudspeth Consulting, LLC, Boise, Idaho,* [2]*Washington State University, Pullman, Washington*

Correspondence: *Randall S. Hudspeth, PhD, MBA, MS, APRN-CNP, FRE, FAANP, RSHudspeth Consulting, LLC, Boise, ID 83704. Tel: 208 860 9338; E-mail: randhuds@msn.com*

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Administration's subsequent report emphasizes the quality of NP practice and the positive impact to patient access and service cost when regulatory and scope barriers are removed (Sheppard, Mullin, Richter, & Hampton LLP, 2018). As of January 2019, 23 states have enacted full practice authority legislation allowing NPs, and other APRNs, to practice to the full extent of their educations.

Two major problems that affect NPs in current practice are the changing landscape of regulation at multiple levels and the employment situation whereby NPs who are educated and certified within one population group are often placed in situations of treating patients outside of this population group, which could result in a practice violation of practicing beyond or outside of the approved SOP. Because establishing SOP is state based, NPs must remain informed about these regulations to avoid SOP conflicts.

Having full practice authority language in Nurse Practice Acts has not totally resolved all barriers to practice. Rules and policies of various state agencies can still prohibit NPs from some functions such as signature authority. These are often times matters of wording in previously written rules and policies that specifically designate the function to a "physician" versus a "licensed provider." An example is a rule in the Bureau of Vital Statistics that states a "physician" must sign a death certificate, versus a "licensed provider." Generally, comprehensive "cleanup wording" legislation can help to resolve these unintended barriers and has been successful in states such as Oregon.

Historically, NP SOP evolved since the first program in 1965 in Colorado, when the common regulatory model was joint regulation between boards of medicine and nursing. The majority of early NPs were prepared in continuing education certificate programs and worked with physicians in a supervisory or collaborative relationship. The NP SOP varied from state to state and was commonly based on what the physician's practice was, and the most common restrictions involved was medication prescribing. Generally, NPs were given an expanded practice authority based on their registered nurse (RN) license that controlled where they practiced and what they could do in an expanded RN role (Fairman, 2009). Common constraints on prescribing included lack of controlled substance or dispensing authority, or limitation of prescribing to drugs provided on a formulary approved by one or more regulatory boards (Keeling, 2007).

Over the years, NP SOP has been modified. These changes were often seen in Nurse Practice Act statute language and resulted in more autonomy, eliminated or re-defined the supervisory roles of physicians, and placed NP regulatory responsibility solely with boards of nursing. The support for these changes has been driven by societal needs to access health care, provider maldistribution, responses to technology, and the need to maintain a viable health care delivery workforce. As SOP was modified, NP education programs also changed to provide consistent content that was supportive of the SOP.

Regulatory perspective in establishing scope of practice

In the United States, the establishment of health care professional SOP is the responsibility of individual states, with a few exceptions for federal agencies such as the Veteran's Administration, military, and Indian Health Agencies. This state's right is identified in Article Four, Section Three of the U.S. Constitution (Constitution of the U.S., 2018). Each state legislature has the responsibility to approve SOPs for all health care professions, and it can accomplish this by either direct approval by vote or by delegation to the appropriate regulatory board. Because of the various skill sets of the individual legislators and the lack of significant numbers of legislators being health care providers, when SOP issues occur, legislators rely heavily on advice by members of professional associations and of the regulatory boards for health professions. This input is usually provided by written testimony to a committee or by a hearing before a vote is held by the full legislative body.

Regulatory boards function under the administrative branch and follow procedures specified in the Administrative Procedures Act (United States Environmental Protection Agency, 2018). With a few exceptions, board members are appointed by the governor and may or may not include public members. Boards have four primary roles that serve to fulfill their mission of public protection. Those roles are (1) approve prelicensure programs that prepare students to enter the profession, (2) issuing or renewing a license to practice in a given role based on documented completion of an education program, a background check that meets the defined acceptable standards if a compact license is to be issued, successful passing of basic competency requirements, and payment of license fees, (3) establishing and monitoring SOP, and (4) using the disciplinary process to remove licensed practitioners from practice when they fail to meet minimum standards and pose a threat to the health and welfare of the public (Hudspeth, 2009).

Parameters of SOP are supported by four levels of instruments: statute, rule, policy, and advisory paper or opinion. Issues of SOP that have major public interest and impact other disciplines are usually managed at the legislative level, such as prescribing rights and levels of supervision. The legislature can delegate other SOP decisions to the regulatory board.

Statute is the major method of SOP definition and its broad contents are the practice acts. Statute language can be proposed by any citizen or constituent organization and requires a sitting legislator to sponsor the bill and shepherd it through the legislative process. This process allows for debate from multiple perspectives, and the statute language can be modified during the process, sometimes resulting in a different outcome than was originally intended. Statute language is usually broad

in nature and provides a framework for the way the legislation will be operationalized. Statutes are passed by the state legislature and signed by the governor before they become law. Some states periodically open statutes for review under "Sunset" clauses, whereas others do not change a statute until mandated by the legislature. When referring to "The Nurse Practice Act," people are typically referencing statute in state law.

Rules are promulgated based on the statute and provide more detail as to how the statute is to be implemented. Rule promulgation is restricted to agencies that have responsibility for implementing the practice act. For nursing, this means that boards of nursing propose the rules that are put forward to the legislature for approval. There is commonly a hearing process to explain and obtain feedback for the rules before they are approved by the legislature, but a board can submit nonopposed rule changes based on the advice of the state attorney general office. A nonopposed rule change would be something minor or specific to the operations of the board office, such as using digital license verification. Rules are approved as a whole, meaning they pass all or none, thus eliminating changes by groups that have no responsibility to implement them. Rules that pass the legislature are not signed by the governor and can become effective when the legislature determines, often when it adjourns.

Policies are developed and approved by the board members appointed by the governor and given the responsibility to regulate the profession. Policy examples could include the acceptance of a national accreditation review for an NP education program versus the board of nursing making an individual site visit to the program. For SOP, boards may adopt a SOP statement produced by a national professional association versus drafting a specific state-based SOP.

Advisory papers or opinions are issued on topics and support the current view of the board, which typically address more narrow clinical topics than policies. These are fact-based papers that present multiple views on a topic and provide solid support for a defined course of action. Examples of advisory opinions could be how the board will respond when schools allow teachers to administer medications to students in the absence of a school nurse.

In 1972, Idaho became the first state to recognize NPs in statute and issued a separate NP license in addition to the RN license and other states soon followed (Hudspeth & Kaiser, 2009). Licensure of NP was based on the completion of an NP education program, having an unencumbered RN license, and having clinical supervision, which was generally provided by a physician in the 1970s and 80s, but it could also be provided by other means such as mentored practice or peer review. This type of supervision was more evidenced in rural communities that lacked a physician to fulfill the role. Physicians were champions of the early NP programs and served as faculty and preceptors, and many hired the new NPs to work in their private practices.

In the 1990s, boards of nursing began using NP certification examinations as one of the requirements for licensure (APRN Joint Dialogue Group Report, 2008). By 1995, the National Council of State Boards of Nursing (NCSBN) began working with certification examination providers to ensure that examinations were psychometrically tested, sound, and legally defensible for licensure purposes. An outcome of this work was that certification examination providers agreed to become accredited as a quality means of examination assessment. By 2002, NCSBN had developed APRN certification criteria and began working with agencies that offered the examinations toward compliance (APRN Joint Dialogue Group Report, 2008).

Since the initial certificate programs, NP education has expanded to the graduate level with increasing numbers of credits being required over time for a master's degree, with some programs exceeding 55 credits. In the mid 2000s, the Doctor of Nursing Practice (DNP) degree was introduced. The DNP used the ever-increasing NP credit requirements to bring a clinical doctorate in line with other disciplines' degree options, such as the PharmD for pharmacists.

Initially responding to either federal funding or workforce need, multiple subspecialty NP programs began to emerge that focused on narrowly defined NP practice areas such as palliative care or dermatology. Graduates from these programs began to seek licensure as NPs, and many boards of nursing were challenged to provide a broad-based NP license to graduates of programs that had a narrow focus due to lack of validated certification and the potential to be employed in roles broader than their original clinical preparation. The latter could pose a threat to public safety, especially when titles used from state to state varied and did not specify the NPs licensure or population focus. To provide some consistency on a national level about how NPs were being licensed, the NCSBN APRN Advisory Panel addressed this issue and produced a vision paper in 2006 urging uniformity in APRN recognition. The vision paper had varied responses from stakeholders, and over the following two years, nursing organizations and regulators met and developed the 2008 Consensus Model for APRN Regulation (APRN Joint Dialogue Group Report, 2008). In the 10 years since the 2008 Consensus Model was published, NP education programs, accredidators, boards of nursing, certification examinations, and professional organizations have worked to comply with its plan and have sometimes grappled over areas of overlapping scope and setting such as practice in the emergency department by NPs.

Today, NP practice uses the foundation of RN education as a basis for NP education. However, transferability of NP licensure across state lines is still challenged by multiple differences in state laws and SOP. Across the United States, the RN enjoys a basically common SOP and licensure process. Thus, movement from state to state is easily facilitated for the RN who holds an unencumbered license in

their home state. Although the Nurse License Compact and Enhanced Nurse License Compact for RNs has been easy to implement in terms of SOP, other issues have been barriers to national acceptance for the APRN License Compact, and currently, only a few states have approved it (National Council of State Boards of Nursing, 2017).

Practice perspective in establishing scope of practice

Unlike the RN and MD, NPs and other APRNs do not enjoy the same multistate common SOP and face significant barriers to implementing their full practice authority. This is in part due to the perceived encroachment of NP SOP into the SOP of medicine that has existed for decades and has served as the basic argument of why physicians should supervise NPs (Safriet, 2002). Increasing health care needs have caused many other disciplines to evolve their practice to what medicine had prior claimed as solely theirs (American Academy of Family Physicians, 2018a; American Academy of Family Physicians letter to NCSBN, 2018b). Scope of practice should be defined for the NP based on the licensee's skill, education, competency, and role congruence rather than by physician or other health care provider supervision (Klein, 2007).

Education consistency of NP from state to state is evaluated with the same Essentials Documents, and graduates of programs take the same certification examinations that are used as one of the licensure requirements (American Association of Colleges of Nursing, 2018). Nurse practitioner graduates of accredited programs are prepared with both the core competencies for the role and the core competencies for at least one of the population foci identified in the Consensus Model (APRN Joint Dialogue Group Report, 2008). Additional subspecialty certification or residency/fellowships may be used to further define practice beyond the core competencies.

Licensure of NP is not site specific; however, since the implementation of the Affordable Care Act, more patients with complex conditions are being discharged from hospitals and receiving care in what were previously lower acuity settings. Thus, the skills sets required of NPs who are not acute care educated and have had mostly primary care experience may be challenged. The level of patient acuity, complex critical decision-making requirement, and procedures such as ventilator weaning and central line placement or management may require functions beyond the defined SOP for the primary care NP (American Association of Colleges of Nursing, 2017; Kleinpell, Hudspeth, Scordo, & Magdic, 2012).

Employment perspective in establishing scope of practice

Nurse practitioners can find themselves in employment situations whereby their practice decisions could be interpreted as practicing outside of their defined SOP. When these situations occur, boards of nursing (BON) may have practice advisors who can answer NP questions about these situations and provide guidance that will help meet the patient need and also maintain the NP SOP. Some also provide a decision tree model, which can be used to determine how the Board would view a SOP concern or issue. Mitigations to gaps in NP preparation to perform procedures and tasks can often be managed by continuing education, defined competency demonstrations, and possibly a period of supervision by a qualified peer to document procedural proficiency as part of privileging processes. All of these should be coordinated with the BON. However, changing an NP patient population or focus is normally facilitated by the NP completing a formal academic program, commonly awarding a certificate, and completing appropriate board certification.

Scenario 1

An NP completes an Adult-Gerontological program and is certified. After 5 years of clinic practice the NP relocates to a smaller rural community that has a critical access hospital. The state has full practice authority. The only job for an NP in the community is part-time working in the hospital emergency department. The NP worked as an emergency department RN for 10 years before becoming an NP and considers this experience will serve well in this role. Issues: The NP is not restricted by physical location of the practice. The NP is restricted by education and certification. Experience as a RN in the emergency department does not translate to experience as an NP in the emergency department, but it will certainly facilitate understanding of department procedures and processes and aid in department orientation. Credentialing and privileging at the hospital should identify that examining and treating patients who are children and adolescents exceed the NP's SOP and a method of managing those patients should be evident so that the NP is not placed in a situation that could lead to regulatory discipline.

Scenario 2

An NP completes an acute care NP program, passes certification, and becomes licensed. The NP cannot find a job in acute care, so opts to accept an NP position in a community care clinic. Being hired into the role is not that uncommon because many hiring managers are not familiar with the APRN regulatory model and the differences in NP educations and roles. Generally, NPs are not restricted by site locations, but the patient types being seen in a community care clinic may not be congruent with the NP education, certification, and SOP. Community-based care clinics typically serve a large number of patients for chronic and nonacute conditions and emphasize preventive care (National Association of Community Health Centers, 2013). Additionally, many previously educated acute care NPs were educated and certified to care

for adult rather than pediatric patients. Current NPs will be prepared in acute care to see either children or adults, in congruence with the APRN consensus model.

Scenario 3

A women's health NP accepts a position in a family practice clinic and is evaluating and treating the full spectrum of family practice patients and taking an equal share of call coverage. Treating men, with the exception of issues related to reproductive health, and treating children and adolescents is outside of the expected SOP for this NP based on his or her national certification and educational preparation. This creates risk for vulnerable patients, who may believe that they are seeing a family practitioner based on the use of the title NP, and the NP could be disciplined for exceeding the SOP.

Scenario 4

An experienced family nurse practitioner (FNP) takes a job in an intensivist group at medical center. The NP routinely rounds on patients in the intensive care unit, in conjunction with a physician intensivist. In the hospital setting, the NP does not independently manage vasoactive medications, ventilator management, intracranial pressure monitoring devices, or hemodynamics. Is this a good position for the FNP? Although the NP may have competent skills in managing patients, in this scenario, the NP is relying on hospital-based protocols or physician supervision to determine scope. This is a step backward to recognition of the NP's full SOP and authorization based on the NP's own skills and expertise and confuses the role of the NP with that of the physician assistant who still must function in a dependent role.

Future changes to consider

The APRN Consensus Model was published and endorsed by the profession more than 10 years ago. In that time, nursing education and regulation have made remarkable strides in complying with the model. However, practice remains problematic because employers are not always familiar with the nuances of NP education and certification, and they often treat all NPs as interchangeable. Nurse practitioners themselves accept positions that can be outside of their SOP because they need jobs. Even with these situations, we have not seen an increase in malpractice cases or regulatory discipline in the United States due to exceeding SOP (American Association of Nurse Practitioners, 2018; Kenward, 2008).

Based on 10 years of experience, has the NP profession come to a time of rethinking and readdressing education and SOP limitations? Would the public and NPs be better served to have one program and one certification that is more broadly based for licensure requirements, similar to that of the RN? How then could functions of credentialing and privileging ensure public protection given some of the current lack of understanding of the NP role and practice? What is the best and most appropriate mechanism to allow for scope specialization and depth of expertise? These are challenging questions that need to be explored as the parameters of the current APRN consensus model are opened up for reexamination and possible refinement.

Conclusion

Clarification of SOP is essential to safe practice and public protection. Individual NPs have the responsibility to know their current SOP limitations as defined by the educations and certifications they hold and what their state regulatory board has defined as NP SOP. Nurse practitioners should not seek employment in positions that could place them in the situation of breeching their SOP and should not rely on employers or physician supervisors to determine their SOP.

The 2008 Consensus Model for APRN Regulation and the 2010 Institute of Medicine report on the Future of Nursing have guided NP education and practice over the past decade. The outcomes of the Affordable Care Act and the increasing needs from an aging and less healthy US population have altered workplace demands on NPs during that time and will continue to do so in the foreseeable future. Evaluating NP education, refining SOP, and aligning NP practice with the most appropriate patient populations, regardless of practice setting, will continue adding value to the NP role, will aid in meeting the health care provider workforce needs, and will benefit the overall health status of US residents.

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