Improving Access to Health Care in Michigan through Full Practice Authority for Nurse Practitioners: Legislative Task Force White Paper

Michigan Council of Nurse Practitioners

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Executive Summary

Michigan is facing a healthcare provider shortage. It is estimated that by 2025 Michigan will need approximately 1000 primary care providers (United States Health Resources and Services Administration [HRSA], 2016). This is compounded by the fact that many residents of Michigan do not have reasonable geographic access to a regular healthcare provider. Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments.

NPs are licensed professional practitioners, educated at the master's or doctoral levels, and "practice at the highest level of professional nursing practice" (American Association of Nurse Practitioners [AANP], 2015). Several decades of data demonstrate that NPs with full practice authority (FPA) increase access to safe, high-quality, cost-effective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. Twenty-three states have FPA for NPs to facilitate access to health care. Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of physicians. Access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not recognize NPs' education, training, and certification. This limits NPs' ability to practice in the communities where physicians are not working.

Michigan Council of Nurse Practitioners (MICNP) recommends that lifting restrictions on NP scope of practice is a prudent decision to facilitate access to care. NPs improve access to health care by increasing the health care workforce capacity of fully qualified professional providers who are available to care for patients in diverse care settings. MICNP calls for Michigan legislators to modernize statutes to adopt and authorize FPA inclusive of full prescriptive authority for NPs in all healthcare settings, permanently. This will make NP practice in Michigan current with evolving national standards of care

and improve Michigan residents' access to affordable health care. This reflects Governor Whitmer's health care priorities which focus on making health care more affordable; expanding access to health care; improving health care quality; and investing in public health.

Introduction/Background

Michigan is facing a healthcare provider shortage; it is estimated that by 2025 Michigan will need approximately 1000 primary care providers (HRSA, 2016). Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. As board certified professionals, NPs support innovative healthcare delivery models that provide health systems the flexibility to implement processes that maximize effectiveness with efficiency to improve access to care and the overall patient experience. The success of Michigan's health care system to adequately respond to health care needs and provide access to care for residents depends on health care providers being able to practice to the full extent of their education, training, and certification.

NPs are licensed professional practitioners, educated at the master's or doctoral levels, and "practice at the highest level of professional nursing practice" (American Association of Nurse Practitioners [AANP], 2015). NPs integrate the nursing model of care-emphasizing health, wellness, disease prevention and early intervention to prevent complications, including patient education, advocacy, and population health, when caring for their patients. NPs, as a profession, have more than five decades of expertise within diverse clinical settings in both rural and urban communities. These clinical settings include primary care, specialty care, acute care (inpatient/ ED/ urgent care) and long-term care settings (residential facilities/ hospice).

AANP (2019) issued the following statement about NP scope of practice (SOP): "As licensed, independent practitioners, NPs practice autonomously and in coordination with health care professionals and other individuals. NPs provide a wide range of health care services including the diagnosis and management of acute, chronic, and complex health problems, health promotion, disease prevention, health education, and counseling to individuals, families, groups, and communities. NPs serve as health care researchers, interdisciplinary consultants, and patient advocates". Twenty-three states, the District of Columbia and two territories have full practice authority (FPA) for NPs to facilitate access to health care. FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. AANP (2020) defines FPA as legal authorization of NPs to "evaluate patients,

diagnose, order and interpret diagnostic tests, initiate and manage treatments - including prescribing medications and controlled substances- under the exclusive license authority of the state board of nursing", without the requirement of physician supervision.

Several decades of data demonstrate that NPs with FPA increase access to safe, high-quality, cost-effective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). NPs mitigate health disparities by improving access to care and quality of care. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments than those cared for by other health care providers (Dill, et al., 2013; Leach et al., 2018). Collectively, these patient behaviors contribute to lower health care costs, overall, as problems are identified early and complications are avoided or minimized (Martin-Misener et al., 2015; Neff, et al., 2018; Newhouse et al., 2011; Phillips & Bazemore, 2010; Sonenberg & Knepper, 2017; Xue, et al., 2016). In 2018, $44.5 billion was saved in Medicare spending in 3,143 counties in the United States (U.S.) in which NPs have FPA. It is recommended to require NP patient encounters to not be billed for services under "incident to" billing. The Commission estimates the Medicare program will reduce spending by $50 – 250 million in the first year and by $1 – 5 billion over a 5-year period (Medicare Payment and Advisory Commission [Medpac], 2019). Cost of clinic visits in states with restricted NP practice averaged the highest in the U.S. (Chattopadhyay & Zangaro, 2019). Studies have also shown NPs are more likely to practice in rural and health care shortage areas and are more likely to provide primary care (Westat, 2015). NPs working in critical care settings have demonstrated reductions in the number of inpatient days (length of stay), shortened time to consultation and treatment, improved mortality, improved patient satisfaction, and cost reductions (Jennings et al. 2015; Woo et al., 2017). It has been noted that NPs are cost effective, provide savings to patients, insurance payers, health systems and society (taxpayers) (Chattopadhyay & Zangaro, 2019; Martin & Alexander, 2019; Poghosyan et al., 2019). Additionally, in states with full NP practice authority, patients received more health education services from NPs as compared to other providers.

States that are highest in health rankings have NP FPA laws (see Appendix A). The United Health Foundation (UHF), American's Health Ranking Report, is an annual snapshot of over 30 measures reported out as a composite index score. States are ranked in order of best outcomes. Michigan ranks 32nd and has restricted NP practice authority. As compared to other states, in 2019, Michigan underperformed in the following core measures, ranked by order of severity: smoking, frequent physical distress, cardiovascular deaths, frequent mental distress, obesity, infant mortality, cancer deaths, preventable hospitalizations, drug deaths, premature deaths, diabetes, excessive drinking, pertussis, childhood immunizations, and physical inactivity (UHF, 2020).

NPs have master's or doctoral degrees in advanced practice nursing from universities that meet national accreditation standards for nursing curriculum. NPs pass competency exams for national board certification in their areas of expertise. Board certifications indicate specialized advanced-practice education in caring for specific patient populations. For primary care NPs, practice populations include family practice, adult/geriatrics, pediatrics, psychiatric mental health, or womens' health. Additionally, there are NPs who specialize in acute care and populations such as adults, pediatrics, neonatal, psychiatric, or emergency. It is important to note that prior to entry into an NP program, candidates have already earned a baccalaureate degree, and have passed state licensure examination as professional registered nurses (RNs).

Statement of the Problem

Michigan has 138,155 actively licensed registered nurses (RNs) as of March 2020 (Michigan Department of Licensing and Regulatory Affairs [LARA], 2020), with 11,708 (8.4%) of those RNs additionally holding specialty certification. Seventy-three percent or 8,602 of the RNs who hold specialty certification in Michigan are listed as NPs (6.2% of total RNs). Michigan recognizes the NP as an advanced practice registered nurse (APRN) in statute 2016 PA 499 (in effect in April 2017). Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of a physician. Currently NPs do not have a defined SOP in statute in the state of Michigan (Patel, Petermann & Mark, 2019; Michigan Public Health Code [PHC], 1978/2017).

Patient access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not authorize NPs to have FPA. Access to health care involves more than just a geographic component. Health care is accessible when it is *available* (timely, near to home), *appropriate* (evidence-based for the condition and measured by health outcomes; given in the appropriate healthcare setting: primary, specialty, long term, or acute care), *affordable* (cost effective, efficient), and *accountable* to patients, as evidenced by provider education, training and certification. This is consistent with Governor Whitmer's health care priorities which focus on: making health care more affordable; expanding access to health care; improving health care quality; and investing in public health (Mich.gov, 2021). According to Hart, Ferguson & Amiri (2020), states with restrictive NP scope of practice laws experience: 1) reduced overall access to care, 2) increased cost of care with no appreciable increase in quality, and 3) stifling of healthcare organizations due to fewer options for innovative business models that respond to market conditions.

Michigan's restrictive practice environment hinders NP recruitment and decreases access to care. Many NPs prefer to work in other states with FPA. This drains the health care NP labor pool resources away from Michigan. To practice in this state, NPs are required to have collaborative agreements with physicians. In some circumstances NPs are required to pay fees to physicians to secure this agreement (Gilman & Koslov, 2014). This can add to the cost of care either directly (payments to the physician) or indirectly, consuming physician time that could be spent on direct patient care (Rudner, 2017). The multitude and complexity of issues related to restrictions on NP practice is vast. There is a considerable array of literature that has been published on these topics. The reader is referred to Appendix B for an annotated bibliography of the available literature. The full article will be made available to the reader upon request.

Current Policies

Currently NPs do not have a defined SOP in statute in the state of Michigan. The practice of nursing is currently defined in statute according to the Michigan Public Health Code (PHC). The Michigan Public Health Code (PHC, 1978) defines the practice of nursing as:

> "...the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury or disability" (p. 449).

On June 1, 2019, Michigan Department of Health and Human Services (MDHHS) issued an updated bulletin regarding the requirement for a collaborative practice agreement between NPs and physicians who care for Medicaid patients. Under the 2019 updates, the NP must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. If the physician is disenrolled from Medicaid, the NP is subject to disenrollment. This requirement for collaborative agreement is not part of the Michigan PHC. Additionally, Centers for Medicare and Medicaid Services (CMS) does not require that the collaborative physician be physically on the premises where NP services are rendered (MDHHS, 2019). Rather, the language states that a physician needs to be available to the NP while they are providing care to patients.

In 2017 the PHC was updated to allow NPs to prescribe non-scheduled prescriptions independently. The PHC (1978/2017), section 333. 17221, states explicitly: PHC, (1978/2017), section 333.17211a (1) (a) outlines that APRNs may prescribe non-scheduled prescription drugs independently. PHC, 333.5658 section (b) explicitly states that prescription of controlled substances is the SOP of the physician (p. 128). In Michigan, physicians may delegate this responsibility to APRNs (pgs. 334/451). A controlled substance prescribed by an APRN must include both the APRN and physician names, with DEA information for both prescribers, on the prescription (p. 451).

Policy Recommendations, Feasibility & Implementation Strategies

Michigan Council of Nurse Practitioners (MICNP) opines that lifting restrictions on NP scope of practice is a prudent decision to facilitate access to care. Health outcomes improve, and morbidity and mortality decrease when people have access to consistent health care. NPs improve access to health care by increasing the health care workforce capacity of fully qualified professional providers who are

available to care for patients in diverse care settings. NPs work in collegial and collaborative multidisciplinary relationships with other health care professionals to provide continuity of care to patients with acute and chronic conditions. They are instrumental in meeting the need of increased demand for timely appointments in outpatient settings (primary, specialty, and commercial care clinics); particularly as health care coverage is expanded throughout the state. NPs facilitate coordination of care and resources within different healthcare organizations. They provide specialty referral and consultations as needed. NPs monitor social determinants of health and connect patients to community resources, and provide education to patients, patients' families, and communities.

Stakeholders such as the Federal Trade Commission (FTC), the Robert Wood Johnson Foundation, the Institute of Medicine (now the National Academy of Medicine), the American Association of Retired Persons (AARP), and the National Governors Association (NGA), recommend FPA for NPs (Institute of Medicine, 2010; Newhouse et al., 2011; Schiff, 2012). The AARP encouraged states, without FPA for NPs, to suspend restrictive laws at the onset of the COVID19 pandemic. AARP has been a proponent of FPA for NPs since well before the recent pandemic. They have been involved in legislative initiatives around the country to achieve NP FPA in other states, as well as Michigan. For each state that acted, the decision to lift restrictions enlarged the pool of available clinicians and gave consumers improved access to care (Quinn, Brassard & Gualtieri, 2020).

Gilman and Koslov (2014) acknowledge that restrictive practice environments preclude healthcare providers and healthcare organizations from developing innovative business models in response to consumer healthcare needs, preferences, and new technologies. They also conclude that direct physician supervision of NP practice is unnecessary in settings where healthcare professionals use many forms of interdisciplinary collaboration within the healthcare team.

Adams and Markowitz (2018) with the Hamilton Project of the Brookings Institute wrote in a strategy proposal that:

> "In an era characterized by high levels of U.S. healthcare spending and inadequate health outcomes, it is vital for policymakers to explore opportunities for enhancing productivity.

> Important productivity gains could be achieved by altering the mix of labor inputs used in the healthcare sector. However, the potential for these gains is sharply limited by anticompetitive policy barriers in the form of restrictive scope of practice (SOP) laws imposed on …advanced practice registered nurses. …these laws restrict competition, generate administrative burdens, and contribute to increased healthcare costs, all while having no discernable health benefits" (p.2).

Summary/Conclusion

Michigan Council of Nurse Practitioners (MICNP) calls for Michigan legislators to modernize statutes to adopt and authorize FPA for NPs in all healthcare settings, permanently. This will make NP practice in Michigan current with evolving national standards of care. MICNP is offering clear guidance in this policy initiative to aid policymakers with meeting the healthcare needs of Michigan residents. FPA will improve patient health outcomes and strengthen Michigan's economic recovery by increasing our healthcare workforce availability, efficiency, effectiveness, and flexibility to address health care disparities. This will strengthen Michigan's ability to meet future care challenges in an ever-changing health care environment.

MICNP recommends that legislators permanently remove restricted practice authority statutes and anti-competitive barriers to NP practice. We recommend legislation to define scope of practice for NPS in the state of Michigan that allows them to practice to their full extent of education and training, including the addition of prescriptive authority to prescribe controlled substances as a function of NP scope of practice. By allowing Michigan to fully benefit from the available NP labor pool, residents will have increased access to care, improved health outcomes, reduced healthcare expenditures, and increased labor flexibility within healthcare organizations.

References

Adams, K. E., & Markowitz, S. (2018, June). Improving efficiency in the health-care system: Removing anticompetitive barriers for advanced practice registered nurses and physician assistants. The Hamilton Project, Brookings. Retrieved from https://www.hamiltonproject.org/papers/removing_anticompetitive_barriers_for_advanced_practice_registered_nurses_a

American Association of Nurse Practitioners, (2015). Use of terms such as mid-level provider and physician extender. Retrieved from https://www.aanp.org/advocacy/advocacy-resource/position-statements/use-of-terms-such-as-mid-level-provider-and-physician-extender

American Association of Nurse Practitioners. (2017). Advocacy resources. Clinical outcomes: The yardstick of clinical effectiveness. https://www.aanp.org/advocacy/advocacy-resource/position-statements/clinical-outcomes-the-yardstick-of-educational-effectiveness

American Association of Nurse Practitioners. (2017). NP Facts. http://www.aanp.org/all-about- nps/np-fact-sheet

American Association of Nurse Practitioners. (2019). Advocacy resources. Scope of practice for nurse practitioners. https://www.aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners

American Association of Nurse Practitioners, (2020, Feb.). Nurse Practitioners. Retrieved from https://www.aanp.org/

Chattopadhyay, S. & Zangaro, G. (2019). The economic cost and impacts of scope of practice restrictions on nurse practitioners. *Nursing Economics 37*(6), 273-283.

Dill, M. J., Pankow, S., Erickson, C., & Shipman, S. (2013). Survey shows consumers open to a greater role for physician assistants and nurse practitioners. *Health Affairs 32*(6), 1135-1142. doi: 10.1377/hlthaff.2012.1150

Gilman, D. & Koslov, T. (2014, March). Policy perspectives: Competition and the regulation of advanced practice nurses. *Federal Trade Commission.*

https://campaignforaction.org/ftc-expanded-aprn-scope-practice-good-competition-consumers/

Hart, L., Ferguson, R. & Amiri, A. (2020, February). Full scope of practice for Alabama nurse practitioners: Act now. *The Journal of Nurse Practitioners*, *16*(2) 100-103. https://doi.org/10.1016/j.nurpra.2019.10.016

Institute of Medicine. (2010). The Future of Nursing: change, advancing health. Washington, D.C.: Institute of Medicine

Jennings N., Clifford S., Fox A. R., O'Connell J. & Gardner G. (2015). The impact of nurse practitioner services on cost, quality of care, satisfaction and waiting times in the emergency department: A systematic review. *International Journal of Nursing Studies*, *52*(1), 421-35. doi: 10.1016/j.ijnurstu.2014.07.006.

Leach, B., Gradison, M., Morgan, P., Everett, C., Dill, M. J. & Strand de Oliveira, J. (2018). Patient preference in primary care provider type, *Healthcare 6*(1), 13-16. https://doi.org/10.1016/j.hjdsi.2017.01.001

Martin, B. & Alexander, M. (2019, January). The economic burden and practice restrictions associated with collaborative practice agreements: A national survey of advanced practice registered nurses. *The Journal of Nursing Regulation*, *9*(4), 22-30. https://doi.org/10.1016/S2155-8256(19)30012-2

Martin-Misener, R., Harbman, P., Donald, F., Reid, K., Kilpatrick, K., Carter, N., Bryant-Lukosius, D. & DiCenso, A. (2015). Cost-effectiveness of nurse practitioners in ambulatory care: Systematic review. *BMJ Open* 5:e007167 doi: 10.1136/bmjopen-2014-007167.

Medicare Payment Advisory Commission (Medpac). (2019, June 19). *Issues in Medicare beneficiaries' access to primary care*. Report to the Congress: Medicare and the Health Care Delivery System. http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf

Michigan Department of Health and Human Services. (2019). Michigan services administration bulletin. MSA 19 - 10. https://www.michigan.gov/documents/mdhhs/MSA-19-10_653847_7.pdf

Michigan Department of Licensing and Regulatory Affairs (LARA). Accessed March 2020.

https://www.michigan.gov/lara/

Michigan.gov. (2021). *Health Care*. The Office of Governor Gretchen Whitmer. https://www.michigan.gov/whitmer/0,9309,7-387-90500_90628---,00.html

Michigan Public Health Code [PHC]. (1978). http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

National Governors Association (NGA). (2012). The role of nurse practitioners in meeting increasing demand for primary care. *NGA Paper*. https://www.nga.org/wp-content/uploads/2019/08/1212NursePractitionersPaper.pdf

Neff, D. F., Yoon, S. H., Steiner, R. L., Bejleri, I., Bumbach, M. D., Everhart, D., & Harman, J. S. (2018). The impact of nurse practitioner regulations on population access to care. *Nursing Outlook*, *66*(4), 379-385. doi:10.1016/j.outlook.2018.03.001

Newhouse, R. P., Stanik-Hutt, J., White, K. M., Johantgen, M., Bass, E. B., Zangaro, G., Wilson, R. F., Fountain, L., Steinwachs, D. M., Heindel, L. & Weiner, J. P. (2011). Advanced practice nurse outcomes 1990-2008: A systematic review. *Nursing Economics, 29(*5), CNE Series, 1-21.

Patel, E., Petermann, V. & Mark, B. (2019). Does state-level nurse practitioner scope-of-practice policy affect access to care? *Western Journal of Nursing Research*, *41*(4) 488–518. doi: 10.1177/0193945918795168

Phillips, R., & Bazemore, A. (2010). Primary care and why it matters for US health system reform. *Health Affairs*, *29*(5), 806-810.

Poghosyan, L., Timmons, E. J., Abraham, C. M. & Martsolf, G. R. (2019). The economic impact of expansion of nurse practitioner scope of practice for Medicaid. *Journal of Nursing Regulation 10*(1), 15-20.

Public Act 499 (2016). http://legislature.mi.gov/doc.aspx?2016-HB-5400

Rudner, N. & Kung, Y. M. (2017). An assessment of physician supervision of nurse practitioners. *Journal of Nursing Regulation 7*(4), 22-29.

Schiff, M. (2012, Dec.). The role of nurse practitioners in meeting increasing demand for

primary care. National Governors Association. Retrieved from https://www.nga.org/center/publications/health/the-role-of-nurse-practitioners-in-meeting-increasing-demand-for-primary-care-2/

Sonenberg, A., & Knepper, H. J. (2017). Considering disparities: How do nurse practitioner regulatory policies, access to care, and health outcomes vary across four states? *Nursing Outlook*, *65*(2), 143-153. doi:10.1016/j.outlook.2016.10.005.

The Hamilton Project. (2018, June). Policy Brief, 2018-08. *Improving Efficiency in the Health-Care System: Removing Anti-Competitive Barriers for Advanced Practice Registered Nurses and Physician Assistant.* www.HAMILTONPROJECT.ORG

Quinn, W., Brassard, A. & Gualtieri, C. (2020, April). Thinking policy: AARP pushes states to increase access to care. *American Association of Retired Persons*. https://blog.aarp.org/thinking-policy/aarp-pushes-states-to-increase-access-to-care

United Health Foundation. (2020). Annual report: America's health ranking report. https://www.americashealthrankings.org/explore/annual/measure/Overall/state/MI

United States Health Resources and Services Administration (HRSA) (2016, November). *State-level projections of supply and demand for primary care practitioners: 2013-2025.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/primary-care-state-projections2013-2025.pdf

Westat (2015, November). Impact of state scope of practice laws and other factors on the practice and supply of primary care nurse practitioners. *Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services*. https://aspe.hhs.gov/system/files/pdf/167396/NP_SOP.pdf

Woo, B. F. Y., Lee, J. X. Y. & Tam W. W. S. (2017). The impact of the advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: A systematic review. *Human Resources in Health 15*(63), doi: 10.1186/s12960-017-0 237-9.

Xue, Y., Kannan, V., Greener, E., Smith, J. A., Brasch, J., Johnson, B. A. & Spetz, J. (2018). Full scope-of-practice regulation is associated with higher supply of nurse practitioners in rural and primary health professional shortage counties. *Journal of Nursing Regulation 8*(4), 5-13.

Xue, Y., Ye, Z., Brewer, C., & Spetz, J. (2016). Impact of state nurse practitioner scope-of practice regulations on health care delivery: Systematic review. *Nursing Outlook, 64*, 71- 85.

Appendix A

State categorized by NP scope of practice laws and 2019 Health Ranking Report

State by NP scope of practice (SOP) laws (includes D.C. & territories)	States	Health Ranking	Average health ranking by category of SOP laws
Full scope of practice	Alaska Arizona California Colorado Connecticut Florida (2020) Guam Hawaii Idaho Iowa Maryland Minnesota Montana Nebraska New Hampshire New Mexico Nevada North Dakota Oregon Puerto Rico Rhode Island South Dakota Washington, D.C. Washington Wyoming Vermont	27 31 12 10 4 33 - 3 16 20 18 7 24 17 6 37 35 14 22 - 13 25 - 9 19 1	Average health ranking: $(\sum/23^*) = 17.5$ *Territories and D.C. excluded due to lack of health ranking data
Reduced scope of practice	Alabama Arkansas Delaware Illinois Indiana Kansas Kentucky Louisiana Mississippi New Jersey New York Ohio Pennsylvania Utah West Virginia	47 48 30 26 41 29 43 49 50 8 11 38 28 5 45	Average health ranking: $(\sum/16) = 32$

	Wisconsin	23	
Restricted scope of practice	Georgia Massachusetts Michigan Missouri North Carolina Oklahoma South Carolina Tennessee Texas Virginia	40 2 32 39 36 46 42 44 34 15	Average health ranking: $(\sum/10) = 33$

(AANP, 2019; UHF, 2020)