

Health Care in Alabama



Facts and Issues



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Introduction

This publication was researched and written by members of the League of Women Voters of Alabama (LWVAL), a nonpartisan political organization, that encourages informed and active participation in government, works to increase understanding of major public policy issues, and influences public policy through education and advocacy.

The research began at the request of League members who wished to know more about health care issues and the problems being faced both nationally and in Alabama. Members also believed it important to supply such information to the Alabama public. As with all League educational efforts, attempts have been made to collect and present material in an unbiased, evenhanded manner.

There are two sections to the material present here. The first section, entitled “Recurring Issues in Health Care: Facts and Issues, is located on pages 3-21, and discusses some of the major issues that face the health care system in the United States and Alabama. In addition, it highlights the degree to which the problems are interrelated.

The second section, entitled “Challenges and Opportunities for the Nursing Profession,” begins on page 22 and focuses on issues related to the single largest group of health care professionals – nurses. Nurses are the focus not only because of their sheer numbers, but because they might be better utilized given the issues raised in the first section of the report. Part of the discussion examines findings of a major research effort reported in *The Future of Nursing: Leading Change, Advancing Health*, which was published by The Institute of Medicine (ICM) in collaboration with the National Academy of Sciences. Emphasis is placed on two of the areas covered in that publication: the need for nurses to practice to the full extent of their education and training and the need for that education and training to be expanded.

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Part One:
Recurring Issues
in
Health Care
that
Impact Public Policy:
Facts and Issues

Recurring Issues in Health Care that Impact Public Policy:

Facts and Issues

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For more than three decades, the American health care system has been the subject of intense scrutiny and debate. Researchers have identified many problems that influence availability and access to care as well as the quality of care received. These problems are often described as health care disparities. Over time researchers also have identified factors in the political, social, and economic environment that have exacerbated many of these problems and have added new factors to the mix as the environment has changed.

This *Facts and Issues* examines some of the problems and issues currently faced by the American health care system, their causes and impacts, and how they have influenced reform efforts, particularly the new federal health care overhaul – the Health Care and Education Reconciliation Act of 2010 also known as the Patient Protection and Affordable Care Act of 2010 (ACA). It also places the problems and issues in the context of Alabama.

What Are Health Care And Health Care Disparities?

The 2010 *National Healthcare Disparities Report* published by the Department of Health and Human Services states:

Health care seeks to prevent, diagnose, and treat disease and to improve the physical and mental well-being of all Americans. Across the lifespan, health care helps people stay healthy, recover from illness, live with chronic disease or disability, and cope with death and dying. Quality health care delivers these services in ways that are safe, timely, patient centered, efficient, and equitable.

Whenever the delivery of services to all racial, ethnic, economic, geographical (urban-rural as well as sectional), or other major groupings are not safe, timely, patient centered, efficient, and/or equitable, **health care disparities** exist. Disparities represent problems that need to be solved. Each problem may have more than one cause, and rarely is there one easy to identify solution that is acceptable to all.

Challenges Facing the Health Care System

The challenges facing the health care system are the result of interrelated factors in the social and economic environments that are making new demands on the system as well as interrelated historical factors in the political, social and economic systems that shaped the system as it evolved during the 20th Century. Each will be discussed below.

Chronic Illness Versus Acute Illness or Injury

The ACA legislation and many regulations created under its authority as well as many studies of the health care system emphasize a need to move the system from a focus on acute care to an emphasis on the

treatment of chronic illness. A major analysis of nursing argues that acute care represents the health care focus of the 20th Century and that the emphasis in the 21st Century is on chronic illness (IOM, 2011, p. 29)

Acute illness is defined by MedicineNet.com as “A disease with an abrupt onset and usually a short course.” It also includes sudden injuries that require limited time for treatment.

Chronic illness lasts over a long period of time or sporadically reappears. Chronic illness includes obesity, hypertension, cardiovascular disease, emphysema, diabetes, arthritis, a variety of mental health problems, and many other illnesses that last over an extended period of time. Many of these illnesses are interrelated. For example, obesity can lead to hypertension, cardiovascular disease and diabetes. Some illnesses are identified as health care disparities because they are more prevalent in minority and/or low income populations or specific geographic areas of the nation (e.g., African Americans have higher incidences of diabetes). Those living with chronic illness often live with issues such as stress, limited physical mobility, numerous medical appointments, and high prescription drug costs. Their problems also impact family dynamics and finances. The National Council on Aging estimates that currently “. . . 80% of older adults cope with at least one chronic disease—50% more than one.” (National Council on Aging, April 07, 2005).

The acute versus chronic illness issue has become a cost problem. Many chronic illnesses and the related illness they may lead to result in large numbers of people in need of treatment and in time hospital care. For example, The Agency for Healthcare Research and Quality (AHRQ, 2011) indicates that that obesity related annual health care expenditures are estimated to be \$11-\$14 billion for children and \$75-\$93 billion for adults and cites research that the costs are much higher for the elderly due to ambulatory care, inpatient care, and prescription drug costs.

Primary Care

The recent federal health care legislation seeks to shift the focus of treatment to preventive treatment through a focus on **primary care** which is “routine health care, including diagnostic, therapeutic and preventive services, as well as management of chronic conditions.” (Arise Citizens’ Policy Project Fact Sheet Fall 2009). It also attempts to shift the payment of health care professions from payment for seeing and treating patients to payment for improvements in patients’ conditions and prevention of chronic illness. This involves emphasis on team approaches where various health care professions would work together to diagnose, treat, and educate patients and their families to prevent and/or live with chronic illness through changes in live styles.

To accomplish these goals the legislation suggests greater use of advanced practice nurses (and physician assistants), particularly in geographic areas with few, if any, physicians; community oriented health care; greater use of telemedicine; centralization of recordkeeping to insure all health care providers have complete information on each patient they see; changes in health care provider education; coordination of care; and increased reimbursements for primary care providers among others changes. It also requires evidence based decision making – research to determine which procedures and actions provide the best outcomes for the patient. Those that

provide the best outcomes would be encouraged and rewarded by federal funding agencies, including Medicare.

Medical Home Model

One example of coordinated care is the patient care concept called the **Medical Home Model** which calls for a medical practice coordinated through a primary physician and staff with a comprehensive approach to care from prevention through hospitalization. In 2007, the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) physician groups published “Joint Principles of the Patient Centered Medical Home.” The goal of this model is for each individual in the country to have a medical home. The authors argue that this should improve the coordination of care, increase the value of health care received, expand administrative and quality innovations, promote active patient and family involvement, and help to control the rising costs of healthcare.

The Medical Home maintains and keeps all patient records and provides patients easy access to medical staff. Included on the staff may be persons trained in physical therapy, cardiology, respiratory therapy, diabetic treatment, mental health, nutrition and prevention, or the Medical Home coordinates such care with those outside their practice. The Medical Home might institute weekend and evening hours, e-mail and phone calls to and from doctors and patients and same day appointments. The ACA supports the Medical Home with the goal that it will provide better case and disease management services, implement continuous quality improvement techniques, and utilize evidence-based practice guidelines and health information technology.

Today, over “3,000 practices and 15,000 doctors and nurse practitioners are certified as providers of medical home by the National Committee for Quality Assurance (NCAQ).” NCAQ began such certifications in 2009; more public and private agencies now have undertaken similar certification activity (Vestal 2010). In general, medical homes receive a monthly per patient fee for primary care practices that fit the model, and some physicians’ practices also receive bonuses tied to clinically positive outcomes (Vestal 2010).

Alabama Arise reports that Alabama Medicaid has pioneered the Medical Home Model in the state with its Patient 1st program which serves some 420,000 persons. Any costs savings have not been reported as of this date. However, the Medical Home Model initiated by Medicaid in North Carolina reported a savings of \$161 million in 2006 (Blair & Carnes, 2010). And, in December 2011 North Carolina reported the results on an independent study (commissioned by its legislature with 90 percent of the costs paid for using ACA monies) that showed almost \$1 billion in Medicaid savings since 1991 (Vestal, 2011). The study compared Medicaid patients in Medical Homes to those who were not:

Researchers found that more frequent office visits and treatment of newly diagnosed conditions initially added to per person costs in the medical homes program. But fewer emergency room visits and hospital admissions combined with greater efficiencies and improved care resulted in better health and sizable savings over the longer term. . . (Vestal 2011).

As more Medicaid patients moved into medical homes, cost savings continued to grow.

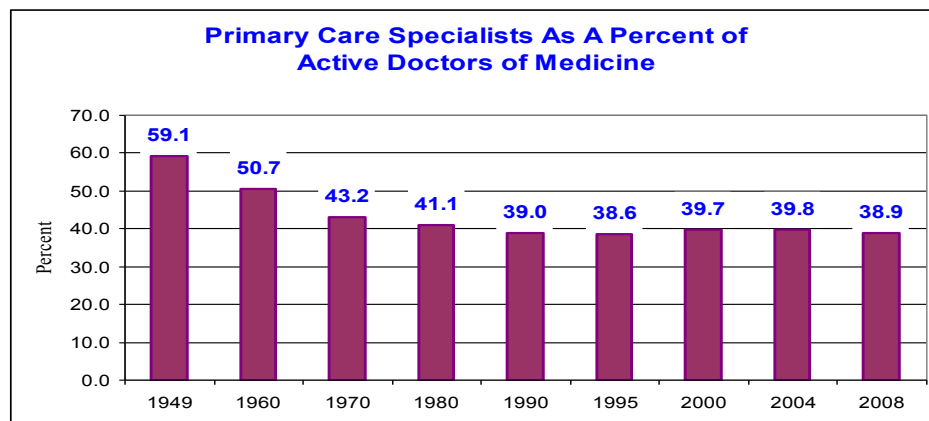
Community Oriented Approaches

A community oriented approach known as **Community Health Centers (CHCs)** or **Federally Qualified Health Centers (FQHCs)** is the establishment of nonprofit facilities in high need areas. The centers offer comprehensive primary care and chronic disease case management. They offer service to insured as well as uninsured patients and receive their funding from federal grants and special reimbursements from Medicare and Medicaid. Alabama Arise reports that there are 16 FQHCs in the state with 100 satellite clinics. (Blair & Carnes, 2010; Alabama Medicaid Agency, 2010) A list of these clinics is available through the Alabama Medicaid office. The Obama administration plans to invest heavily in these programs.

An interview with Susan Stiegler, Director of Family Health Clinical Services, Mobile County Health Department, (Stiegler 2010) indicated that the Mobile County Health Department is unique in that it is the only health department in the state functioning as a FQHC. This allows the Department to receive higher Medicaid and Medicare reimbursements, free malpractice insurance coverage for its physicians, and to provide care to a wider range of patients in the Mobile area. Patients are served on a sliding scale whether or not they are insured. Ms. Stiegler reported that the greatest unmet demand is in the mental health arena. The Mobile Department lacks psychiatrists, psychologists, and masters level therapists. With funding cutbacks by the state, health departments do not have adequate resources, supplies, or staff. Because more people are out of work and losing their insurance coverage, their patient population is increasing. Ms. Stiegler reported that the cost of medications and co-pays is a problem for many patients.

Shortage of Primary Care Physicians and Nurses

Physicians, physician assistants and advanced practice nurses (APRNs), also known as nurse practitioners (NPs), are the central providers of primary care. According to a recent study in the *Journal of the American Medical Association* cited by Herrick (2010), the United States has only 778,000 practicing doctors with less than one-half of these primary care doctors. Primary care doctors “deliver routine health care, including diagnostic, therapeutic and preventive services, as well as management of chronic conditions.” The Association of American Medical Colleges estimates that another 45,000 primary care doctors will be needed by 2020 to meet the demand for services (Arise Citizens’ Policy Project Fact Sheet, Fall 2009).



The Future of Nursing, a major research based analysis co-sponsored by the Institute of Medicine and the Robert Wood Johnson Foundation (IOM 2011, p. 88) indicates:

Physicians account for 287,000 primary care providers, NPs for 83,000, and physician assistants for 23,000 (HRSA, 2008; Steinwald, 2008). While the numbers of NPs and physician assistants are steadily increasing, the numbers of medical students and residents entering primary care have declined in recent years (Naylor and Kurtzman, 2010). The demand to build the primary care workforce, including APRNs, will grow as access to coverage, service settings, and services increases under the ACA. While NPs make up slightly less than a quarter of the country's primary care professionals (Bodenheimer and Pham, 2010), it is a group that has grown in recent years and has the potential to grow further at a relatively rapid pace.

The same IOM study identifies research previously read by those who prepared this *Facts and Issues* as well as other studies that show that care rendered by physicians' assistants and NPs is safe and that care delivered by NPs is rated positively by patients. The study also argues that: "Much of the practice of primary care—whether provided by physicians, NPs, physician assistants, or certified nurse midwives (CNMs)—is of low to moderate complexity." (p. 88) And, the pattern of complexity in decision-making was very similar across the first three groups. CNMs, however, largely dealt with low complexity decision-making. Overall, the literature suggests that properly trained non physicians are able to deliver much of the primary care that physicians do.

One reason for fewer medical students specializing in primary care is simple economics. Reimbursement is lower for primary care physicians, given the time an average patient visit takes (Bodenheimer 2006). Primary care doctors like their specialist colleagues are more likely to practice in urban areas than rural areas. Their number per 1,000 residents is lower in the southern and western states (0.9 to 1.00) and highest in northeastern states (1.4 to 2.8). (Bodenheimer 2006; see also Bodenheimer & Pham 2010).

The ACA contains provisions that attempt to increase the number of physicians serving rural areas by improving reimbursement rates through Medicare. The law authorizes bonus payments

to primary care physicians, qualifying practitioners and general surgeons practicing in health care professional shortage areas (HPSA) beginning January 1, 2011, for a period of five years. To qualify, 60 percent of the provider's Medicare claims must be for primary cases services. Yet, some rural family practice physicians may have difficulty reaching this threshold, as they are more likely to provide non-primary care services because of the scarcity of specialists in rural areas (AHA, no date).

A detailed report from the Medicare Payment Advisory Commission is due to Congress in 2012. The report must evaluate the adequacy of Medicare payments to rural health care providers.

The Alabama Situation

The Alabama Community Health Resources Guide indicates that in 2006 there were 7.2 primary care physicians per 10,000 population nationally while Alabama had only 6.5 primary care physicians per 10,000 population. Rural areas had only 4.6 per 10,000 and urban areas 8.0. By 2011 over one-half of the primary care physicians will be over 50 years of age (Alabama Community Health Resources Guide 2010).

The Arise Citizens' Policy Project based on its review of several studies, reports that roughly one to two million Alabamians lack access to primary care doctors. In 2006 there were 2,160 residents for each primary care doctor in rural areas, compared to 1,250 for those in urban areas. The Arise document presents Alabama Department of Public Health statistics showing that eight counties in Alabama do not have a hospital and 35 counties do not have obstetrics service. As a result of the primary care doctor shortage, 60 of the state's 67 counties are designated as full or partial Health Professional Shortage Areas (HPSAs) (Blair & Carnes, 2010).

Alabama Medicaid estimates based on a study done by the University of Alabama at Birmingham that 207,000-540,000 Alabamians will be added to the Medicaid rolls when the new federal health care reform law (HR 3590, The Patient Protection and Affordable Care Act) is fully implemented. (Rawls 2010) In addition to expanding insurance coverage for all Americans, the law seeks to alter the manner in which health care is delivered. Among other actions, the law emphasizes primary care and preventive services, reimbursing primary care doctors at higher rates than presently applied as a way to make specialization less attractive, emphasizing a team approach to the delivery of health care services, and expanding the role of non physician caregivers. (McEldowney, 2010) Many of these reforms have been discussed for years – see Congressional Budget Office, 1979; Office of Technology Assessment, 1986; and Institute of Medicine, 2001 and 2011.

Rural Health Care

A recent American Hospital Association (AHA) report (no date) focuses on rural hospitals and health centers. The report identifies them as major economic and social centers for their community, noting:

These hospitals are typically the largest or second largest employer in the community, and often stand alone in their ability to offer highly-skilled jobs. . . . A strong health care network also adds to the attractiveness of a community as a place to settle, locate a business or retire.

Limited financial resources, health care workforce shortages, a small workforce and physical size, low-patient volume, and high fixed costs (e.g., high tech equipment) make rural hospitals “particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts.” Recession and economic downturns exacerbate the problem.

The AHA acknowledges that while the Patient Protection and Affordable Care Act of 2010 (ACA) attempts to deal with some problems faced by rural hospital, particularly patients without health care insurance, the law will make also place greater strains on rural hospitals. In particular it cites potential increased patient demand for services due to expansion of Medicaid and commercial insurance coverage.

Additional issues discussed by the AHA are that rural areas compared to urban areas have:

- Older and lower income populations.
- A population more likely to be reliant on government programs.
- Populations more likely to suffer from chronic diseases.
- Smaller hospitals with fewer staff and fewer patients, which result in higher per patient costs.
- Experienced a greater shift to outpatient services.

- Hospitals more likely to offer assisted living and home health services, community education services, home delivery of meals, and skilled nursing services.
- Lower access to capital for investment in new medical technology as well as support technology such as new software and advanced communications.
- Lower access to capital for investment in new facilities.
- Lower use of electronic record keeping and ordering software and hardware.

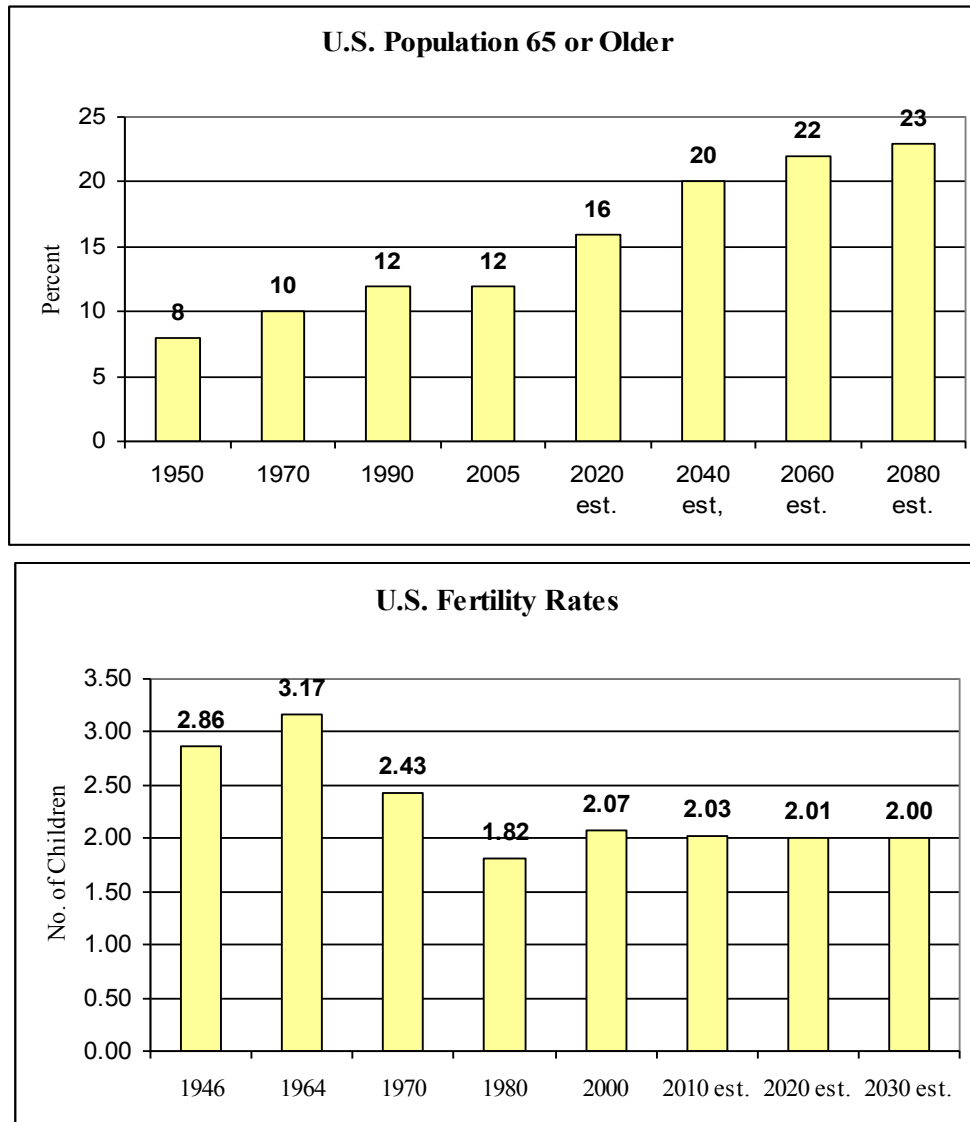
Medicare cuts (found in the ACA as well as recent proposals from the Obama Administration) have a greater impact on outpatient, home health, and skilled nursing services than inpatient services. Therefore, they affect rural areas health care facilities with particular severity. The Critical Access Hospital program (CAH) and other special programs have compensated for the rural hospital's heavy dependence on Medicare. For example, the CAH program is for the smallest rural hospitals. In 2010 CAH paid over 50 percent of rural hospitals a prime rate of 101 percent in Medicare reimbursements. While other rural hospitals get aid from other programs, about 13 percent are still paid under normal Medicare reimbursement rates. (AHA no date)

Changes in Population Demographics

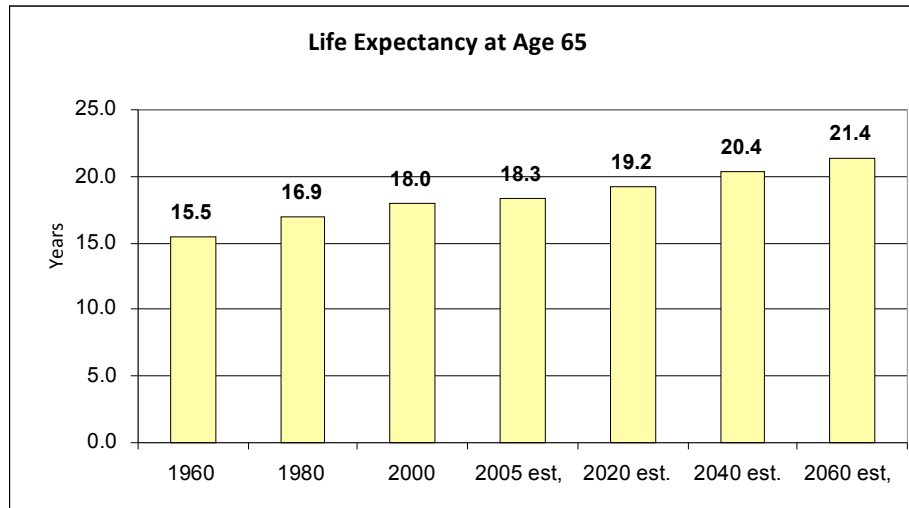
The U.S. population has changed greatly over time. Too often, however, government policies are created based on a set of assumption about future population changes that prove incorrect. For example, changes in science and technology (e.g., advances in the study of genes leading to new drugs and a better understanding of genetically caused conditions and new diagnostic devices allowing for earlier detection of disease and tumors). And, medical advances led to decreased infant mortality rates which together with improved sanitation, adequate food and other factors expand life expectancy. Economic prosperity leads to smaller families and alters the birth rate. Such changes have direct and indirect impacts on the health care system.

Living Longer and Having Fewer Children

Those born between 1946 and 1964 are often called the Baby Boom Generation. A policy study conducted for the Social Security Administration (Reznik, Shoffner & Weaver, 2005/2006) indicates that in 1946 "the average number of children born to a woman in her lifetime was 2.86. By the end of the baby boom (1964), that number had increased to 3.17. The fertility rate was much lower in the post boomer years, although the rate has increased since 1980 and is projected to decline slightly in the coming decades." (p. 3)



While fertility rates have declined overall, the percentage of the population 65 years of age and older has increased, and the life expectancy of those in that age group has increased. The longer life expectancy is partly due to medical advancements including new technologies and to the fact that unlike a century ago a much higher percentage of the population is living past the age of two. Recently, immigration (legal and illegal) has mitigated some of the population changes. Immigrants tend to be younger with higher fertility rates (Reznik, Shaffner & Weaver, 2005/2006, pp 4-5).

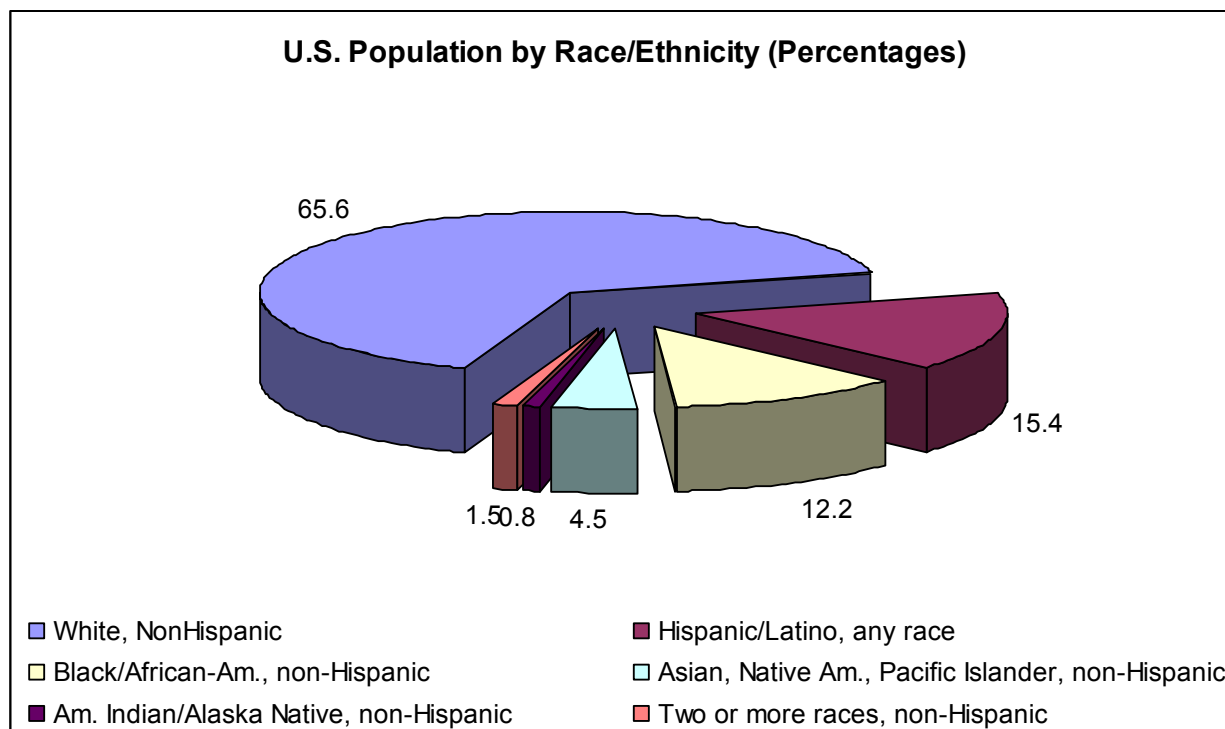


These demographic changes are straining the Social Security and Medicare Systems. As the baby boom retirees enter the systems, fewer young people are paying into them. The numbers are expressed as a ratio with “. . . the worker-to-beneficiary ratio . . . fairly stable in years the boomers are in the workforce (1980-2005) but is substantially lower when the boomers are in their retirement years (2020-2040). (Reznik, Shaffner & Weaver, 2005/2006, p. 5) The ratio was 5.1 in 1960 and 3.3 in 2005, but it will slip below the current breakeven point of 2.8 by 2020. By 2040 the ratio is projected to be 2.1, a level that would exhaust Social Security funds (p. 6). These projections are based on current tax laws and current benefit levels and have not been adjusted for lost revenues due to the 2011 and 2012 paycheck tax cuts enacted to stimulate the economy. With Medicare a similar funding problem exists due to the same demographic changes, but Medicare problems also are compounded by rising health care costs.

The recent recession and higher unemployment rates exacerbate funding problems for Social Security and Medicare as well as Medicaid. And, the elderly poor rely heavily on Medicaid for their care, especially nursing home care.

Racial and Ethnic Population Changes

Population changes related to race and ethnicity also impact the health care system. Today, the Hispanic/Latino population has passed African Americans in terms of percentage share of the U.S. population. And, the two groups combined now compose over 27% of the population. Chronic illnesses levels in both groups and many other than Hispanic/Latino newer immigrant groups are at high rates due to financial and cultural factors. Preventive public health care (e.g., vaccination rates for communicable diseases) varies depending upon the nation from which immigrants migrate.



Source: Figure 3.9 in *The Future of Nursing* which is based on HRSA 2010 data.

Minority populations often settle in areas where other immigrants, including family and friends already live. Many use their native tongue as the primary language and continue their cultural traditions. The cultural traditions may be reinforced by religious teachings with the two combining to limit initiating contacts with health care providers. Language and cultural barriers to care and treatment may limit communications when contacts are made.

Child Birth Patterns Differ Among Whites and Minorities

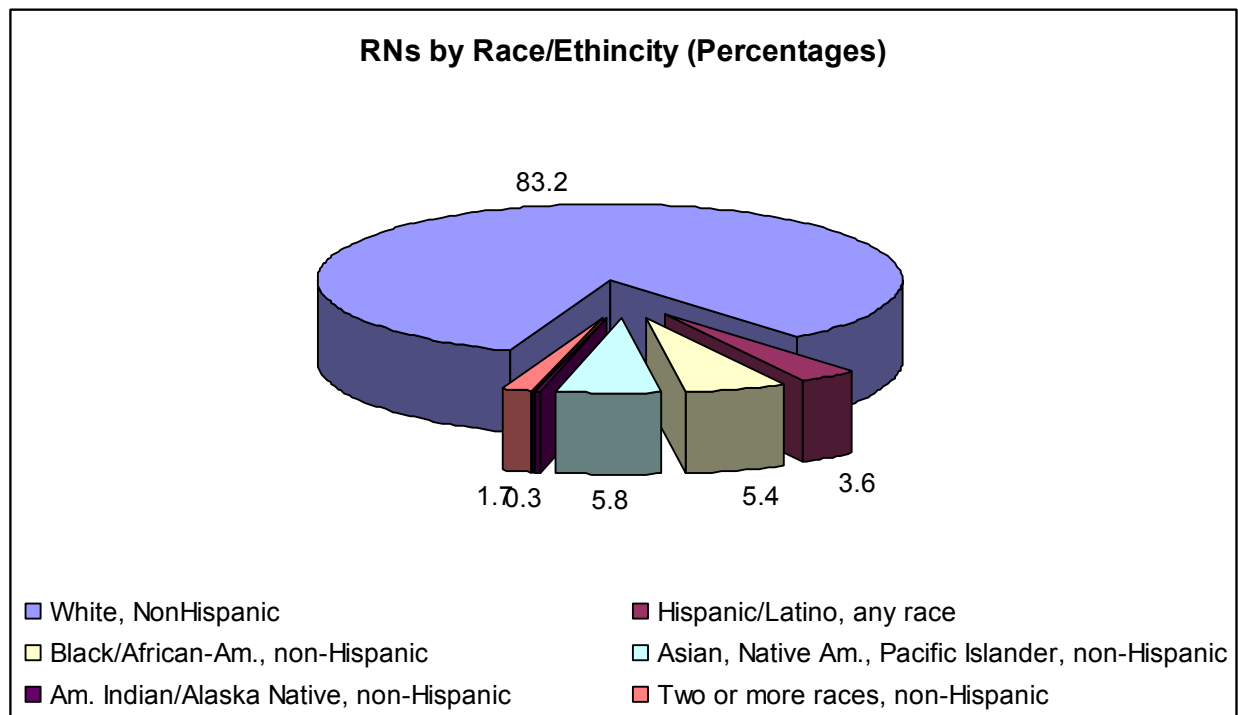
On May 17, 2012, Passel, Livingston, and Cohn of the Pew Research Center cited newly released U.S. Census data indicating that for the first time minority births in the U.S. outnumber white births. They state: “The bureau reported that minorities – defined as anyone who is not a single-race non-Hispanic white – made up 50.4% of the nation’s population under age 1 on July 11, 2011. Members of minority groups account for 49.7% of children younger than age 5 . . . and for 36.6% of the total population.” Hispanic children made up 26.3% of those younger than the age of one. Furthermore, “the 2010 Census showed that racial and ethnic minorities accounted for 91.7% of the nation’s growth since 2000.”

The increases result from at least three factors. First, immigration has altered the population base. Second, the fertility rate among Black Americans and Hispanics is higher than for whites. Third, minority populations are younger than the white population and therefore are more likely to be of childbearing ages and to be younger when they have children. And, in the case of Hispanics, family size tends to be greater.

Figures from the National Center for Health Statistics cited by Pew for 2009 also indicate that 41% of births were to unwed mothers with variation in the rates by group – Hispanics at 53 percent, non-Hispanic Whites at 29 percent, and non-Hispanic Blacks at 73 percent. All of these changes impact the health care system.

Nursing Predominately a White, Female Profession

Nurses make up the largest single professional group in health care. Over 80 percent of the RN population is white and mostly female. African Americans and Hispanics/Latinos combined are less than 10 percent of the RN population. Diversifying the RN population is recognized as a necessary step to improving the health care system.



Source: Figure 3.9 in *The Future of Nursing* which is based on HRSA 2010 data.

Aging Physicians

In February 2011, a *New York Times* correction identified 20.3 percent of American physician as over the age of 65. (Correction found after Tarkan 2011). This number will grow as doctors in the baby boom generation age. A growing concern is that given lower compensation levels likely under the federal health care reforms and the impact of the recent recession, more - retirement age doctors may not retire.

Cognitive and/or physical impairment can come with age. As a result age related competency to practice requirements has become a recent issue. Medical specialists take certification examinations and are now required to periodically be reexamined. However, many older doctors

were grandfathered – that is, exempted from the examination – and while they may be encouraged to take the examinations, few do so.

An Aging Nursing Population

In 2010 the Health Resources Services Administration (HRSA) estimated there were just over 3 million registered nurses in the United States. RNs represent the single largest segment of the health care professions. According to HRSA, almost 1.7 million RNs were over the age of 50. And, over 60 percent of nurses who held faculty positions as their principle position were over 50.

Most of these older RNs (just over 93 percent) were female, white non-Hispanic (83.2 percent), and held either an associate's degree (36.1 percent) or a bachelor's degree (36.8 percent) as their highest level of nursing or nursing related education. A graduate degree was held by 16.8 percent.

Among those under 50 years of age, 80.0 percent were white, non-Hispanic, 92.3 percent female, and 40.0 percent held an associates degree while 43.1 percent held a bachelors as their highest nursing related degree. Only 10.3 percent held a graduate degree.

Some nurses drop out of the profession to raise children and then return. Others suffer physical and mental strains from the job and find these strains exacerbated by increasing age and leave the profession. Burnout cases increase in number when shortages exist in the profession or at the place of employment and patient loads and/or hours worked increase.

State Controlled Licensure and Scope of Practice

The health care professions are regulated primarily by the states. This is done through the licensing process and through **scope of practice laws**. Licensure and scope of practice laws are both designed to ensure the safety of the patient. They represent the minimum standards of training and practice that must be met by a practitioner in a specified field. These laws also define how the health care workforce is deployed. As a result, how professionals are paid for their services varies by state as this is largely determined by insurance companies within the state which also has primarily regulatory over the insurance companies.

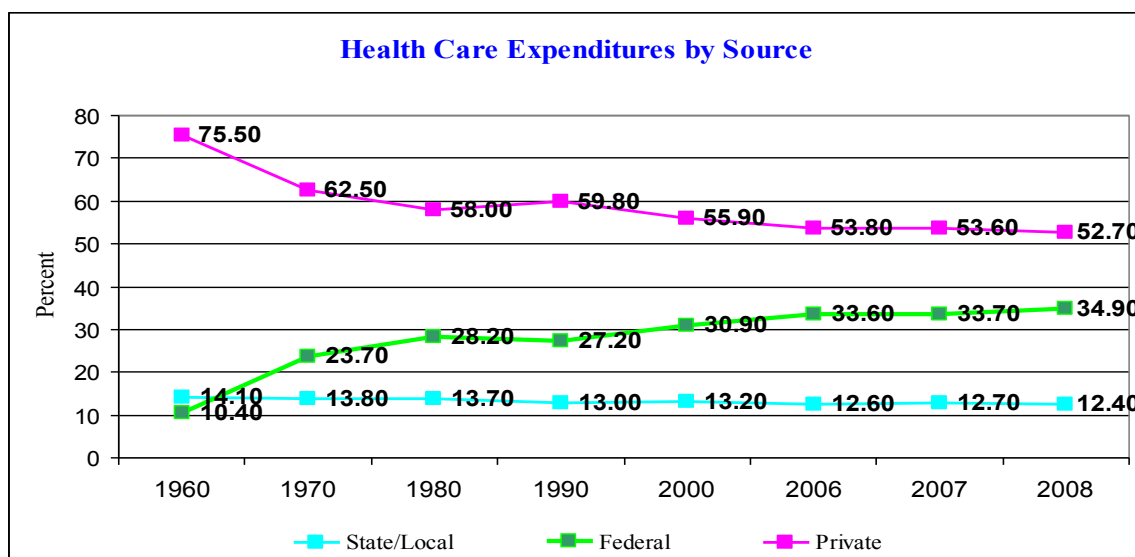
Because both licensure and scope of practice laws are defined at the state level, they directly impact implementation of many health care reforms such as multidisciplinary team approaches to delivery of care, expanded roles for non-physicians (e.g., Advanced Practice Registered Nurses or APRN), and telemedicine which involves the exchange and discussion of information across state lines through the use of various media, including such examples as teleconferencing, computer based diagnoses, and the sharing of electronic records. Often jurisdictional issues (both interstate and inter professional) and/or liability issues develop (IOM 2001 and 2011).

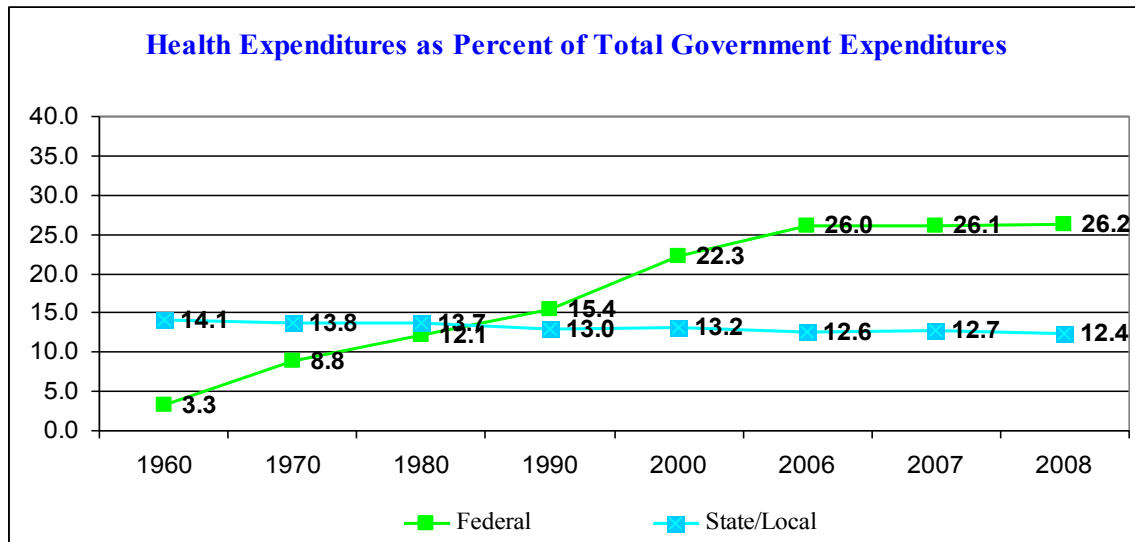
By simply moving from one state to another, health care professionals such as RNs, APRNs and physicians assistants may find that the procedures they are allowed to perform, reimbursement levels, level of autonomy, and other aspects of their practice expand or contract depending upon where they move to and from. And, in some states APRNs may find that what they are allowed to do varies depending on whether they practice in a more urban setting with numerous health care facilities or in a rural region that is greatly underserved when it comes to health care. As a result those with equal training and skills are not treated the same throughout the country and sometimes within the same state.

Challenges and Opportunities for the Nursing Profession: Facts and Issues looks in greater detail at how scope of practice laws impact nursing and the advanced practice nurse with masters and doctoral degree level training. Licensure is also discussed.

Costs/Expenditures and How Government Calculates Data

The tables below are based on Center for Disease Control data. They point to the increased role of government (local, state and national) as a financier of health care delivery. The numbers predate the severe recession that hit heavily in 2008.





These numbers point to one of the central issues behind passage of the Affordable Care Act – rising health care costs. Several of the concerns discussed above (e.g., an aging population, demographic changes, an aging health care workforce, etc.) and numbers insured or not insured impact the rate at which the health care system is accessed and the rates at which health care providers are reimbursed for their services. Using another source for the data would result in a presentation with slightly different numbers.

There are many reasons for the variation in cost estimates, usage estimates, estimates of the number without health insurance, and other government statistics. All government agencies may not use the same definitions for a term/concept. They often disagree on criteria for counting cases to include or exclude. They may make different assumptions in their calculation process (e.g., differing rates of economic growth) and begin their analyses at differing starting points. These and other factors mean they are often using differing mathematical models. Each model may be “correct” within the context of the assumptions and definitions used. That does not mean they will agree with each other. And, if the model is attempting to forecast the future (revenue levels, services usage levels, costs, and the like), the model is built on past patterns of activity. If the past pattern changes, the model will no longer give accurate forecasts. A new model must be developed.

Often state and local governments must calculate data and present information in varying formats in order to meet the requirement of both state laws and federal laws which differ. And, unlike Alabama, most states are not on the same fiscal year as the federal government. So, even the definition of the year in a graph or report may vary.

Congress and the President rely on differing agencies to analyze legislative proposals for cost purposes. The Congressional Budget Office is a nonpartisan agency while the Office of Management and Budget is part of the Executive Office of the President and works for whomever is President. Their analyses vary based on assumptions they are told to use.

Congressional Republicans and Democrats have differing views as well. Republicans champion dynamic scoring as a more accurate way to calculate costs and forecast the impact of tax rate changes, elimination or creation of specific taxes, etc. Republicans argue the key aspect to dynamic modeling is that it does not take a set of numbers collected from the past and use those numbers to calculate what future will look like if policy is changed. Instead, how the policy change will alter behavior and thereby future numbers is also taken into account. Emphasis is placed on how the macro economy changes government taxing and expenditure policy. An example in the news recently is the argument that raising taxes on capital gains will change behavior – that fewer people will sell their stock in order to avoid the tax and that in turn will result in less money being collected and less stock market activity and therefore less money at work in the economy and diminished tax revenues.

Republicans also champion dynamic analysis of programs and call the Democratic approach static analysis. For example, if one looks at the numbers receiving government benefits such as Medicaid or welfare calculated as a percentage of the population, the numbers often appear to be stable over time unless a recession hits. This is what Republicans call static analysis. They argue the focus should be on the individuals receiving aid to determine if the same people are staying on the welfare or Medicaid rolls over time. For some the aid is a temporary measure as they rebound from a major change in their family situation. For others (e.g., the aged poor) long term support is required. Each group would then be examined in greater detail to learn more about their needs and the causes of the need for aid. For the temporary program beneficiaries the factors assisting their move off the program rolls would help to determine how best to direct policy. This is the idea of dynamic analysis.

Democrats oppose dynamic scoring, arguing that it is more difficult to perform dynamic analysis; requires too much information, computer capacity, and time; is built on assumptions like any other model; and does not increase the accuracy of forecasts. Some recent analyses using both scoring approaches on the same data sets are more supportive of the Democrat position and argue that dynamic scoring tied to tax decreased results in short term but not long term positive impacts on the economy; however, these studies are very few in number. (See Furman 2006; Understanding Dynamic Scoring 2012; and Kobes and Rohaly 2002.)

So, if reader ever wonders why so much of the statistical information that is reported does not agree, all of the factors discussed in this section are the answer.

Conclusion

The central theme of this *Facts and Issues* is that the problems the health care system must deal with are numerous, interrelated and difficult to solve. They are impacted by social, economic, and political forces that change with time. They are also impacted by our federal system of government which creates multiple levels of government (local, state, and national) with separate but often overlapping authority.

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Part Two:

Challenges

and

Opportunities

for the

Nursing Profession:

Facts and Issues

Challenges and Opportunities for the Nursing Profession: Facts and Issues

Published by the League of Women Voters of Alabama Education Fund

The Affordable Care Act enacted in 2010 called for a transformation from the current health care system to a system that focuses on the ability to offer quality care that is safer, more accessible to a larger portion of the U.S. population, and focused on preventive and primary care. The increased access to health care by more people envisioned by the Act also increases the responsibilities of health care providers. The expansion is especially relevant to the nursing profession, the single largest professional health care group—over 3 million members.

The Institute of Medicine (IOM) in collaboration with the National Academy of Sciences recently published *The Future of Nursing: Leading Change, Advancing Health* (2011) to explore the impact of changes in health care and make recommendations for improving the nursing profession. Its findings are based on an examination of existing research studies, new analyses generated for the report, and discussion among panels of experts. Perhaps the most detailed study of nursing ever done, the IOM report addresses three areas of recommended changes: nursing education, nursing practice, and nursing leadership. The emphasis is upon the Registered Nurse (RN).

The IOM report focused on four key messages to shape the discussion and recommendations. These four messages are:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

This *Facts and Issues* focuses on the first two messages from the report. To understand the report's recommendations for action, the reader must understand the current nursing environment which begins with nursing education.

Nursing Education and Practice Today

Nursing is unique as a health care profession as it is the only one that licenses graduates without requiring a minimum of a baccalaureate degree. However, nurses can continue their education through the doctoral level.

Nurses practice in a variety of settings and in a variety of roles. Each setting and role carries its own levels of responsibility and decision-making. Nurses focus on acute and chronic health needs, palliative care (hospice), and community care that emphasize health promotion and disease prevention. Nurses coordinate care, engage in research and education, and provide consultation.

The following table shows the various levels of nursing education in place today as well as the typical practice setting for those trained at each level.

Table 1. Nursing Categories and Levels of Education

Title	Training Required	Licensure	Typical Practice and Employment
Nursing Assistant	Up to 75 hours of training.	No license given.	Provides basic personal care commonly in homes or nursing care facilities.
Licensed Practical Nurse (LPN)	12–18 months of study and passage of national licensure exam.	LPN licensure by state board of nursing.	Provides basic nursing care under supervision of RNs or MDs in long-term care, acute care, and ambulatory settings.
Associate Degree (ADN) Registered Nurse ¹	2-3 years, usually in a community college or technical school, and passage of national licensure exam.	RN licensure by state board of nursing.	Provides direct patient care in various health settings.
Baccalaureate Degree (BSN) Registered Nurse	4-year college degree and passage of a licensure exam.	RN licensure by state board of nursing.	Provides direct patient care, nursing leadership, and uses nursing research in practice across all health care settings.
Master's Degree (MSN/MS)	2 years of study after the BSN level.	RN licensure by state board of nursing. APRNs must meet additional requirements beyond passage of the licensure exam and holding the master's degree.	Employed as educators, clinical leaders, administrators, or Advanced Practice RN (APRN) such as: clinical specialist (CNS), nurse practitioner (CRNP), nurse midwife (CNM), or nurse anesthetist (CRNA).

Doctoral Degree such as Doctor of Philosophy (PhD), Doctor of Nursing Practice (DNP) or Doctor of Nursing Science (DNSc)	4-6 years beyond the baccalaureate degree.	RN licensure by state board of nursing. APRNs must meet additional requirements beyond passage of the licensure exam and holding the masters degree.	Employed as health system executives, educators, deans, clinical experts/Advanced Practice RN (APRN), researchers, or senior policy analysts.
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[†] Diploma school graduates are comparable to ADN nurses but lack a college degree. Diploma programs are disappearing or merging with community colleges.

No matter in what capacity nurses practice, each nurse must be licensed by the state where she or he practices. To obtain a nursing license, a person must graduate from an accredited nursing program and then pass the NCLEX exam. While the exam is a national one, each state determines the criteria for licensure and scope of practice (what a nurse can legally do). Table 2 shows the numbers of licensed nurses in Alabama today.

Table 2. Licensed Nurses in Alabama

Registered Nurses	65,857
Certified Registered Nurse Practitioners (CRNPs) in collaborative practice with medical doctor	2,017
Certified Nurse Midwives (CNMs) in collaborative practice with medical doctor	18
Active Certified Registered Nurse Anesthetists (CRNAs)	1,598
Active Clinical Nurse Specialist (CNS)	89
Licensed Practical Nurses	16,971

Source: Alabama Board of Nursing. Daily Statistics at <http://www.abn.state.al.us/> Downloaded April 16, 2012

Advance Practice Nurses licensed and regulated by the Alabama Board of Nursing (ABN) are licensed registered nurses who have completed a Master's or a Doctorate program. They must hold advanced practice specialty certification from a national certifying agency recognized by the Board of Nursing in the clinical specialty consistent with educational preparation and

appropriate to the area of practice. The Alabama Board of Nursing licenses four categories of Advanced Practice nurse: (ABN, 2010)

(1) Certified Registered Nurse Practitioner (CRNP) whose graduate training is as a clinical nurse in one of 12 available specialties such as pediatrics, family practice, gerontology, psych/mental health, acute care, etc. They also are educated in the diagnosis and management of common as well as complex medical conditions. In Alabama a CRNP must have a formal written collaborative agreement (contract) with a physician in order to practice as a CRNP. At this time in Alabama CRNPs can only prescribe drugs in Class I which includes antibiotics.

(2) Certified Nurse Midwife (CNM). A CNM is certified by the American College of Nurse-Midwives and fully licensed by the State of Alabama. The CNM can provide a full range of services from prenatal care through delivery and postpartum care. Since CNMs must work under the collaborative agreement of a physician, they may not make home deliveries (Dowdy 2010). They may request prescribing authority for non-controlled drugs.¹

(3) Certified Registered Nurse Anesthetists (CRNAs) work mainly in the hospital setting and perform many tasks similar to those exercised by their physician counterparts.

(4) Clinical Nurse Specialist (CNS) focuses on the diagnosis and treatment of illness

Both CRNAs and CNSs are in independent practice with no required collaborative agreements with a physician. All four groups, like all RNs and LPNs in Alabama must complete continuing education requirements in order to renew their licenses which are issued for a two year period. Certification agencies also set such requirements for the Advanced Practice Nurses under their area of specialization.

Currently the focus of the NCLEX examination (for both the LPN and RN) is on acute care where the majority of nurses practice. However, changes in health care and patient populations show a shift toward care in the community and an expanded practice role for the RN and for the masters educated Advanced Practice Nurses. Thus, nursing education and the entrance exam for RNs will need to change to reflect the competencies needed in community health, primary care, geriatrics, and other topics that show nurses prepared to practice in a changing health care

¹ A CPM or certified lay midwife, also known as a Granny midwife, may have some training or certification but is not recognized by a state agency and is unable to procure liability insurance or practice in an established health care setting. In other states, but not Alabama, mechanisms are in place for these types of midwives to practice with connections to established medical providers who can provide backup for them in the event of complication (Dowdy 2010). Bills to establish such a system in Alabama have been before the legislature in recent years.

environment. Their education will need to better prepare them for leadership and management roles, work in interdisciplinary teams, and dealing with changing technologies.

Message 1: Need to Practice to Full Extent of Education and Training

Each state has a State Board of Nursing that administers the laws governing nursing practice under the state's Nurse Practice Act. This law is enacted by the legislature just like any law and is subject to amendment. The Nurse Practice Act defines a nurse's Scope of Practice and outlines the authority of the Board of Nursing.

"Scope of Practice" is a concept in state law and state regulations that is used by state licensing boards for various professions. It defines the procedures, actions, and processes that are permitted for the licensed individual. While each profession develops its own scope of practice for its licensees, each state has laws, licensing bodies, and regulations that describe requirements for education and competency and define the scope of practice in that state. There is wide variation among the states in what is contained in their Scope of Practice laws for the same profession.

Licensure and scope of practice laws are both designed to ensure the safety of the patient. They represent the minimum standards of training and practice that must be met by a practitioner in a specified field. These laws also define how the health care workforce is deployed. Because both licensure and scope of practice laws are defined at the state level, they directly impact implementation of many health care reforms such as multidisciplinary team approaches to delivery of care, expanded roles for nonphysicians (e.g., APRNs and physicians assistants), and telemedicine which involves the exchange and discussion of information across state lines through the use of various media, including such examples as teleconferencing, computer based diagnoses, and the sharing of electronic records.. Often jurisdictional issues (both interstate and inter professional) and/or liability issues develop. (IOM 2001 and 2011).

Safriet's (2011) research on the scope of practice laws concludes that:

. . . virtually all states still based their licensure frameworks on the persistent, underlying principle that the practice of medicine encompasses both the ability and the legal authority to treat all possible human conditions. That being so, the scopes of practice for APNs (and other health care professionals) are exercises in legislative exception making, a "carving out" of small, politically achievable spheres of practice authority from the universal domain of medicine. (p. 450)

She traces the historical development of this approach back to the initial regulation of health care providers in the early 1900s. The first to be regulated were physicians whose scope of practice laws were "extremely broad" (p. 451). Given as a typical example is the Washington law that defines practicing medicine as:

1. Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
2. Administers or prescribes drugs or medicinal preparations to be used by any other person;
3. Severs or penetrates the tissues of human beings. (Safriet 2011, cited on p. 452)

Other sections of the law make it illegal to perform any actions included in the definition unless one is licensed as a physician. “The claim staked by medicine was thereby rendered not only universal but (in medicine’s own view) exclusive.”(p. 452) In other words, scope of practice laws for other health care professions were viewed as carving out exceptions to the practice of medicine. And, generally these laws placed their practice under the supervision of the physicians.

Safriet and others argue that the nature of scopes of practice laws mean the level of training and competence of Advanced Practice Nurses far exceeds their authority to practice. As Safriet puts it, “They *can* do much more than they *may* legally do.” (p. 453, emphasis in original). And, every time they develop new skill sets, they must expend time, energy, and money as they seek changes in the SOP laws through administrative or statutory revision. This process may take years as it requires action in the political arena. As a result interest group activity and turf protection issues become part of the decisional process for both sides. (pp. 453-454).

In Alabama Certified Registered Nurse Practitioners and Certified Nurse Midwives are regulated by The Joint Committee of the State Board of Medical Examiners and the Board of Nursing for Advanced Practice Nurses. Committee members include: two physicians; one licensed physician engaged in a collaborative practice with a CRNA or CNM; one registered nurse; one certified registered nurse practitioner engaged in advanced practice with a physician; and one CNM engaged in advanced practice with a physician (Alabama Nurse Practice Act, Article 5). The Board of Medical Examiners appoints the physician members and the Board of Nursing the nurses.

The American College of Physicians (ACP) indicates that when it comes to rule-making authority, Boards of Nursing and Boards of Medicine inherently conflict. NP scopes of practice continue to lag behind NPs' professional development. Theoretically, education should correlate with scopes of practice. (ACP 2009)

ACP issued a lengthy report titled *Nurse Practitioners in Primary Care* (2009) which points out that the education of physicians and nurse practitioners have different levels of knowledge, skills, and abilities and that while not equivalent, are complimentary. The report states that some research indicates that NPs can provide care for 60 to 90 percent of patients in primary care. The findings suggest that appropriately trained nurses can produce care that is equal in quality to that achieved by primary care doctors with equal health outcomes for patients. However, the report’s

conclusion was viewed with caution given that only one study was empowered to assess equivalence of care and follow-up was generally 12 months or less. The more comprehensive 2011 Institute of Medicine (IOM) study of nursing cites research that places nurse practitioners at the high end of the estimate. The ACP report acknowledged the fact that the presence of NPs can reduce the impact of physician shortages and allow physicians to tend to more serious illnesses. The IOM (2001 and 2011) reaches the same conclusion. In fact, some states give NPs greater authority if they work in underserved rural areas. As a result equally trained individuals working within the same state and with the same education and competencies must operate under very different regulations, including rules related to supervision and/or prescription authority.

The ACP Executive Summary states that physicians and NPs have common goals of providing high-quality, patient-centered care and improving the health status of those they serve. Both share concerns regarding appropriate reimbursement for services provided and ongoing interdisciplinary communication about the care of individuals and populations of patients in order to promote quality and cost-effective care. It is important that members of a health care team should understand their complementary roles in the delivery of care. Collaboration between physicians and NPs can occur during both face-to-face encounters and electronically through the use of technology, including telephone, e-mail, telehealth,² and electronic health records. Effective collaboration requires appropriate sharing of information and mutual acknowledgment of and respect for each professional's knowledge, skills, and contributions to the provision of care.

The ACP (2009) report also states that certification examinations for NPs should be developed by the nursing discipline and based on standardized training involved in graduating from advanced practice nursing programs as well as scope of practice statutes and regulations. Certification examinations should be carefully constructed so as to avoid any appearance of equivalency of training/certification with physicians. ACP opposes use of test questions developed by the National Board of Medical Examiners on NP examinations.

ACP (2009) suggests the use of demonstration projects testing the effectiveness of NP-led patient-centered medical home (PCMH) model recognizing the same eligibility requirements and standard as physician-led practices. It advocates workforce policies to ensure adequate supplies of primary care physicians and NPs to improve access to quality care but notes that training more NPs does not eliminate the need nor substitute for increasing the numbers of general internists and family physicians trained to provide primary care.

² The Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services defines telehealth as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.” <http://www.hrsa.gov/telehealth/> Accessed October 4, 2010.

The Federation of State Medical Boards of the United States (FSMB) (2005) acknowledges that:

Debates on scope of practice can be contentious and are influenced by a variety of factors, including: fluctuations in the health care workforce and specific health care specialties; geographic and economic disparities in access to health care services; economic incentives for physicians (M.D., D.O.) and other health care practitioners; and consumer demand. Requests to create, change, or expand scope of practice should be supported by a verifiable need for the proposed change. Patient safety and public protection must be the primary objectives when evaluating these requests. (p. 1)

The National Council of State Boards of Nursing (2009) notes:

Sometimes such modifications of practice acts are just the formalization of changes already occurring in education or practice within a profession, due to the results of research, advances in technology, and changes in societal healthcare demands, among other things.

This process sometimes pits one profession against another before the state legislature. As an example, one profession may perceive another profession as “encroaching” into their area of practice. The profession may be economically or otherwise threatened and therefore opposes the other profession’s legislative effort to change scope of practice. Proposed changes in scopes of practice that are supported by one profession but opposed by other professions may be perceived by legislators and the public as “turf battles.” These turf battles are often costly and time consuming for the regulatory bodies, the professions and the legislators involved. (p. 7)

Both the NCSBN and the FSMB identify public protection as the first priority for consideration when changes in scope of practice laws are sought. NCSBN (2009) suggests that:

When defining a profession’s scope of practice, the goal of public protection can be realized when legislative and/or regulatory bodies include the following critical factors in their decision-making process:

- Historical basis for the profession, especially the evolution of the profession advocating a scope of practice change,
- Relationship of education and training of practitioners to scope of practice,
- Evidence related to how the new or revised scope of practice benefits the public, and
- The capacity of the regulatory agency involved to effectively manage modifications to scope of practice changes.

Overlapping scopes of practice are a reality in a rapidly changing healthcare environment. The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice. (p. 15)

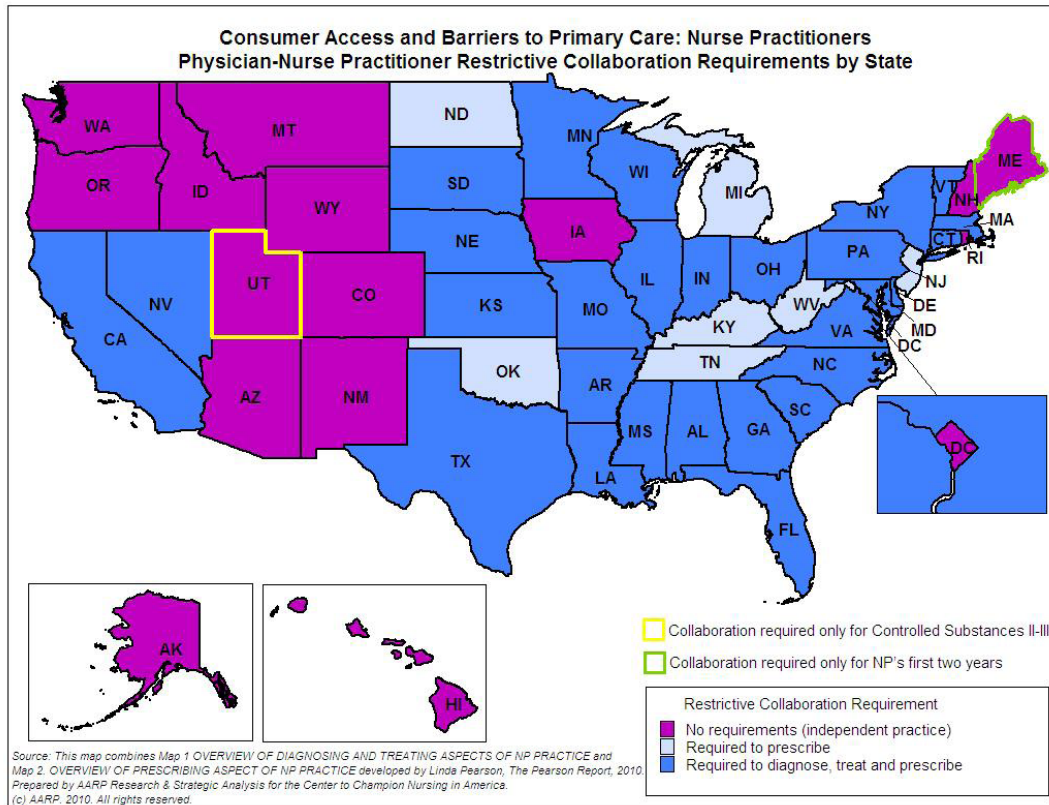
Alabama Nurses and Expansion of Scope of Practice

The Alabama State Nurses Association (ASNA) believes that Nurse Practitioners (NP) offer the possibility of providing access to quality healthcare to many more Alabamians. It also indicates that there is a clear possibility for significant cost savings as well. ASNA notes that it is not possible for medical schools to increase the number of doctors, especially primary providers, in time to respond to the demands of the new patients that will enter the system with the new healthcare reform law. It argues that the law's emphasis on preventive care plays to the strengths of NPs and PAs.

In Alabama a NP must have a formal, written Collaborative Agreement (contract) with a physician in order to practice as an NP. The ASNA (May 2010) notes that "collaboration among medical specialties is already a fact of life. Each specialist operates as required within his or her own scope of practice, and refers patients to another as circumstances dictate. Operating outside your own scope of practice already has definite negative legal consequences."

The American College of Physicians (2009) reports that in 14 states and the District of Columbia NPs are allowed fully independent practices with no collaborative agreement with a physician.

A Center for the Health Professions report by Christian, Dower and O'Neil (2007) notes that NPs are overeducated for the narrow range of services they are permitted to provide. It argues that the systemic inefficiencies caused by this dichotomy between clinical ability and legal authority contradict patients' interest.



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For at least the past five years the Alabama State Nurses Association has drafted a bill to be considered in the legislature which would give nurse practitioners prescriptive authority for controlled drugs – Class II-V. The Medical Association of the State of Alabama (MASA) opposed and stopped such a bill in previous legislative sessions.

Forty-eight of the 50 states already allow NPs prescriptive authority for controlled drugs. Only Alabama and Florida do not (ASNA, May 2010). In 2009 Physician Assistants in Alabama were granted prescriptive authority to prescribe controlled drugs. Physician Assistants are not independently licensed and are accountable to their physician employer and the Board of Medical Examiners.

In almost all states where NPs have controlled substance prescriptive authority, the state Board of Nursing is named as the Certification Authority for the Drug Enforcement Administration (DEA), and it issues the DEA certification number. It is noted that the DEA certification process, education requirements and licensure are a revenue producer for whatever Board controls the process and so there may be an economic incentive. In Alabama the above mentioned BME (made up of physicians) controls certification authority for NPs. The physician's organization opposes allowing the Alabama Board of Nursing to regulate such

certification. The nurses argue that dentists, podiatrists and optometrists do not have physicians as their regulatory authorities. In fact, very few states have physicians involved in regulation of Nurse Practitioners. Certifications in most states are simply administered by that state's Board of Nursing as sole regulatory authority (ASNA, May 2010).

In Alabama an NP must have a formal, written Collaborative Agreement (contract) with a physician in order to practice as an NP. The ASNA (May 2010) notes that:

. . . collaboration among medical specialties is already a fact of life. Each specialist simply operates as required within their own scope of practice, and refers patients to another as circumstances dictate. Operating outside your own scope of practice already has definite negative legal consequences.

In 14 states and the District of Columbia NPs are allowed fully independent practices with no collaborative agreement with a physician. A table comparing practice restrictions on NP in the southern states is located in Appendix I.

There is no disagreement that physicians are at the top of the pyramid in terms of education, training and responsibility (ASNA May 2010, IOM 2001 and 2011). The Center for the Health Professions reports that NPs are overeducated for the narrow range of services they are permitted to provide. It notes that the systemic inefficiencies caused by this dichotomy between clinical ability and legal authority flagrantly contradict patients' interests. In 2006 a national study measured and ranked the regulatory environment for NP practice and consumer healthcare choice in each of the 50 states and the District of Columbia. An expert panel examined the state rules and regulations in three dimensions: (1) legal capacity, (2) NPs patients' access to services, and (3) NP patients' access to prescription medications. Scores in each of these domains were calculated for each state and DC and states were ranked by the composite scores of the three domains. Arizona was the top scorer with 100 points. Alabama was 51st with a score of 35 (Lugo, O'Grady, Hodnicki, & Hanson, 2007).

While many physicians support enlarged scopes of practice for NPs and PAs, the American Medical Association (AMA) does not. The letter of introduction to the "Scope of Practice Series: Nurse Practitioners" by Dr. Michael Maves, AMA's CEO, explains that the purpose of the series was to serve as a resource for state medical associations, national medical specialty societies and policy makers to "challenge the state and national advocacy campaigns of limited licensure health care providers who seek unwarranted scope of practice expansions that may endanger the health and safety of patients". Maves acknowledges that:

. . . without a doubt, limited licensure health care providers play an integral role in the delivery of health care in this country. Efficient delivery of care, by all accounts, requires a team-based approach, which cannot exist without inter-professional collaboration between

physicians, nurses and other limited licensure health care providers. With the appropriate education, training and licensing, these providers can and do provide safe and essential health care to patients. The health and safety of patients are threatened, however, when limited licensure providers are permitted to perform patient care services that are not commensurate with their education or training. (AMA October 2009)

The IOM (2011) report and others cite studies that find Advanced Practice Nurses perform at high levels of safety and receive very positive evaluations from patients.

The Medical Association of the State of Alabama (MASA) and the Board of Medical Examiners (BME) have opposed efforts by the Alabama Board of Nursing to expand the practice environment for NPs. They have consistently opposed what they term as either an expansion of scope of practice or the "practice of medicine" for NPs and PAs. (ASNA May 2010) No studies were found by the study committee that cited any poor practice which endangered the health or safety of patients by "limited licensure health care providers" (a term used by the AMA and specialty organizations representing doctors in their attempts to stop expanded scopes of practice for other health care professions and professions that work within a health care setting including not only nurses but psychologist, PhD pathologists, dentists among others. Its usage is consistent with the content of the Seifert analysis discussed earlier in this paper.)

Many question why physicians are reluctant to give NPs and PAs more autonomy. Dr. Jack Needleman, a health policy expert at the University of California Los Angeles, School of Public Health asks, "Where is the evidence that patients' health is put in jeopardy by NPs? There's no evidence to support that." Dr. Needleman reports that studies have shown that NPs are better at listening to patients and: "They make good decisions about when to refer patients to doctors for more specialized care." The AMA is fighting proposals in about 28 states that are considering steps to expand what nurse practitioners can do. (Robert Woods Johnson Foundation, August 2001).

The Associated Press reports that the best American study comparing nurse practitioners and doctors involved over 1,300 patients who were randomly assigned to either a nurse practitioner or a doctor. After six months, overall health, diabetes tests, asthma tests and use of medical services like specialists were essentially the same in the two groups (Johnson April 16, 2010).

As early as 1979, the nonpartisan Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction. (CBO, 1979; see also U.S. Congress, Office of Technology Assessment 1986). Later studies reach similar conclusions (e.g., Horrock, Anderson & Salisbury 2002; Robert Woods Johnson Foundation, August 2001; and *Journal of the American Medical Association*, June 12, 2001).

Another advantage that the use of limited licensure providers is said to have is the lowering of health care costs. In some states NPs can receive payment under their own Medicare provider number and are reimbursed at 15% less than a physician would receive (Blair & Carnes February 24, 2010). Most insurance companies follow Medicare's reimbursement policy fairly closely. NPs in Alabama cannot at this time receive direct reimbursement from insurance companies. In Massachusetts, the model for the federal health care reform plan, a law was passed in 2008 requiring health plans to recognize and reimburse nurse practitioners as primary care providers. That greatly opened up the supply of primary care providers, yet, there was still a large demand for primary care. The committee was unable to determine if PAs were included in the payment plan.

The Affordable Health Care Act expands the role of NP by allocating: \$50 million to nurse-managed health clinics that offer primary care to low-income patients; \$50 million annually from 2012-2015 for hospitals to train nurses with advanced degrees to care for Medicare patients; and 10% bonuses from Medicare from 2011-2016 to primary care providers, including nurse practitioners, who work in areas where doctors are scarce. (Johnson April 16, 2010) These moves not only are aimed at lowering costs but to push state and state regulated institutions toward advocacy of a great role for the Advanced Practice Nurse.

Dr. Lori Lioce, Professor of Nursing at the University of Alabama in Huntsville, argues that in order for NPs to function effectively to the full scope of their education, the Alabama legislature needs to authorize the following: (1) recognition of NPs as "Primary Care Providers," in the statute; (2) expanded authority to prescribe "Scheduled Drugs II-V," and (3) making the Alabama Board of Nursing the DEA Certifying Body for NPs. (Lioce August 24, 2010)

Message 2: Need for Expanded Education and Training

The second key message of *The Future of Nursing* addresses the ability of nurses to advance their education in a seamless academic system. This means that a nurse with an ADN (Associate degree) or diploma (limited college credits) RN should be able to add to the basic education to advance a career, open up other career options, or advance in the nursing field.

Presently 50 percent of RNs have a baccalaureate degree. To achieve the proposed goal of 80% with BS degrees by 2020, partnerships would be necessary among nursing accrediting bodies, funding sources, and nurse employers. Hospitals are the major employer of nurses. Many hospital organizations now provide scholarships to students who agree to work at the hospital after graduation. Other employers encourage nurses to obtain further education by offering career advancement incentives, adjustable work schedules, salary differentials or tuition reimbursement. With the increased acuity of patients, nurses who can utilize decision-making skills and assessment skills are in demand. BSN nurses develop these skills during their basic education and continue to refine the skills.

In addition to student incentives, private and public funding sources would need to collaborate and perhaps share funds to expand the student capacity of baccalaureate programs. These efforts would also involve hiring more faculty members, expanding clinical partnerships, and using technology for instruction. Strategies to increase diversity of the nursing workforce must be implemented. When gender, racial/ethnic, and geographic distribution is increased, nursing will better serve a diverse nation.

By encouraging education advancement beyond basic education, using collaboration between the hospital and school of nursing staff, on-line technology, and joint clinical lab facilities, nurses can increase available faculty for pre-licensure students. Having an RN to BSN program allows a seamless transition and use of both college/university and hospital resources. BSN requirements after the basic nursing degree usually involve non-nursing disciplines with specific nursing courses available on-line or with preceptorships with practicing nurses. New providers of nursing education offer additional opportunities. Some are for-profit nursing school. Some combine LPN-BSN or ADN-MSN programs.

One area of concern is that of nursing faculty shortages. Currently there are more qualified applicants to nursing schools than can be accepted. The main challenge is the aging of the current faculty and shrinking numbers of newer faculty. The IOM (2011) reports that 84% of nursing schools found it difficult or very difficult to higher new faculty. The major problems are not finding enough qualified candidates or not being able to offer competitive salaries. Faculty teaching particular nursing specialties must be certified in those areas. Thus, a pediatric nurse cannot teach psychiatric nursing without evidence of study in the particular field. Often salaries for administrative or executive nurses are greater than faculty salaries. Increasingly nursing faculty must hold an appropriate doctoral degree. Nursing faculty in an academic setting must meet the same requirements for tenure and promotion that faculty in other disciplines meet. This involves research, teaching, and service. However, the majority of nursing faculty has greater contact time with students due to clinical supervision with an 8:1 ratio. This aspect often is not accounted for in meeting academic obligations.

Exploring clinical partnerships, using technology or simulation labs and on-line courses to provide instruction might encourage more nurses to explore an academic career. Promoting preceptorships for students with practicing nurses, supplementing faculty salaries with clinical practice options, and engaging in joint research projects can also attract faculty. Offering competitive salaries to nurse faculty, offering tuition reimbursement or loan forgiveness to those seeking advanced degrees will promote greater faculty numbers. With larger faculty numbers, more qualified students can be enrolled in nursing schools.

Another barrier in meeting educational needs is the shrinking number of clinical placement opportunities for students to learn their profession in reality settings. Most nursing courses include a clinical practice component. Students work at a designated clinical site under faculty or clinical preceptor supervision. Students interact with “real” patients to sharpen skills, make decisions, record actions, and learn to be a team member. Most of the clinical settings are in acute care areas though some experiences occur in community-based agencies. The challenge is to ensure that students do not just repeat routine care tasks but develop clinical reasoning skills. Innovations in this area include using skilled and experienced nurses to oversee student practice. It is essential to have a variety of practice settings to accommodate the number of students. Some practice settings refuse to allow students while others will accept one or two. Partnerships with the academic and practice settings are essential to offer students a variety of situations. One innovative option is the use of a dedicated educational unit (DEU). A particular hospital unit is used only to instruct students. Staff nurses on the unit are there to teach with faculty support. Students have a particular rotation with a specific staff nurse. The hospital employs the staff nurses so the school can increase enrollment without additional costs.

Changes in the nursing curriculum need to reflect the changing practice environment and the impact of health policy and research on knowledge. Currently, most nursing curricula focus on acute care rather than community settings especially in the Associate Degree programs. Curricula generally follow the traditional medical specialties such as maternal health, pediatrics, medical-surgical or adult health areas. These traditional models do not reflect the increased knowledge, decision-making skills, care coordination, and changing technology that impact current nursing practice.

To alter curricula, the teaching-learning strategies require adaptation. Faculty would benefit from preparation in curriculum development, instructional design and performance assessment. Accreditation standards ought to support such changes. Efforts to make nursing courses transferable between institutions would benefit mobile students and faculty. Encouraging life-long learning in students promotes continued competency. Collaboration with other professions is essential to competent practice. Whenever possible, nurses should be educated in classes with other disciplines.

In summary, to achieve the goal of providing a health care system that responds to the needs for quality care to those who need care will require a transformation in the nursing profession. Changes are needed in the work environment, the numbers of nurses, the education system, and the scope of practice for nurses. *The Future of Nursing* study argues that nurses can play an essential role in meeting the needs of diverse populations across the lifespan now and in the future if major changes occur within the profession and the education and health care communities.

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Asterisk (*) indicates highly recommended readings

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Appendix

Comparisons of Advanced Practice Registered Nurses Restrictions in Southern U.S. States

State	Physician Involvement	Prescribing Restrictions	Additional Restrictions
Alabama	<ul style="list-style-type: none">• Required Collaborative Practice Agreement (CPA) and protocol with Alabama MD	<ul style="list-style-type: none">• Restricted to formulary—cannot Rx any new drugs unless CPA revised.• No controlled substances (CS)	<ul style="list-style-type: none">• Can only order labs or x-rays as specified on protocol• Cannot order physical therapy• Can perform but cannot sign sports physicals• Recent state Medicaid ruling NOT to list nurse practitioners (NPs) as primary care providers
Arkansas	<ul style="list-style-type: none">• Required CPA for prescribing	<ul style="list-style-type: none">• CS restricted to III-V	<ul style="list-style-type: none">• NPs have no legal right to be listed on provider panels as primary care providers
Florida	<ul style="list-style-type: none">• Supervision by a Florida MD or dentist• Written protocol required	<ul style="list-style-type: none">• No CS• Written practice protocol—outlines generic and broad drug categories	<ul style="list-style-type: none">• NPs who practice in specialty areas must have all consultations reviewed and co-signed by the supervising physician• No NP reimbursement by HMOs

State	Physician Involvement	Prescribing Restrictions	Additional Restrictions
Georgia	<ul style="list-style-type: none"> • Required Nurse Protocol Agreement that spells out what drugs, medical treatments, and diagnostic tests NP can order 	<ul style="list-style-type: none"> • Protocol limits number of refills which may be ordered • NPs may order CS II-V but physician must review and sign all records and patients must be examined by the delegating physician at least quarterly 	<ul style="list-style-type: none"> • Radiographic image tests (CT, MRI) may be ordered in life-threatening situations • Delegating physician required to review and sign 10 percent of all NP's medical records
Kentucky	<ul style="list-style-type: none"> • Two required CPAs – one for non scheduled drugs and one for controlled substances 	<ul style="list-style-type: none"> • CS II-V after one year of practice • Schedule II limited to a 72 hour supply • Valium, Xanax and Hydrocodone prescriptions limited to a two week supply with no refills 	<ul style="list-style-type: none"> • NPs' hospital privileges limited as regulations specify that a physician has overall responsibility for each patient
Louisiana	<ul style="list-style-type: none"> • Practice in collaboration with MD or dentist with written CPA and with detailed protocols 	<ul style="list-style-type: none"> • Schedule II under certain circumstances • No CS for treating chronic and intractable pain 	<ul style="list-style-type: none"> • Detailed protocols are clinical practice guidelines that describe a specific sequence of orders to be followed in various clinical situations • Requires physician examination when patient needs are outside of protocol
Mississippi	<ul style="list-style-type: none"> • NPs must practice in a collaborative/consultative relationship with a physician. Board of Nursing must approve specific and detailed protocols/guidelines that APRN and MD develop • Protocol must identify diagnoses within APRN's scope of practice 	<ul style="list-style-type: none"> • For CS, the Board of Nursing requires a letter from NP and the collaborative/consultative physician outlining the NP's practice including population served and types of diseases treated • Board of Nursing may approve any combination of Schedules II-V or may deny CS 	<ul style="list-style-type: none"> • A detailed quality assurance program to evaluate NP prescribing practices is required
North Carolina	<ul style="list-style-type: none"> • Board of Nursing and Board of Medicine must authorize "Approval to Practice" under a CPA requiring an MD to continually supervise and evaluate the APRN 	<ul style="list-style-type: none"> • Included in the CPA—CS-II-V but limited to 30 days and no refills 	<ul style="list-style-type: none"> • During the first six months of the CPA, the physician must review and sign all of the NP's medical records

State	Physician Involvement	Prescribing Restrictions	Additional Restrictions
South Carolina	<ul style="list-style-type: none"> • Supervision by an MD who delegates medical acts by protocols subject to Board of Nursing and Board of Medicine approval 	<ul style="list-style-type: none"> • Prescriptions are limited to drugs for “common well-defined medical problems” included in protocols • CS limited to III-V only 	<ul style="list-style-type: none"> • Number of NPs supervised by physician or dentist is limited
Tennessee	<ul style="list-style-type: none"> • Written guideline/protocol/formulary for prescribing only—with a supervising MD 	<ul style="list-style-type: none"> • Physician shall “supervise, control, and be responsible” for NP’s prescriptions. • Certificate of Fitness to Prescribe required for NPs 	<ul style="list-style-type: none"> • Physician must sign the NP’s chart documentation for all patients prescribed a controlled drug
Texas	<ul style="list-style-type: none"> • Delegation and supervision by MD with protocols agreed upon by APRN and MD 	<ul style="list-style-type: none"> • Agreed upon protocols—CS-III-V, limited to 90 days 	<ul style="list-style-type: none"> • NPs working in medically underserved areas must report daily to delegating physician and physician must review 10% of NP’s charts • NPs practicing in facilities may sign drug orders only for those patients for whom physicians have given their prior consent
Virginia	<ul style="list-style-type: none"> • In collaboration with and under the medical supervision of an MD, an APRN may engage in practices constituting the practice of medicine 	<ul style="list-style-type: none"> • A separate written practice agreement with the supervising MD—CS-II-V 	<ul style="list-style-type: none"> • Number of NPs supervised by physician is limited • Physician required to conduct a monthly random review of NP’s charts

Source: Access to Care and Advanced Practice Nurses: A Review of Southern U.S. Practice Laws, Table 1. ARRP Public Policy Institute, Center to Champion Nursing in America. Washington, DC: 2010.