



INDEPENDENT PRACTICE & THE CERTIFIED NURSE PRACTITIONER A White Paper

**National Organization of Nurse Practitioner Faculties
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Introduction

A Certified Nurse Practitioner (CNP) is a licensed, advanced practice registered nurse (APRN) who has completed a prescribed educational program that includes advanced knowledge, skills, and abilities in assessment, diagnosis, treatment, and management. CNPs provide care to individuals, families, and groups in accordance with their educational preparation and national certification, both independently and in collaboration with other healthcare professionals. Using a population-based focus, the CNP works to reduce disparities in access to care and promotes cost effectiveness through patient advocacy, policy advancement, and the development of innovative models of care to improve patient outcomes (National Organization of Nurse Practitioner Faculties [NONPF], 2012). Currently, state-specific scope of practice regulations that mandate collaboration and/or supervision by physicians constrain full utilization of CNPs to meet the healthcare needs of the population. This lack of full practice authority interferes with the CNP's ability to care for clients independently. Therefore, the purpose of this paper is to outline the major issues related to CNP independent practice and to highlight recommendations that will assist nurse practitioner faculty and policy makers in determining a model of care that enables CNPs to contribute fully to the present and future healthcare needs of the nation.

Background

The need for qualified health care professionals has never been greater. The current health care system is challenged by gaps in quality of care, patient safety, and accessibility of affordable care. The United States (U.S.) has a rapidly aging population; nearly 18% of whom will be 65 years old or greater by 2025 (U.S. Census Bureau, 2012). These changing demographics, coupled with longer life expectancies, will result in an explosion in the number of Medicare beneficiaries who will need primary care and chronic disease management. Chronic

illnesses account for 7 out of 10 deaths annually, with almost 50% of Americans suffering from at least one chronic disease (Centers for Disease Control and Prevention [CDC], 2012). In a 2011 report, the U.S. ranked last out of 16 high-income nations in preventable deaths (Commonwealth Fund, 2011). As a result of the Patient Protection and Affordable Care Act (PPACA), over 30 million people will gain access to primary care services by 2014 (Naylor & Kurtzman, 2010). However, physician shortages, especially in primary care, will not be able to meet these demands, as the nation will require 40% more primary care providers by 2020 (Hauer et al., 2008).

Addressing these increased demands for primary care and chronic illness management will require significant changes in the organization and delivery of health care in the U.S. Accountable care organizations, patient-centered medical homes, and community-based care will require the development of interprofessional teams, who work in concert with each other to improve health outcomes (Fairman, Rowe, Hassmiller, & Shalala, 2011). Moreover, all members of the health care team will need to work to their full capacity. A key message in the Institute of Medicine (IOM) *Future of Nursing: Leading Change, Advancing Health* document is that CNPs should be utilized to the full extent of their education and training and that they need to become full partners with physicians and other health care professionals (IOM, 2011).

One of the reasons that many CNPs are unable to practice to the full extent of their education and training is rooted in history and traditions that are no longer appropriate for today's rapidly advancing health care system. Physicians were the first group of health care providers to be regulated through state licensure. As a result, medical scope of practice is all encompassing in regards to the ability to diagnose, prescribe, treat, and cure (Safriet 1992). As other health care professions required regulation, they had to "carve out" tasks or functions from those belonging to the medical scope of practice (Safriet, 1992). Currently, multiple health care professions such as psychologists, optometrists, pharmacists, advanced practice nurses, physician's assistants, and physicians have overlapping scopes of practice. Organized medicine has supported scope of practice regulations to safeguard patient safety and to ensure that CNPs are only allowed to practice primary care with physician supervision (Iglehart, 2013). These historical factors have played a significant role in the current lack of standardization in NP scopes of practice across the U.S.

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (APRN Consensus Work Group & National Council of State Boards of Nursing [NCSBN] APRN Advisory Committee, 2008) is a unifying framework for the licensure, accreditation, certification and education of all APRNs. As stated in the Consensus Model document, “individual (nurses) will be licensed as independent practitioners at the level of one of the four APRN roles within at least one of the six identified population foci” (APRN Consensus Work Group, & NCSBN APRN Advisory Committee, 2008, p.6). The four APRN roles include Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, and Certified Nurse Practitioners.

A CNP is considered an independent practitioner with full practice authority when both the registered professional nurse (RN) and CNP state licenses do not mandate a practice agreement with a physician or another healthcare provider. A CNP, who is an independent practitioner, has full prescriptive privileges that include the administration and prescription of pharmacologic and non-pharmacologic interventions without a requirement for collaboration, supervision, or oversight by any other health care provider. In addition, CNP prescriptive privileges are not limited to a defined formulary (APRN Consensus Work Group, & NCSBN APRN Advisory Committee, 2008). Currently, only 17 states in the U.S. (AL, AZ, CO, DC, HI, ID, IA, ME, MT, NH, NM, ND, OR, RI, VT, WA, WY) have adopted full practice authority, with Nevada becoming the 18th state in July 2014 (American Association of Nurse Practitioners [AANP], 2013). While many states allow autonomous practice (i.e., CNPs diagnose and treat patients without physician involvement), collaboration or supervision requirements for both the provision of care and the ability to prescribe medications vary widely in the remaining states.

Contributions of Certified Nurse Practitioners

CNPs are well-educated, licensed, skillful professionals who are prepared to function within various health care settings, including both primary and acute care environments. The APRN Consensus Model defines the specific population foci of the CNP and completion of a CNP program requires mastery of specific, validated core competencies within that population (NCSBN, 2012). These competencies are acquired through mentored patient care experiences that emphasize independent and interprofessional practice, evidence-based and patient centered care, and knowledge of a complex health care delivery system (NONPF, 2012; Population-Focused Competencies Task Force, 2013). Thus, CNPs are well qualified to advance health and lead change in the health care system and have long had the potential to

positively impact the three main factors that determine efficacy of a health care system: Access to care, quality of care, and cost of care (Safriet, 1992; IOM, 2011).

Access to Care

Implementing the PPACA will result in an increased demand for health care, specifically primary care (Josiah Macy, Jr. Foundation, 2010). Primary care access is of particular concern as a strong primary care foundation has been shown to improve quality of care and reduce health care costs (Josiah Macy, Jr. Foundation, 2010). In 2010, of the estimated 624,424 practicing physicians in the US, less than one-third were primary care physicians (Agency for Healthcare Research and Quality [AHRQ], 2010a). These numbers are expected to decline, as fewer medical students choose to enter primary care specialties (IOM, 2011; Naylor & Kurtzman, 2010; Bodenheimer & Pham, 2010). In 2010, CNPs accounted for 56,000 of the primary care providers in the US (AHRQ, 2010b); by 2025, the number of CNP's who are primary care providers is projected to reach 198,000 (Auerbach, 2012).

Unfortunately, numbers alone will not produce increase access to care without the development of new and innovative health care delivery models. The success of delivery models such as accountable care organizations (ACA), patient-centered medical homes (PCMH), community health centers and nurse-managed health centers, will require that CNPs have the ability to practice independently, without restrictive regulations that impede patient access (Fairman et al., 2011). CNPs cannot achieve this level of practice and improve access to care if their practice is subordinate to physicians by means of supervisory or collaborative requirements (Lee, 2011). A physician's decision to enter into such agreements is voluntary and unregulated by any medical standards, thus the CNP's ability to practice under these types of clauses is completely dependent upon the physician's willingness to do so (Safriet, 1992). Full scope of practice within a true partnership relationship cannot be achieved under the premise of a defined hierarchical relationship.

Quality of care

The current literature clearly indicates that CNPs deliver high quality, effective care (O'Grady, 2008; Kuntz, 2011; Health Policy Brief, 2012). Numerous individual and comparison studies, as well as meta-analyses, have demonstrated that the quality of CNP care is comparable to, and in some cases better, than the care provided by physicians. In 1986, the U.S. Congress, Office of Technology Assessment released a policy analysis examining nurse

practitioners, physician assistants, and certified nurse-midwives. Studies addressed CNPs' abilities to resolve acute problems, adequacy of prescribing practices, communication and counseling, treatment of ambulatory chronic conditions, patient outcomes (patient return to employment, reduction in symptoms, control of blood pressure, reduction in pain, weight gain reduction), health status and patient satisfaction. Results indicated that CNPs provided equivalent (10 studies), and in some cases, better care (12 studies) than physicians (U.S. Congress, Office of Technology Assessment, 1986).

In a more recent investigation, Mundinger and associates (2000) performed a randomized controlled trial to compare the outcomes of patients assigned to either a CNP or a physician. The results indicated that patient outcomes were comparable both at six months (Mundinger et al., 2000) and at two years (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004). In the largest systematic review to date, Newhouse and colleagues (2011) found that patients reported equivalently high levels of satisfaction with care from both CNPs and physicians. Outcomes related to self-perceived health status, level of functional ability, blood glucose and hypertension control were also comparable. Of interest, lipid control was found to be better with a CNP provider than with a physician provider. Together, these studies provide additional evidence to the solid body of research that supports the role and contributions of CNPs in providing effective and high quality care.

Cost of care

Ignoring the key messages of the *Future of Nursing* report (IOM, 2011) and underutilizing CNPs by denying them primary care provider status, has a direct economic impact on health care expenditures in the U.S. (Weiland, 2008). Studies have shown that costs for similar services are generally less when provided by CNPs (Bakerijan, 2008; Bauer, 2010). Savings have been demonstrated across settings including primary, acute, and long-term care (Chen, McNeese-Smith, Cowan, Upenieks, & Afifi, 2009; Doddington & Sands, 2009; Paez & Allen, 2006). Chenoweth and colleagues (2005) reported that annual health care costs were reduced by \$1.3 million by implementing an on-site nurse practitioner-directed program in a manufacturing plant.

Restriction of CNP practice has repercussions for innovative health care delivery models, such as retail clinics, where cost savings have been documented (Fairman et al., 2011). Utilizing CNPs has demonstrated a cost savings in Massachusetts of \$4.2 to \$8.4 billion

dollars over a 10-year period; additionally, estimations are that removing restrictions on CNP practice and offering more retail clinics will save an additional \$6 billion dollars (Eibner, Hussey, Ridgely, & McGlynn, 2009).

Compared to physicians, CNPs traditionally are reimbursed at a lower Medicare rate for delivery of the same services. Yet, it is estimated that a cost savings would remain, even if CNPs were to receive equivalent reimbursement, because they utilize fewer resources than physicians (Health Policy Brief, 2012). In acute care settings, provision of critical care services contributes significantly to health care spending and resource utilization. High costs in acute care settings are often related to extended lengths of stay. Studies have shown a trend in decreased critical care unit length of stay when CNPs and physician assistants are utilized (Medeiros, NeSmith, Heath, Hawkins, & Hawkins, 2011). Additional studies are required to further elucidate the financial impact and cost savings associated with CNPs in both primary and acute care. However, obtaining any meaningful cost, safety, and/or efficacy data related to CNP scope of practice is extremely difficult to produce without first lifting practice restrictions.

CNP Scope of Practice

Scope of practice defines the activities permitted by a health care provider in the delivery of patient care. The entire scope of activities within the practice makes any profession unique. Simply because a skill or activity is within one profession's scope of practice, does not mean another profession cannot or should not include it in its own scope of practice (Safriet, 2010). Currently, there are overlapping scopes of practice among a variety of health care providers. However, according to NCSBN (2009) being "qualified to perform functions safely without harm to the public, should be the only justifiable conditions for defining scopes of practice" (p 15).

Scope of practice is determined primarily by each state legislature via the Nurse Practice Act and reflects education, competence, and responsibility (Skar, 2009). The nursing profession, through its professional associations, recommends a scope of practice for APRNs based on level of education, competency, and certification. The individual state boards of nursing, along with the state legislature, determine the state Nurse Practice Act, or rules and regulations that codify the professional scope and standards of practice for CNP's. The scope of practice for CNPs in each state reflects a dynamic interaction between the regulatory body for the nursing profession and the policy makers (Edwards, Rowan, Marck & Grinspun, 2011).

Scope of practice is what the law allows a CNP to do in providing patient care (Klein, 2005). Although simple, the definition of scope of practice is the crux of the issue with full practice authority and independent practice. One of the most pressing issues is the lack of standardization and discrepancy in the level of practice among CNPs across states (Kuntz, 2011). Pearson (2012) provides a yearly report of CNP legislation and scope of practice issues in each state and the District of Columbia. In the past 24 years of the report, the most consistent barrier to full practice authority and independent practice by CNPs is the requirement for physician input into CNP diagnosing, treating, and prescribing. According to Safriet (1992), when physician supervision/direction of CNP practice is required, the state has privatized a core governmental function, assessing competence for licensed practice. When physician supervision/collaboration is required, scope of practice is no longer determined by the state, but by the physician supervisor.

Scope of practice determines the activities that are reimbursable by third party payers and directly impacts the independent practice of CNPs (Safriet, 2010). When physician collaboration/supervision is required, CNPs are less likely to be empanelled by insurers and are unable to directly bill for the services they provide (Weiland, 2008). Instead, their services are billed under the physician's provider number. Eliminating the requirement for physician involvement will allow CNPs to be credentialed as providers and be directly reimbursed for services.

Another issue related to scope of practice is the lack of universal, federal recommendations for mobility across states for practitioners involved in telemedicine. The significant discrepancy in CNP scopes of practice across states limits the ability of expert CNPs to be utilized as consultants across state lines, thereby directly affecting the ability of individuals to get specialty consultation that may not be locally available.

The need for consistency in state regulations has never been more relevant and has significant implications for both providers and patients. Naylor and Kutzman (2010) presented a compelling argument for standardization of state laws governing practice. In their study of nurse migration, it was reported that nurses, including CNPs, move to states with less restrictive scopes of practice. Migration of CNPs may contribute to the shortage of primary care providers, especially in disadvantaged areas (Kalist & Spurr, 2004). In their study of how scope of practice legislation impacts the decision to enter a CNP program, Kalist and Spurr (2004) reported that

the rate of student enrollments in APRN programs was 30% higher in states with less restrictive scopes of practice. These investigators assert that more of these graduates will stay and practice, thereby increasing primary care access in these states.

Regional differences in scope of practice have a direct impact on nurse practitioner faculty and the education of novice CNP students. Despite the relative standardization of the didactic content of CNP programs, the standardization of CNP clinical preparation as an independent provider can be limited because of the state by state variations in scope of practice. For example, a student may be enrolled in an educational program delivered in a state that has statutes and regulations supporting full practice authority for independent practice; however, some of the student clinical practice experiences may occur in another state with collaborative or supervisory requirements.

Education and Independent Practice

The construct of independent practice is an integral component of the competencies upon which CNP education is based. The student acquires the NONPF NP Core Competencies (2012) through mentored patient care experiences with particular emphases: fostering independent and interprofessional practice, building analytic skills for evaluating and providing evidence-based and patient centered care across settings, and advancing knowledge of the health care delivery system. The goal of CNP education is to prepare practitioners who are competent to manage a patient's health/illness status, including health promotion and disease prevention, regardless of the population served. To accomplish this goal, graduates must have the knowledge, skills, and abilities that are essential to independent clinical practice.

Nurse practitioner faculty must continue to emphasize this educational content with students. Ongoing development and implementation of programs that prepare CNPs to practice to the full scope of their education as collaborative, yet equal partners and leaders of health care, is essential. Additionally, in preparing for true interprofessional practice, health care educators across disciplines need to role model collaborative communication as well as continue to design and develop interprofessional educational programs (Pohl, Hanson, Newland, & Cronenwett, 2010).

As faculty continue to prepare CNPs for full practice authority and independent practice, students need ongoing and specific didactic content as well as clinical practice experiences in

effective team leadership, health policy change, and practice management. Additionally, CNP students will continue to need the skills to analyze and improve their own health care microsystems using evidence-based practice and quality improvement initiatives. These programs also need to continue to include course work that prepares CNPs to be leaders in the analysis and evolution of larger macrosystems, including the nation's health care system.

Conclusion

The current U.S. health care system faces numerous challenges presented by demographic, economic, and political pressures. Projected increases in the number of individuals able to access health care, increased expenditures, and growing populations of the elderly and chronically ill all point to a critical need to expand the number of primary care providers. Despite the abundance of evidence that CNPs are well educated, competent, health care professionals who are able to improve access to high-quality health care and lower health care costs, restrictive practice regulations still exist. The quest for independent practice with full practice authority for CNPs has surpassed the need for professional recognition; it has become a necessary practice transformation to improve the health of our nation.

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