**APRN Full Practice Authority Evidence: How Do We Use This Evidence?**

**New Research Findings**

**ACCESS**


Data source was SK&A provider files and Area Health Resources Files. Nurse practitioners (NPs) increased from 17.6% of rural providers to 25.2% from 2008 to 2016.


Since the enactment of the Affordable Care Act, eight states have adopted full practice authority (from 2011 to 2016), twice as fast as prior ten years. Seven states adopted Medicaid expansion.


Study linked providers listed in the 2014 National Plan and Provider Enumeration System to Medicare claims. Adjusted for county-level differences, the supply of primary care physicians increased across socioeconomic status. Chiropractors and physician assistants (PAs) had a similar pattern. NPs exhibited an inverse association between county socioeconomic and health status.


Opt-out and less restrictive scope of practice regulations were consistently correlated with a greater supply of certified registered nurses anesthetists (CRNAs), especially in rural counties.


Data sources were a 2011 American Medical Association masterfile and a subgroup sample of 2013 members of the American Association of Nurse Practitioners. Study showed estimated travel time was about 20 percent less to NPs or MDs in states with full practice authority.


Medically underserved women living in states with laws that restrict NP full–scope of practice are twice as likely to be diagnosed with late-stage cancer, adjusted odds ratio (2.08) and confidence intervals (1.4 to 3.1). These disparities were not observed among underserved
women living in areas with NP full practice authority (OR 0.95, 95% CI 0.7 to 1.3). Note study limitations:

- Cross-sectional study – cannot establish a causal relationship between NP full practice authority and Pap testing
- Just 15 states participate in the cancer registry data source


Using Medical Expenditure Panel Survey (MEPS) data from 1996-2012 the researchers found that NP independence increases the frequency of routine checkups, improves care quality, and decreases emergency room use by patients with ambulatory care sensitive conditions.


From 2010 to 2016, the number of primary care NPs increased from 59,442 to 123,316 and the number of primary care physicians increased from 225,687 to 243,738. Primary care NP supply increased more than physician supply, with the highest NP supply observed in rural health service areas (HSAs) and the highest physician supply observed in metropolitan areas.

**QUALITY**


Data source was Medicare parts A and B claims during 2012-2013. Beneficiaries attributed to NPs had lower hospital admissions, readmissions, inappropriate emergency department use, and low-value imaging for low back pain. Beneficiaries attributed to physicians were more likely to receive chronic disease management and cancer screenings. Findings are limited due to incident to billing which does not identify NP services.


Data source was Federally Qualified Community Health Clinics (FQHCs) data from six states with required physician contracts (Alabama, Missouri, Nevada, South Dakota, Texas, and Virginia) and ten states with full practice authority (Alaska, Arizona, Idaho, Iowa, Maine, New Hampshire, New Mexico, Oregon, Washington, and Wyoming) in 2013. No difference was found in rates of hypertension and diabetes control.


States which required physician oversight for NPs had higher rates of emergency department visits following Medicaid expansion than states without physician oversight.

Researcher examined all US births between 1998 and 2015 and found that allowing advanced practiced registered nurses (APRNS) and PAs to practice with more autonomy reduces the use of medically intensive procedures. Eliminating restrictive laws may better promote patient safety.


Data source is Medicare Part B claims 2010-2013. Found no differences between primary care NPs and primary care MDs when accounting for organization.


Data from the National Ambulatory Medical Care Survey from 2012-2016 in which an NP or certified nurse midwife (CNM) and no physician or a physician only provided care during a patient visit. There were no differences in the number of services provided but NP or CNMs on average provided one fewer billed service in general medical visits compared to physicians.


Data from the Veterans Health Administration data warehouse. Patients managed by NPs, PA, and physicians had comparable hemoglobin A1C at diagnosis and initiation of oral medications and insulin after 4 years of follow up.

**COST**


The cost of required collaborative practice agreements (CPA) often exceeded $6,000 annually, with numerous respondents reporting fees between $10,000 and $50,000. Although CPA fees are meant to compensate physicians for the time spent supervising APRN caseload, in person communication is infrequent and chart reviews rare.

Ritter, A. "Exploring Collaborative Practice Agreements Between Nurse Practitioners And Physicians" (2018). *Publicly Accessible Penn Dissertations.* 3176. [https://repository.upenn.edu/edissertations/3176](https://repository.upenn.edu/edissertations/3176)

Structures of regulation similar to collaborative practice agreements CPAs in various health disciplines increase the cost of health services and decrease the number of health professionals delivering care. CPAs include vague language and 24 percent of nurse practitioners in Florida report no terms of physician collaboration in the agreement. Ten percent of nurse practitioners report paying a physician for participation in a CPA. Fifty percent of self-employed NPs paid for their CPA compared to only 6.2 percent of non-self-employed CPAs.