

Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion

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Notes: This report discusses information found in the *Chart Overview of Nurse Practitioner Scopes of Practice in the United States (2007)* available at <http://futurehealth.ucsf.edu>. The information in this report is intended to be informative for professionals and policy makers. Efforts have been made to ensure accuracy at the time of publication. However, laws, regulations and interpretations of such often change and may no longer be current. In addition, nothing in this document should be interpreted as legal advice.

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Executive Summary

Nurse Practitioners (NPs) are registered nurses who are prepared beyond initial nursing education in an NP program to provide primary care directly to patients. The profession originated in the mid-1960s in response to shortages of physicians (MDs). NP educational requirements, certification mechanisms and legal scopes of practice are decided at the state level and vary considerably.

NP scopes of practice vary widely among the states.

- Eleven states permit NPs to practice independently, without physician involvement.
- Twenty-seven states require NPs to practice in collaboration with an MD. Collaboration definitions vary, but written practice protocols are often required.
- Ten states require MD supervision of NPs.
- NPs in all states may prescribe, but MD involvement is generally required to varying degrees. Additional limitations such as 72-hour or 30-day supplies may apply.
- Specific practice authorities are sometimes articulated although states may require MD involvement for any task: 44 states explicitly authorize NPs to diagnose (sometimes limited to a nursing diagnosis); 33 states explicitly authorize NPs to refer; and 20 states explicitly authorize NPs to order tests.

Education and certification requirements vary.

- Forty-two states require national certification as part of NP licensure.
- Just over half of the states require NPs to be prepared with a master's degree, while some states only require completion of a few months of post-RN education.

Implications of current policy

- Preventing professionals from practicing to the full extent of their competence negatively affects health care costs, access and quality.
- NP practices are impeded by scope of practice laws, financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models.
- The professions and the public are ill-served when practice authorities differ dramatically among states.

Policy options to consider

- Continue trend to expand NP scope of practice to match competence.
- Adopt uniform scope of practice laws to reduce variability among states.
- Increase number of NP programs to reflect growing demand for primary care.

I. Introduction.

This brief discusses the findings of the *Chart Overview of Nurse Practitioner Scopes of Practice in United States* (the “Chart”). The Chart provides a current overview of statutes and regulations governing the practice of nurse practitioners (NPs). It is a snapshot of NP scopes of practice in the 50 U.S. states and the District of Columbia.

The first part of this paper presents a brief background of NPs in the United States. Part II summarizes the findings of the Chart. Part III articulates complications in composing the Chart. The final part discusses ways in which more efficient utilization of NPs may alleviate the alarming maldistribution of primary healthcare providers across the U.S. Appendix 1 provides examples of: 1) a state with restrictive NP scope of practice laws (Georgia); 2) a state with a unique legislative proposal (Massachusetts); and 3) a state with permissive NP scope of practice laws (New Mexico). Appendix 2 offers four policy points for legislative consideration.

A. Background: statistics, history and trends.

NPs are registered nurses who are prepared beyond initial nursing education in an NP program of at least three months. According to the most recent U.S. Department of Health and Human Services Sample Survey Report in 2004, there were an estimated 141,209 NPs in the U.S., an increase of 38,560 from 2000.¹ In 2004, about 65.5 percent of NPs had completed a master’s degree program, and an additional 10.5 percent had a post-master’s certificate in NP preparation.² Over 74 percent of NPs reported being certified by a national organization in an advanced practice nursing specialty.³ The number of NPs in 2006 was estimated to be at least 145,000.⁴

The NP role had its inception in the mid-1960s in response to a nationwide shortage of physicians.⁵ The first NP program was developed as a master’s degree

¹ “The Registered Nurse Population: National Sample Survey of Registered Nurses,” U.S. Department of Health & Human Services, Health Resources & Services Administration (March 2004: Preliminary Findings), <http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm>.

² Id.

³ Id.

⁴ “What is a Nurse Practitioner?”, American College of Nurse Practitioners, <http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3479>.

⁵ “Frequently Asked Questions about Nurse Practitioners,” American College of Nurse Practitioners, http://www.acnpweb.org/files/public/FAQ_about_NPs_May06.pdf.

curriculum at the University of Colorado’s School of Nursing in 1965. Initial programs that subsequently followed were programs in pediatrics.⁶

NP education and training programs have since grown in parallel across the U.S.⁷ Federal law defers to state law regarding NP training requirements, which vary widely among states. NPs must earn master’s degrees in 24 states. Three additional states will require a master’s degree as of 2008.⁸ Some NPs have doctorates.

Overall, NP curricula have expanded over the past four decades. Programs are now more refined as candidates may select various specialties, such as anesthetics, geriatrics and obstetrics, under the umbrella of advanced practice nursing. Notably, the California Office of Statewide Health Planning and Development (OSHPD) provides funding for 11 family NP education programs in the state under the Song-Brown Health Care Workforce Training Act.⁹ The 1973 Act encourages graduates to practice in designated underserved areas in California.¹⁰

Progress can also be measured by efforts to adopt more uniform standards. For example, most states now require NPs to be nationally certified. Moreover, RNs in 21 signatory states of the Nurse Licensure Compact now have multi-state practice privileges. Similarly, the APRN Compact for NPs was developed in 2000.¹¹ Like the Nurse Licensure Compact recognizing RN and LPN (licensed practical nurse) licenses, the APRN Compact offers states a mechanism for mutually recognizing APRN licenses.

⁶ Id.

⁷ For the number of NP schools in each state, *see*, Linda Pearson, “The Pearson Report,” *The American Journal for Nurse Practitioners* (February 2007), http://www.webnp.net/images/ajnp_feb07.pdf.

⁸ Carolyn Buppert, *Nurse Practitioner’s Business Practice and Legal Guide* (Third Edition; Jones and Bartlett 2008), p. 5.

⁹ It also provides funding for family physician and physician assistant education programs. Cal. Health & Safety Code §§128200-128241, http://www.oshpd.ca.gov/HWDD/pdfs/health_safetycodes_rev.pdf; “The Song-Brown Program,” OSHPD, Healthcare Workforce & Community Development Division, http://www.oshpd.ca.gov/HWDD/Song_Brown_Prog.html. For a list of approved NP programs in California, see “Approved Advanced Practice Programs,” California Board of Registered Nursing, <http://www.rn.ca.gov/schools/apprograms.shtml#np>.

¹⁰ Id.

¹¹ “The Uniform APRN Licensure/Authority to Practice Requirements,” National Council of State Boards of Nursing, https://www.ncsbn.org/Uniform_Advanced_Practice_Registered_Nurse_Licensure_Authority_to_Practice_Requirements.pdf; “Participating States in the NLC,” National Council of State Boards of Nursing, <https://www.ncsbn.org/158.htm>. (As discussed in Part III, Section B, in most states, the umbrella APRN (advanced practice registered nurse) title includes the NP title.)

Although no date has been set for the implementation of the APRN Compact, Iowa, Texas and Utah have passed laws to join the Compact.¹²

Currently, NPs may perform services authorized under the “scope of practice” provisions of the Nurse Practice Acts of their states. NP scopes of practice vary widely among states. Some states, for example, permit NPs to practice independently without physician involvement. Most states require NPs to practice in collaboration with a physician. In the mid-1970s, state legislators began to consider allowing NPs to prescribe drugs.¹³ NPs have since gradually achieved prescriptive authority in all 50 states and the District of Columbia.

B. Types of legal authority.

Some states define NP scopes of practice in statutes enacted by the state legislature. Other state legislatures authorize the Board of Nursing of their state to establish NP scopes of practice in regulations. Statutes and regulations carry the same legally enforceable weight.¹⁴ Regulations, however, often expand upon statutes to provide more detail of administration.¹⁵

Federal laws govern NPs to the extent that federal law has authority (“jurisdiction”) over a particular subject matter. For example, the Drug Enforcement Administration (DEA) categorizes NPs as “mid-level practitioners,” in accordance with federal law requiring mid-level practitioners to register with the DEA prior to dispensing controlled substances.¹⁶ The United States Code also defines NPs in accordance with corresponding Social Security provisions.¹⁷

C. The rapidly evolving state of nurse practitioner scopes of practice.

By the time this paper is published, the scope of practice laws of some states will be amended. The landscape of NP scopes of practice is regularly in flux as legislators respond to reform demands from groups and individuals with interests that often conflict. Typically, Boards of Nursing and NPs favor laws that would expand NP scopes of practice, which would allow NPs to practice more autonomously or permit them to

¹² Id.

¹³ Buppert, *supra*, note 9 at 7.

¹⁴ Id. at 38.

¹⁵ Id. at 123.

¹⁶ 21 CFR §1300.01(b)(28).

¹⁷ 42 USC §1395x(5)(A).

perform a wider variety of tasks.¹⁸ For example, a broad California bill proposes to authorize NPs to perform comprehensive health care services for which they are educationally prepared and competent to perform.¹⁹ Another pending California bill seeks to remove the provision prohibiting physicians from concurrently supervising no more than four NPs who furnish drugs.²⁰ A separate California bill aims to revise the educational requirements for NP certification and would require an NP to be certified by a nationally recognized certifying body approved by the board.²¹

Opposing groups, such as state Boards of Medicine, typically argue that NPs are not competent to practice more independently, or that they are insufficiently educated and trained to perform the disputed procedures safely. Those who oppose expanded NP scopes of practice out of concern for public protection, however, are often also motivated by hidden competitive self-interests.²² Some health professions, for example, may view NPs as financial threats, and thus commit to block any legislation that would recognize overlapping scopes of practice among professions.²³

II. Summary of the Chart.

The Chart notes that Alaska, Arizona, New Hampshire, New Mexico, Oregon and Washington are among states that have enacted the most expansive NP scopes of practice. In all of these states, the authority of NPs to practice independently includes the authority to prescribe drugs without physician involvement. Reasons for permissiveness could be that Alaska, Arizona and New Mexico have significant rural, underserved populations with more pressing needs for primary care providers, while New Hampshire, Oregon and Washington generally tend to enact more progressive legislation. Legislators

¹⁸ For in-depth policy arguments, see Barbara J. Safriet, “Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing,” *Yale Journal on Regulation*, Yale University (Summer 1992), 9 *Yale J. on Reg.* 417 (“Safriet (1992)”).

¹⁹ 2007 CA AB 1436. For a summary of legislative plans in each state, *see*, “The Pearson Report,” *supra*, note 8.

²⁰ 2007 CA AB 1643.

²¹ 2007 CA SB 809.

²² Remarkably, the Office of Technology Assessment summarized ten studies which concluded that the quality of care provided by NPs and physicians was equivalent. “Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis,” Office of Technology Assessment, U.S. Congress (1986), <http://www.princeton.edu/~ota/>.

²³ For example, *see*, Resolution: 904 (I-06), American Medical Association House of Delegates, http://www.acnpweb.org/files/public/AMA_Resolution_904_11_06.pdf.

in these states may therefore be more willing to acknowledge that properly trained nonphysician providers can autonomously provide safe, high-quality healthcare.

Notably, Michigan has no scope of practice law specifically governing NPs. There, NPs practice under a general delegation and supervision statute for all licensed and unlicensed individuals in the state.²⁴ Laws specific to NP prescriptive authority, however, have been enacted, allowing NPs in Michigan to prescribe drugs only if directed in writing by a physician.

Alabama, Florida, Georgia, North Carolina, Oklahoma and Pennsylvania are among states with the most restrictive NP scopes of practice. NPs in Alabama and Florida may not prescribe controlled substances. Practicing NPs in North Carolina, Ohio and Pennsylvania must be supervised by physicians. NPs in Georgia were not authorized to prescribe any drugs until July 2006.²⁵

A. Independent practice and physician involvement.

NPs are explicitly authorized to practice independently without physician oversight in 11 states. NPs in remaining states must practice with varying degrees of physician involvement. For example, stricter states, such as Oklahoma and Virginia, require NPs to practice under direct physician supervision. Most states, on the other hand, require NPs to “collaborate” with physicians. States may also require ranging levels of physician oversight depending on geographical location (such as inner cities or rural areas), practice setting (such as nursing homes or hospitals) and service (such as diagnosing or writing prescriptions).²⁶ For example, NPs in states with large rural, underserved populations tend to be entrusted to practice with minimal, or no, physician involvement. As another example, some states require only prescribing NPs to collaborate with a physician.

B. Written practice protocols between nurse practitioners and physicians.

NPs in 21 states, including California, must practice under a collaborative written agreement with a physician. The requisite level of specificity and the circumstances under which these agreements are mandated vary. Louisiana’s collaborative protocol

²⁴ See the Chart for citations of each state’s NP scope of practice laws.

²⁵ Pearson, *supra*, note 8 (citing 2003 GA SB 376).

²⁶ “Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety,” Federation of State Medical Boards (2005), http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf.

requirement, for example, is situation-dependent. There, NPs who “engage in medical diagnosis and management shall have a collaborative practice agreement.” NPs in Louisiana practicing solely within their nursing scope of practice, however, are not required to have an agreement with a physician. NPs in Louisiana must therefore distinguish between services legally classified as “medical,” and those deemed to be “nursing,” even though, in reality, the line between the practice of medicine and the practice of nursing is sometimes unclear.

C. Nurse practitioners’ authorities to diagnose, order tests and refer patients.

Of the 44 states that explicitly allow NPs to perform diagnoses under varying physician supervision and collaboration requirements, seven states distinguish between “medical diagnoses,” which are generally not permitted, and “nursing diagnoses,” which are generally within NPs’ scopes of practice.²⁷ Twenty states explicitly permit NPs to order tests. Thirty-three states explicitly permit NPs to refer patients to other providers, under varying physician oversight requirements, as indicated in the first three columns of the Chart.

D. Prescriptive authority.

By 2006, NPs in all 50 states and the District of Columbia had achieved some degree of prescriptive authority.²⁸ NPs in 11 states may now prescribe drugs independently without physician involvement. The remaining states allow NPs to prescribe drugs with ranging levels of physician oversight. In 34 states, for instance, prescribing NPs must first secure a written prescriptive protocol with a physician. In ten states, physician supervision or collaboration is required only where NPs seek to prescribe drugs.²⁹ NPs in these states are otherwise authorized to practice independently.

State laws also differ regarding the types of drugs that NPs may prescribe. Generally, NPs may prescribe drugs listed in their official state “formulary” or “legend.” In most states, NPs are also permitted to prescribe controlled substances.

²⁷ Delaware, Kansas, Kentucky, Maine, Missouri, North Dakota and New York.

²⁸ Buppert, *supra*, note 9 at 7. For a detailed summary, see “U.S. Nurse Practitioner Prescribing Law: A State-by-State Summary,” <http://www.medscape.com>.

²⁹ Colorado, Hawaii, Kansas, Kentucky, Michigan, New Jersey, North Dakota, Rhode Island, Tennessee and Utah.

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Controlled dangerous substances are narcotics, depressants, stimulants and hallucinogenic drugs under the federal Controlled Substances Act.³⁰ Controlled substances are categorized in five “schedules” based on whether they have a currently accepted medical use in treatment in the U.S., their relative abuse potential and the likelihood of dependence when abused. Schedule I drugs, such as heroin and marijuana, have no currently accepted medical use in treatment in the U.S., and therefore may not be prescribed for medical use. Drugs listed in Schedules II through V have some accepted medical use, and therefore may be prescribed.³¹

To prescribe controlled substances, NPs must first register with the Drug Enforcement Administration (DEA) and obtain a DEA number, which must be used on prescriptions for controlled substances.³² The DEA will not issue DEA numbers to NPs in states that do not permit NPs to prescribe controlled substances.³³

NPs in all states, except Alabama, Florida and Missouri, may prescribe controlled substances. NPs in Arkansas, Illinois, Oklahoma, South Carolina and West Virginia may prescribe only Schedules III-V controlled substances. Most other states, including California, permit NPs to prescribe drugs in Schedules II-V.³⁴ State laws also differ with regard to allowable prescriptive quantities within particular schedules. For example, in Pennsylvania, Schedule II prescriptions by NPs are limited to 72-hour supplies, while Schedule III-IV prescriptions are limited to 30-day supplies. As another example, NPs in South Dakota may not prescribe Schedule II drugs for a period of more than 30 days.

E. National certification.

NPs in 42 states, excluding California, must be nationally certified in order to practice.³⁵ The passage of a written examination is generally required for national

³⁰ Buppert, *supra*, note 9 at 197 (citing 21 CFR, part 1300 to end, §1308); “Controlled Substance Schedules,” U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, <http://www.deadiversion.usdoj.gov/schedules/schedules.htm>.

³¹ *Id.*

³² “Questions and Answers,” U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, <http://www.deadiversion.usdoj.gov/drugreg/faq.htm#2>.

³³ *Id.*

³⁴ The Hawaii legislature is currently drafting the rules to implement NP privileges to prescribe controlled substances. Pearson, *supra*, note 8; *see also*, www.hawaii.gov/dcca/areas/pvl/main/press_releases/nursing_announcements/pvl_ia_exc_aprn.pdf; www.hawaii.gov/dcca/areas/pvl/main/reports/pvl_legislature_reports/JFAC_2004_Legislature_Report.pdf.

³⁵ For more detailed discussion of national certification requirements, see “Using Nurse Practitioner Certification for State Nursing Regulation: A Historical Perspective,” National Council of State Boards of

certification. For example, according to the New Jersey Administrative Code, “Each applicant for certification shall be required to successfully pass the **highest level of practice examination** in the area of specialization approved by the Board. Written verification that the applicant has successfully passed the exam is to be submitted directly from the national certifying agency to the Board.”³⁶

F. Joint authority.

Seventeen state Boards of Nursing, to varying extents, share rule-making authority with the Board of Medicine of their state. For example, the Georgia Board of Medical Examiners promulgates the rules and regulations for the nurse protocol agreement. Further, the Boards of Nursing and the Boards of Medicine of Indiana, Minnesota, New Jersey, Oklahoma, and Tennessee share rule-making authority over NP prescriptive privileges.

III. Ambiguities associated with compiling the Chart.

The first section of this part describes difficulties in compiling the Chart. Specifically, it illustrates ambiguities in some state laws with regard to physician involvement, practice protocols, NP privileges and prescriptive protocols. The second section articulates the array of titles for NPs adopted by different states. It then elucidates the surprising degree of effort required to locate some states’ key legal NP scope of practice provisions.

A. Some legal provisions are open to interpretation.

The Chart’s data was cross-referenced with data from reliable sources, such as “The Pearson Report,” Nurse Practitioner’s Business Practice and Legal Guide and data from the American College of Nurse Practitioners website.³⁷ The Chart’s data conflicts with these resources in some instances.

Our findings are most consistent with those of “The Pearson Report.” Most discrepancies between this leading authority and the Chart occurred because many laws governing NP scopes of practice are open to interpretation. The specific causes of

Nursing, <https://www.ncsbn.org/938.htm>; “Requirements for Accrediting Agencies and Criteria for APRN Certification Programs,” National Council of State Boards of Nursing (2002), https://www.ncsbn.org/Requirements_for_Accrediting_Agencies_and_the_Criteria_for_Certification_Programs.pdf.

³⁶ N.J. Admin. Code §13:37-73 (emphasis in original).

³⁷ Pearson, *supra*, note 8; Buppert, *supra*, note 9; American College of Nurse Practitioners, <http://www.acnpweb.org/i4a/pages/index.cfm?pageid=1>.

ambiguities range from overly broad rules to inconsistencies within single provisions. We were thus forced to make borderline judgment calls for some of the Chart's markings.

More significantly, because of these ambiguities, NPs in many states must make discretionary calls about whether some services that they are willing and capable of providing are within their lawful scope of activity.³⁸ If an NP reasonably treats a patient based on an apparent authority that actually leaves room for judicial interpretation, the NP will be susceptible to malpractice liability and discipline by the Board of Nursing. NPs, out of caution, may consequently be disinclined to provide care. Laws that prevent patients from receiving care and routinely place practitioners in such compromising positions are contrary to model legislation.

1. Independent practice.

According to "The Pearson Report" and the American College of Nurse Practitioners, 23 states allow NPs to practice independently.³⁹ The Chart, however, indicates only 11 states because we excluded states that require physician involvement where prescriptive privileges are exercised, but otherwise permit NPs to practice independently.

Substantive questions arise where laws of a single state encourage NPs to make independent decisions regarding their general practices, yet mandate physician oversight for specific services. Kansas law, for example, requires NPs to "prescribe drugs pursuant to a written protocol as authorized by a responsible physician."⁴⁰ Inconsistencies surface, however, where Kansas law also authorizes NPs "to make independent decisions about nursing needs of families and clients, and interdependent decisions with physicians in carrying out health regimens for families and clients."⁴¹ Further confusion about the afforded degree of autonomy results as Kansas law additionally makes NPs "directly accountable and responsible to the consumer."⁴² Likewise, Rhode Island law requires

³⁸ Barbara J. Safriet, "Closing the Gap Between Can and May in Health Care Providers' Scopes of Practice: A Primer for Policymakers," *Yale Journal on Regulation*, Yale University (Summer 2002), 19 *Yale J. on Reg.* 301, 302 ("Safriet (2002)").

³⁹ Pearson, *supra*, note 8; "NP Scope of Practice," American College of Nurse Practitioners, <http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465>. According to Wikipedia, NPs may practice "totally autonomously" in eight states, http://en.wikipedia.org/wiki/Nurse_practitioner.

⁴⁰ Kan. Stat. Ann. §65-1130.

⁴¹ Kan. Admin. Regs. §60-11-101.

⁴² *Id.*

NPs “to prescribe [drugs] in accordance with annually updated guidelines, written in collaboration with the medical director or physician consultant of their individual establishments.”⁴³ Yet, NPs are called to broadly utilize “independent knowledge of physical assessment and management of health care and illnesses.”⁴⁴

2. Physician supervision.

Some state laws that require NPs to practice under physician supervision do not specify the requisite extent or form of physician oversight. Required forms and extents of supervision range from physical presence to phone accessibility, regular meetings, and periodic chart reviews. It can also depend on practice setting. NPs who are not formally trained to interpret laws must therefore risk their licensure where they are liable to unintentionally overstep the outer bounds of vague laws. Alternatively, NPs must decline care where laws are unclear. Confounding the disadvantage, most NPs, understandably, are not even cognizant of the need to make this choice, because most are not legally trained to dissect weak legislative provisions.

A positive example of an adequate supervision clause exists in the Pennsylvania Code, which articulates that supervision entails the immediate availability of a physician “through direct communications or by radio, telephone or telecommunications.”⁴⁵ Similarly, a pending California bill seeks to clarify the physician supervision requirement for prescribing NPs by proposing that supervision “shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.”⁴⁶

3. Written practice protocols.

Some states that require NPs to establish practice protocols with physicians do not explicitly require that the protocols be in writing. For example, the Indiana Code simply requires NPs to operate “in collaboration with a licensed practitioner as evidenced by a

⁴³ R.I. Gen. Laws §5-34-39.

⁴⁴ R.I. Gen. Laws §5-34-3.

⁴⁵ 49 Pa. Code §21.251.

⁴⁶ 2007 CA AB 1643.

practice agreement . . .”⁴⁷ Likewise, under Pennsylvania law, physicians must be “available on a regularly scheduled basis for [e]stablishing and updating standing orders, drug and other medical protocols within the practice setting.”⁴⁸ Because of the consequent interpretation that oral agreements between NPs and physicians may be legally sufficient, the Chart does not indicate that a written practice protocol is required in these states.

Further, many states have created their own legal phrases to communicate a writing requirement. For example, California requires a “standardized procedure”; Colorado, a “written collaborative agreement to prescribe”; Massachusetts, “written guidelines”; Michigan, a “Delegation of Prescriptive Authority Agreement”; Nebraska, an “integrated practice agreement”; Ohio, a “standard care arrangement”; South Carolina, an “approved written protocol”; and Wyoming, a “written plan of practice and collaboration.” The cumulative usage of this many terms to articulate a requirement for the single concept of a written agreement between NPs and physicians can frustrate NPs considering relocating to a different state, which, in turn, can hamper access to care.

4. Practice authorities.

Some state laws that allow NPs to practice independently do not specify that NPs may perform diagnoses, order tests or refer patients to other providers. Arguably, these practice privileges may be presumed in states that explicitly permit NPs to practice independently. Due to such ambiguities, however, the Chart does not indicate that NPs have these privileges in states that allow them to practice independently, absent explicit legal permission. New Mexico, for example, does not explicitly allow NPs to perform diagnoses, order tests or refer patients to other providers. Alaska does not explicitly allow NPs to order tests and refer patients. The District of Columbia and Idaho do not explicitly allow NPs to order tests.

Ambiguities also occur where differently worded provisions describe, in effect, the same practice privilege. For example, most states openly permit NPs to perform diagnoses. The language of the Hawaii Administrative Rules, however, comes very close

⁴⁷ Ind. Code §25-23-1-19.4.

⁴⁸ 49 Pa. Code §21.251(iii)(C).

to, but stops short of, literally permitting NPs to perform diagnoses. Instead, Hawaii law favors the word “assess” over the word “diagnose”:

(1) Nurse practitioner scope of practice:

(A) Evaluate the physical and psychosocial health status of the patient through a comprehensive health history and physical examination, using skills of observation, inspection, palpation, percussion, and auscultation, and using or ordering diagnostic instruments or procedures that are basic to the nursing evaluation of physical signs and symptoms;

(B) Assess the normal and abnormal findings from the history, physical examination, and diagnostic reports;

(C) Plan, implement, and evaluate care . . .⁴⁹

As another example, states that allow NPs to perform “diagnoses” allow NPs to conclude that “the patient is dead.” States that merely allow NPs to perform “assessments,” in contrast, only permit NPs to observe that “the patient appears dead.”⁵⁰

5. Prescriptive authority.

A few states authorize NPs to prescribe drugs by utilizing terminology that is evidently synonymous with the word “prescribe,” yet explicitly prohibits NPs to “prescribe” drugs. Notably, NPs in California may “furnish” or “order” drugs. However, they may not “prescribe” drugs. Oklahoma law allows NPs to “prescribe,” but not “dispense,” drugs. Inscrutable provisions that fail to elucidate the difference between “furnishing” and “prescribing” may deter NPs from moving their practices to certain states.

B. Additional ambiguities that may cause confusion for nurse practitioners.

The following section first discusses several titles that refer to NPs. It then elaborates on the difficulty of accessing some states’ key scope of practice provisions.

1. Different titles.

In many states, the advanced practice registered nurse (APRN) title encompasses NPs, certified nurse midwives, nurse anesthetists and clinical nurse specialists. NPs have various titles, depending on the state in which they practice. For example, Alabama calls its NPs “certified registered nurse practitioners”; NPs in California are simply “nurse practitioners”; NPs in Hawaii are “advanced practice registered nurses”; NPs in Nevada

⁴⁹ Haw. Admin. R. §16-89-81.

⁵⁰ Safriet (2002), *supra*, note 39, footnote 11.

are “advanced practitioners of nursing”; and NPs in New Jersey are “advanced practice nurses.” There is no sense in maintaining all of these titles to describe a single practitioner group.

Moreover, Arkansas law distinguishes registered nurse practitioners (RNPs) from advanced nurse practitioners (ANPs). The ANP title in Arkansas is more closely aligned with most NP titles in other states. For instance, ANPs in Arkansas are allowed to prescribe drugs, whereas RNPs in the state are not. Also, ANPs must be nationally certified, whereas RNPs need not be nationally certified. As another example, NPs in Iowa may not prescribe drugs, whereas advanced registered nurse practitioners (ARNPs) may prescribe drugs independently without physician involvement.⁵¹ In an era of increasing national homogeneity in education, competence examinations and practice settings, it is counterproductive to continue the use of different titles for practitioners who are similarly educated, pass the same examinations and practice in the same ways.⁵²

2. Difficult to find laws.

Locating key NP scope of practice laws of each state was not a simple task. Ideally, a comprehensively gathered set of provisions would readily be accessible in a “Nurse Practice Act” section of each state’s Board of Nursing website. Seventeen Board of Nursing websites, however, failed to direct users to all of the state’s major NP scope of practice laws, although many of the same websites purported to do so. Users are thus prompted to stop searching for additional important provisions because they are misled to believe that the state’s entire NP scope of practice law is before them. Indeed, a small, but significant, number of statutes and regulations listed in the Chart were discovered by consulting other resources. Further, a few Boards of Nursing do not even have websites. Typically, in such states, a general professional health board website provides only contact information for the Board of Nursing.

IV. Conclusion.

To summarize, 11 states currently allow NPs to practice independently. Ten states require practicing NPs to be supervised by physicians, while 27 states require varying degrees of collaboration between NPs and physicians. Moreover, NPs in 21

⁵¹ “Scope of Practice of the Advanced Registered Nurse Practitioner (ARNP),” Iowa Board of Nursing, http://www.state.ia.us/nursing/nursing_practice/arnp.html.

⁵² Safriet (1992), *supra*, note 19 at 447.

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states must first secure a written practice protocol with a physician. With regard to practice authorities, 44 states explicitly permit NPs to diagnose patients, 20 states explicitly permit NPs to order tests and 33 states explicitly permit NPs to refer patients to other providers. With regard to prescriptive privileges, 11 states allow NPs to prescribe drugs independently, 40 states allow NPs to prescribe in collaboration with a physician, 34 states require NPs to first secure a written prescriptive protocol with a physician and 48 states allow NPs to prescribe controlled substances. NP candidates in 42 states must be nationally certified. In 17 states, the Board of Nursing and the Board of Medicine share joint rule-making authority over NP practices.

Although NP scopes of practice have steadily broadened over the past four decades, the actual practice has experienced some contractions. Despite an overall expansive trend, NP scopes of practice still vary widely among the states. The consequent inconsistencies among actual NP practices constrain the uniform expansion of NP services. The profession and the public are ill-served where practice authorities can be dramatically different between bordering states. For example, an NP in Iowa may practice with complete independence, while an NP a few miles away in Missouri may not prescribe controlled substances under any circumstance. Moreover, the laws of certain states internally conflict. Such inconsistencies point to the inescapable realization that NPs are needlessly restricted by divergent practice laws for reasons that have nothing to do with their competencies.

Different scope of practice laws among states reflect only one way in which NPs are impeded from performing to their highest capabilities. Other negative influences include financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models. In most states, NPs are not eligible for direct reimbursement. Because states regulate the insurance industry, whether an NP qualifies for third-party reimbursement depends largely on state law.⁵³ For example, although federal law now mandates direct Medicaid reimbursement to NPs, states retain broad discretion in determining both fee levels and payment methodology.⁵⁴ Further, despite the predominance of laws that require NPs to practice collaboratively with physicians, the

⁵³ Safriet (1992), *supra*, note 19 at 466.

⁵⁴ *Id.*

increased exposure to malpractice liability, and consequent increased physicians' insurance rates, are often strong disincentives for physicians to engage in practice with NPs. Adherence to traditional forms of practice also impedes NPs' full contribution to national health.

To conclude, the evolution of the NP profession is restrained due to current delivery models. First, physician preferences and NP practices are inextricably intertwined. Remarkably, a 2003 study of rural and urban physicians' perceptions of NPs found that physicians in both settings perceived that nonphysician providers: 1) possess the necessary skills and knowledge to provide primary care to patients; 2) are an asset to a physician's practice; 3) free the physician's time to handle more critically ill patients; and 4) increase revenue for the practice.⁵⁵ The results of this study may be useful in reducing barriers to access by encouraging other physicians to recognize that NPs are an untapped resource. Secondly, corporate assumptions about consumer perceptions may affect the professional development of NPs. For example, health maintenance organizations may shift the number of NPs they employ, depending on presumed public opinion of NPs' ability to provide adequate care. Finally, efficient utilization of the NP workforce may be hindered by traditional views of physician-run practices as the only mechanism for quality delivery.⁵⁶

Currently, there is considerable discussion about a looming physician shortage in primary and specialty medicine. These shortages, real or speculative, are driven in part by existing rigid practice models that focus on physicians as sole providers. Indeed, researchers are noticing a trend indicating that NPs are migrating to states that have enacted more permissive scopes of practice. The clustering of NPs in progressive states will not alleviate, and may exacerbate, the existing maldistribution of primary care providers. This trend suggests that efficiency, access and quality would be significantly

⁵⁵ Stephanie E. Burgess, et. al., "Rural and Urban Physicians' Perceptions Regarding the Role and Practice of the Nurse Practitioner, Physician Assistant and Certified Nurse Midwife," *Journal of Rural Health*, Vol. 19, pp. 321-328, Suppl. S (2003).

⁵⁶ These rigid views are perpetuated by the tremendous amount physician groups spend on lobbying. Medical societies are well-known for their efforts in securing proprietary legislation manipulatively couched in neutral terminology. The American Medical Association spent \$39 million on lobbying in the first half of 2004. "Lobbying Tab Is \$1.1 Billion for Half a Year," *Los Angeles Times* (December 29, 2004), <http://www.commondreams.org/cgi-bin/print.cgi?file=/headlines04/1229-02.htm>.

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improved by more interprofessional collaboration and revised delivery models with uniform, shared scopes of practice.

Appendix 1: Excerpts of Legislation in Georgia, Massachusetts and New Mexico⁵⁷

We selected the following three states to exemplify the complexities of NP scope of practice legislation in all 50 states and the District of Columbia. Georgia is a relatively restrictive state, while New Mexico is a relatively permissive state. Massachusetts is unique because a crucial bill to grant primary care provider status to NPs is being considered by the state legislature, despite the state’s relatively restrictive scope of practice laws and intense opposition from the state medical society.

I. Georgia.

There are 3484 NPs in Georgia. A physician must be onsite for at least four hours per month at each NP practice location. The Georgia Board of Medical Examiners promulgates the rules and regulations for the mandatory written “nurse protocol agreement,” by which a physician may delegate to NPs the authority to perform certain medical acts.⁵⁸ The agreement must be updated annually, and include a schedule for periodic physician review of patient records.

In July 2006, legislation was passed allowing NPs to prescribe legend drugs and controlled substances in Schedules III-V.⁵⁹ However, a physician must review all charts of patients who receive prescriptions from NPs. The rules and regulations of the Board of Medical Examiners are much more restrictive than Georgia legislation governing the practice of NPs. In 2007, the legislature will address this discrepancy. Not surprisingly, the Medical Association of Georgia is strongly opposed to NP autonomy. Last year, the executive director of the Medical Association stated that the “significant liberation of healthcare in Georgia . . . [is] really a degradation of medical care in [the] state.”⁶⁰

II. Massachusetts.

There are 5600 NPs in Massachusetts. The Massachusetts Board of Registration in Nursing drafts the “Regulations Governing the Practice of Nursing in the Expanded Role.” Before they are enacted, the Regulations must be approved by the Board of

⁵⁷ Data largely referenced from, Linda Pearson, “The Pearson Report,” *The American Journal for Nurse Practitioners* (February 2007), http://www.webnp.net/images/ajnp_feb07.pdf.

⁵⁸ Ga. Code Ann. §§43-34-26.3; 43-34-26.1(c).

⁵⁹ Ga. Code Ann. §43-34-26.1(b)(3).

⁶⁰ “Doctors Fight Scope-of-Practice Bills at Capitol,” *Atlanta Business Chronicle* (March 10, 2006), <http://www.bizjournals.com/atlanta/stories/2006/03/13/story3.html>.

Registration in Medicine.⁶¹ NPs in Massachusetts must practice in accordance with “written guidelines” developed in collaboration with a physician.⁶² The guidelines must describe the NP’s scope of practice, the circumstances in which physician consultation or referral is required, procedures for the treatment of common medical conditions and provisions for managing emergencies.

NPs in Massachusetts must apply separately for prescriptive authority by providing documentation of a minimum of 24 contact hours in pharmacotherapeutics, and valid registrations to prescribe controlled substances from the state and the Drug Enforcement Administration.⁶³ In addition, written guidelines must include a mechanism to monitor NP prescribing practices, which must be reviewed by NPs and their supervising physician at least every three months.

Notably, in December 2005, a bill was introduced to grant primary care provider status to NPs in Massachusetts. It aims to prohibit discrimination against NPs by insurance carriers and give consumers the opportunity to choose an NP as their primary care provider.⁶⁴ The proposal is currently being reconsidered by the Committee on Financial Services.

III. New Mexico.

There are only 672 NPs in New Mexico. Because the state also has few physicians in rural and frontier areas, legislators and the New Mexico Medical Board are supportive of NP practices.⁶⁵ Remarkably, the New Mexico Nurse Practitioner Council employs a professional lobbyist to monitor legislative activities and represent the interests of NPs in the state.⁶⁶

Boards of Nursing in other states might similarly consider employing a representative to report on breaking events of each legislative session. All NPs should be aware of regulatory issues that affect their practices. However, because most NPs already practice full-time, they may have difficulty with following pertinent ongoing

⁶¹ 244 Code Mass. Regs. §4.01.

⁶² 244 Code Mass. Regs. §4.22.

⁶³ 244 Code Mass. Regs. §4.22.

⁶⁴ MA HB 921, MA SB 1248 (“An Act to Ensure Consumer Choice of Nurse Practitioner Services”).

⁶⁵ “2007 Quick Facts,” New Mexico Health Policy Commission (January 2007), <http://hpc.state.nm.us/QuickFacts/quickfacts2007.pdf>.

⁶⁶ “Legislative Liaison Information,” New Mexico Nurse Practitioner Council, <http://www.nm-nursepractitioners.org/serv04.htm>.

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legislation in their spare time. NPs would likely be more than willing to collectively appoint a professional lobbyist to apprise them of relevant initiatives and actively work for their interests. New Mexico, the legislative liaison's fees are paid for by voluntary donations made primarily by member NPs.

Appendix 2: Policy Considerations – Four Areas for Improvement with Examples of Progress

- Continue trend to expand NP scopes of practice.
 - The Columbia Advanced Practice Nurse Associates (CAPNA) is the first NP practice in the U.S. run exclusively by NPs. CAPNA was developed by Columbia University School of Nursing faculty members who worked at various sites in Manhattan beginning in 1994. The group has admitting privileges to New York Presbyterian Hospital.⁶⁷
 - In 1992, the Supreme Court of Georgia decided that a state statute that prohibited persons other than physicians from performing any invasive procedure was unconstitutional because it “violated due process and equal protection as overly broad.”⁶⁸
 - In 1983, the Missouri Supreme Court refused to “draw that thin and elusive line that separates the practice of medicine and the practice of professional nursing in the modern day delivery of health services.” It decided, instead, that the legislature had intended to accommodate advanced practice nurse roles by avoiding “statutory constraints on the evolution of new functions for nurses delivering health services.”⁶⁹
- Adopt uniform scope of practice laws.
 - There is no single source to which decision-makers can turn for information about regulatory matters. NPs and state legislators face obstacles in obtaining the information they need to identify promising courses of action.⁷⁰ Even the most sophisticated healthcare consumer or policy-maker can easily be confused by the scattered form and fragmented substance of current NP legislation.⁷¹

⁶⁷ Columbia Advanced Practice Nurse Associates, <http://www.capna.com/>; “Nurse Practitioners: Growing Competition for Family Physicians?”, American Academy of Family Physicians (October 1998), <http://www.aafp.org/fpm/981000fm/nurse.html>.

⁶⁸ *Miller v. Medical Ass’n of Georgia*, 262 Ga. 605, 423 S.E. 2d 664, 665 (Ga. 1992).

⁶⁹ *Sermchief v. Gonzales*, 660 S.W. 2d 683, 688-689 (Mo. 1983); upheld in *Howenstine v. Roper*, 155 S.W. 3d 747, 753 (Mo. 2005).

⁷⁰ Benjamin Shimberg, *Occupational Licensing: A Public Perspective*, Educational Testing Service (1980), p. 185.

⁷¹ Barbara J. Safriet, “Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing,” *Yale Journal on Regulation*, Yale University (Summer 1992), 9 *Yale J. on Reg.* 417, 446.

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- Most legislators lack the expertise to answer technical questions regarding the healthcare industry.⁷² Understandably, they are not experts in scope of practice issues. Legislators might, however, consider minimizing arbitrary semantic deviations from ordinary terminology adopted by most states. These seemingly minor differences in wording may confuse and mislead NPs, jeopardize their licenses, expose them to malpractice claims and prompt discriminatory reimbursement practices by the federal government and private insurance companies.
- Substantive scope of practice variations among states may also obstruct the spread of national organizations seeking to establish more facilities to provide basic medical care. For example, in some states, NPs are blocked from offering simple treatments at inexpensive retail clinics by rules requiring costly supervision by doctors.⁷³
- Access may also be impeded by sharply contrasting and inadequately drafted laws that prevent professional mobility. Scope of practice laws should be more consistent so that NPs will not be burdened with re-licensure requirements every time they relocate to another state. Legislators might consider adopting nationally agreed upon standards. Clarity of expression should be a priority when drafting subsequent legislation. Concise, solid statutory language, leaving little room for interpretation, would help stabilize the practice.
- Rescind Board of Medicine rule-making authority.
 - The interests of Boards of Nursing and Boards of Medicine inherently conflict. The professional development of NPs will consequently be retarded by the perpetuation of joint rule-making authorities, because, naturally, Boards of Medicine tend to block all legislation perceived to have the slightest possibility of impinging physicians' financial interests. Overly prohibitive NP scopes of practice, in turn, obstruct access to care.

⁷² Shimberg, *supra*, note 4 at 94.

⁷³ Mary Kate Scott, "Health Care in the Express Lane: Retail Clinics Go Mainstream," California HealthCare Foundation (September 2007), <http://www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics2007.pdf>. (The report focuses on some government regulations that pose challenges to the establishment of retail clinics in California.)

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- NP scopes of practice continue to lag behind NPs' professional development.⁷⁴ Theoretically, education and training should correlate with scopes of practice. Realistically, however, NPs are overtrained for the narrow range of services they are permitted to provide. The stunning systemic inefficiencies caused by this dichotomy between clinical ability and legal authority flagrantly contradict patients' interests.⁷⁵ Reconciliation may begin by the relaxation of rigid, arcane laws that blanketly require NPs to defer to physicians.
- The misallocation of rule-making authority also breeds interprofessional conflicts. Laws that paternalistically discourage NPs from practicing to the capacity to which they were educated and trained cripple professional morale. Interprofessional animosity follows where one profession can successfully advocate for the enactment of laws that debilitate another profession. The failure of the present framework to support collaboration among professions, in turn, disserves the public. Logically, uncoordinated care unavoidably compromises quality and safety.
- Present dysfunctional professional relationships may be repaired by more inclusive laws that encourage team-based care. A sensible minimal starting point may be to focus on peaceful coexistence. Professional boards should be motivated to shift the focus of their agendas by enabling more cohesive practices. After a common ground is achieved, the conversation may then proceed to shared scopes of practice with overlapping forms of accountability. The discussion may gradually evolve into discourse on transforming outdated models of delivery by acknowledging the NP workforce as a resource.
- In 2007, the Oregon Legislative Assembly defeated Senate Bill 717, which proposed to authorize the Board of Medical Examiners to appoint a scope of practice review committee to review scope of practice expansion proposals from all of the state's health professions.

⁷⁴ "Diversifying the Nursing Workforce: A California Imperative," Catherine Dower, et. al., Center for the Health Professions, University of California, San Francisco (February 2001), p. 33.

⁷⁵ Barbara J. Safriet, "Closing the Gap between Can and May in Health Care Providers' Scopes of Practice: A Primer for Policymakers," Yale Journal on Regulation, Yale University (Summer 2002), 19 Yale J. on Reg. 301, 301.

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- In 2004, the Supreme Court of Illinois ruled that in malpractice cases, the standard of care to which nurses must be accountable must be established by the testimony of other nurses. The court held that physician testimonies may not be considered in establishing the requisite nursing standard of care.⁷⁶
- Transform NP programs to reflect growing demand for primary care.
 - Along with continued efforts to expand scopes of practice, legislators might consider strengthening NP programs by devising more comprehensive curricula. Intensifying NP programs would alleviate the maldistribution and shortage of primary care providers in the long term more efficiently than concentrating solely on medical programs.⁷⁷
 - Decision-makers may consider continuing to expand NP curricula, and increasing the number and capacity of NP programs. A 2007 study found that despite a growing nationwide shortage of nurses, the number of applicants denied admission to nursing schools has increased sixfold since 2002 because of lack of instructors.⁷⁸ However, we are optimistic about the long term. In the past, NP programs have been responsive to fluctuating demands for primary care providers. When demands rise, programs are bolstered to increase the supply of NPs and widen the range of their competencies. When demands contract, programs are correspondingly downscaled.

⁷⁶ Sullivan v. Edward Hospital, 209 Ill. 2d 100, 111-127, 806 N.E. 2d 645, 653-662 (2004).

⁷⁷ See, Jessica McCann, et. al., “Physician Assistant and Nurse Practitioner Workforce Trends,” The Robert Graham Center, No. 37 (September 2005).

⁷⁸ “What Works: Healing the Healthcare Staffing Shortage,” PricewaterCoopers’ Health Research Institute (2007), <http://www.pwc.com/extweb/pwcpublishations.nsf/docid/674D1E79A678A0428525730D006B74A9>; see also, Richard A. Cooper, “New Directions for Nurse Practitioners and Physician Assistants in the Era of Physician Shortages,” *Academic Medicine*, Vol. 82, No. 9 (September 2007) (“Indeed, a major impediment to training more NPs is an insufficient number of faculty.”).