Podcast Transcript

Nurse Practitioner Regulations and Practice Issues: Pandemic to Future Considerations

The following transcript has been lightly edited for clarity. Elite Learning does not warrant the accuracy or totality of audio transcriptions provided by an independent contractor resulting from inaudible passages or transcription error. An occasional transcription error may occur.

Listen, Learn, and Earn CE Hours with this podcast course. Available on Apple, Spotify, and other podcast apps.

Guest

Alysia Pack, DNP, APRN, FNP-C

- Nurse practitioner
  - Virginia Council of Nurse Practitioners, State President-Elect, 2022-2024 term
  - Autonomous licensed, board certified family nurse practitioner
  - Helped to create academic-community partnerships for NP-led, behavioral integrative care clinics to promote health equity of vulnerable populations
- Advocate, collaborator, educator
  - Over 20 years of work in patient care and health advocacy
  - Has advocated at Capitol Hill and collaborated with lobbyists, lawmakers, and interprofessional provider groups to promote the advancement of nursing practice and patient access to quality, affordable, and accessible healthcare
  - Adjunct faculty for a graduate nursing program

Host and Content Reviewer

Maria Morales, MSN, RN, CLNC

- Maria Morales is a nurse planner for Colibri Group and a certified legal nurse consultant. She is a quality-focused, results-driven nursing education professional. As a continuing education leader with nurse executive experience in developing interprofessional educational programs, she supports healthcare workers with educational activities to help increase communication within the healthcare team.

Transcript

Episode 1 – NP Practice: Then and Now

SOUNDBITE OF MUSIC

MARIA MORALES, HOST: Hello, and thank you for taking the time to join us today. I am Maria Morales with Colibri Healthcare. Our goal for this podcast is to highlight nurse practitioners and talk about some of the changes related to regulations and practice issues that have been shifting lately.

The background setting for this conversation is how the pandemic led to emergency measures, which enabled some nurse practitioners to be able to practice more fully than before (Stucky et al., 2021). We can dive into this some more later, but the question remains as to what happens when we approach the end phase of the pandemic, and states continue to end their emergency orders and return to non-emergency status (Ballotpedia).

So during the podcast episodes, we will discuss nurse practitioner practice and what it may have looked like before the pandemic and during the pandemic. Then we can talk about how practice might be looking as state emergency measures expire (and some state's emergency measures have already expired). We wanna examine the differences between scope of practice and practice authority, and who doesn't want to chat about the possibilities of how the pandemic might have set the stage for more nurse practitioners to practice at a fuller extent? Could the need for an all hands-on deck kind of approach to healthcare during the pandemic have helped to advertise how much more nurse practitioners can continue to help with the provision of healthcare? Or, will regulations just quietly go back to pre-pandemic normals?

To address some of those interesting topics and jump into this nurse practitioner practice debate, we are joined by Dr. Alysia Pack, a doctor of nursing practice-prepared and board certified nurse practitioner. She is the president elect of the Virginia Council of Nurse Practitioners. So, let's learn some more about Dr. Pack here. Dr. Alysia E. Pack, DNP, APRN, FNP-C is an autonomous licensed advanced practice registered nurse and board certified family nurse practitioner with over 20 years of work in patient care and health advocacy. From her experiences as a novice nurse practitioner, grew an intense interest and passion to make changes to the existing healthcare landscape, whereby the autonomy, voice, and respect of the nurse practitioner was the rule and not the exception. That's great! Her career has led her to advocate at Capitol Hill and most recently to collaborate with lobbyists, lawmakers, and interprofessional provider groups to promote the advancement of nursing practice and patient access to quality, affordable, and accessible healthcare. In addition to her grassroots efforts, Dr. Pack is currently the state president elect for the Virginia Council of Nurse Practitioners and serves on their board of directors and government relations committees. She also works as adjunct clinical faculty for Old Dominion University, College of Health Sciences School of Nursing's graduate program. And I'm kind of local in Virginia, so big shout out to ODU. And within their research foundation, she helps to create academic community partnerships for nurse practitioner led behavioral integrative care clinics to promote health equity of vulnerable populations and the increased access of advanced practice clinical training sites throughout Southeast Virginia.

Okay! So, you have a lot going on and that all sounds very interesting. So, before we talk about your successful journey from CNA all the way up to DNP, please share with us more about your research and your work with the integrative care clinics. I'd love to hear some more about that and, uh, what some of the great work overall that's happened as you help promote health equity via nurse practitioners.

DR. ALYSIA PACK, GUEST: Wow. Well, thank you Maria for such a generous introduction and for inviting me here to be with you today. And, yes, most recently my colleagues and I have developed and implemented a nurse

practitioner led primary and behavioral integrative clinic based within a preexisting homeless program. Discovering that many of the populations, over social determinants of health, were being met through the daily program, such as food, shelter, placement, job training, and more. There was kind of one thing missing, and that was the access to continuous and reliable healthcare. This was a federally funded academic community collaboration that allowed both primary and behavioral healthcare to be delivered to the communities' underserved population as well as it increased the opportunities for clinical training of both undergraduate and graduate nursing students enrolled in the university. It initially started as a pop-up clinic, sort of a pilot study, and has since expanded to being a full-time clinic, offering an array of primary and specialty onsite and telehealth services. It really is truly an innovative project in something I plan to carry on in other underserved and geographically remote regions within my community.

MORALES: Oh yeah. That's great! I really like that. It's fantastic! And, how did you enter the world of the "political machine" of DC so to speak? How did you transition from provider of care duties to then working with lobbyists and lawmakers? Because that's, it's kind of a different specialty area kind of thing, you know, not every nurse does that. So how, how did that work?

PACK: Yeah, "the political machine!" Yes. Well, it, it most certainly wasn't my plans to enter the machine, I guess, but rather the machine kind of found its way to me meaning like through, through my years of work as an NP and in advocating for change and working tirelessly on the floor but continuing to get shut down by leaders, who didn't really prefer to hear the insights or recommendations of an NP.

In addition to my participation as a member of my local professional organization, I actually realized there was a tool to help us make changes, in what I thought were injustices of care, legislation, and professional practice. I have to say, I, I was also influenced and educated by my partner, who is an active member in the community town council and other decision-making boards and, and through the many years of his service and then listening to all the things, I indirectly learned a lot about the political landscape and how to navigate pathways for change. So, it, it incrementally became a part of my daily life, and I guess as a result, kind of became a passion of my own.

MORALES: Oh yeah, that's great. We, we need people like you out there advocating, so I'm glad to hear about it. Okay. And so something else that was interesting though is you had mentioned to me something about progressing from your CNA up through your DNP. So, I wanted to make sure we had some time to talk about that. So, your professional journey allowed you to work at most every level of the nursing practice continuum. In high school as a CNA, then going through LPN school, receiving your RN diploma, attending nights and weekend courses to earn your BSN, obtaining your masters, practicing as a family nurse practitioner since 2009, and then most recently your academic accomplishment as a doctor of nursing practice. So, congratulations to you!

PACK: Thank you. Thank you. Thank you!

MORALES: I would just say, hey, I'm kind of astounded by your commitment and definitely congratulate you on your successes! Yeah. I'm kinda wondering how you got all this in! Maybe that would be another podcast. How did you do all this? So yeah, so congratulations again and just tell what was your driving force? Did you set out thinking, I have this long-term goal, and this is where I'll get by such and such a year? Or, did it kind of just come in piece by piece?

PACK: Yeah, I, I think more of the, the piece by piece, you know. I must be honest. And looking back at the, the high school part, it, it wasn't what I thought I was going to have as a career. In fact, I ….

MORALES: Oh, I like stories like this, Yes! Tell us.

PACK: I recall trying hard to pick something else, maybe something more glamorous or, or at that time what I thought was, uh, more respectable. But I was good at caring for people. I, I discovered that, this was in fact a way that I could make a lasting and positive impact in someone else's life, and even my own. I mean, instinctually, I've somehow always been a disruptor. So, the good thing about that is, it works well to be, such a thing in my profession, especially now as the nation, you know, has called for change and the reinnovation of healthcare systems and healthcare delivery.

MORALES: Okay. All right. There's one thing to, let's say you've had your diploma, you become an RN, and then you, you know, you go back to school to get, you know, your next, uh, academic training.

PACK: Right.

MORALES: But can you tell us just a little bit more of, of deciding, “Okay, I'm going to be an NP,” and then, “Okay, I'm going to get my doctorate” or my doctor of nursing practice.

PACK: Well, I, I, I always will tell you I wanted to be an RN, you know, and after, I guess years of work, and many listeners can, can probably, you know, have felt the same, working in the ER year after year and on the floors. Well, to be honest, your body kind of starts hurting. Right, right? And, and more and more, you know, I started becoming confident in, in my knowledge and ability and, and ultimately wanted to be a leading decision-maker in collaboration with my patients. So, I became a nurse practitioner. And, and I do recall on the day of my graduation, in December of 2008, the day of, I looked at my husband and said, “I'm gonna go get my doctorate.”

And, you should have seen his face! Like, literally, I'm pretty sure the word “divorced” was somewhere soon after that because, you know, he is like, you know, it's a lot that they also contribute towards your education. You know, so here we are after many years, you know, I fulfilled those goals, and received my terminal degree within the past year. I definitely will say I am the classic textbook case definition of a professional student, and yes, I can accept it!

MORALES: Okay. Okay. All right! And, then there is something else we haven't talked about! Something about being a nurse leadership fellow.

PACK: Yes, Yes.

MORALES: Tell us about that.

PACK: So I, I started my family nurse practitioner practice actually in the foundations of emergency and, and urgent care practice. I've also undertaken various clinical leadership roles, within the outpatient setting, I guess to include like hospice and corporate health and …

MORALES: Hmm.

PACK: … and primary and behavioral health. Which kind of led an opportunity to be led to apply to Duke, uh, Johnson and Johnson's, Nurse Leadership Fellowship. So me, along with like 30 other colleagues across the nation, trained for a fellowship for about a year, and it was absolutely exciting.

MORALES: That's great. Love it! Okay, so, before we jump into more of the heavy nurse practitioner regulatory type stuff, I just wanted to ask you, what is one of the highlights for you of being a nurse practitioner in these current times?

PACK: Okay, so in these current times, it's truly empowering actually. We're currently bearing witness to a massive growth and advancement of nurse practitioners’ practice and profession. There's 355,000 nurse practitioners nationwide (AANP, 2022, NP Fact Sheet). This is markedly higher number than that was first

anticipated. I think it was 328,000 that was projected, for 2030 by the U.S. Labor Department (NursingProcess.org). But for 2031, projections of employment have increased to about 359,000 (BLS.gov), close to there.

MORALES: That's a jump!

PACK: Yes. Yes. It's incredible! So because of our, professional growth, low unemployment rate and advantageous career trajectory, the U.S. World and News Report actually has rated the nurse practitioner as the number one best healthcare job.

And, number two, yeah, number two, best jobs overall in their 2022 report. So that's even more thrilling. And, even more thrilling is that the call by leading healthcare organizations such as the, you know, the National Academies of Medicine has helped facilitate the support of the dissolution of many kinds of antiquated practice barriers that nurse practitioners have faced. So, what's exciting for me? I'd say these are historical times for our profession, and I'm just gracious to be a part.

MORALES: Okay. And, when you talk about antiquated practice barriers, are you talking about some of the like limitations on practice in some areas?

PACK: Yes, there's a lot of, uh, a lot of red tape. I, I think a, a quick answer to your question would be, uh, we know how nursing started, Florence Nightingale, in the, in the 1800s. She sought a need, for human touch and caring. And generationally we've evolved from being someone who is, from only assisting then actually being a part of the patient healthcare team.

So with evolution comes change and innovation. And, when there's need then we, we too have to evolve. So the red tape with practice barriers has created somewhat of challenges in order to evolve. And so that's kind of what I mean.

MORALES: Okay. All right. Well, it's nice to have you here speaking with us today. I know you bring an interesting perspective since you have the nurse practitioner clinical background along with the heart for health equity and then the lobbying/legislative/advocacy context to your career. And I've found that you speak very practically and real, and you also bring the scholarly components.

Anyway, I look forward to this. So let's take some time to discuss some of the regulatory related nurse practitioner practice issues and go ahead and jump in. Okay! So, for quite sometime, there have been articles, blogs, uh, you know, coworker chats, academic discussions, even political conversations where people are talking about the scope of practice issues for nurse practitioners.

There's possibilities for enhanced or less restricted scope of practice. How NPs could support the provision of quality care and quantity of care, how they could fill some gaps. The sometimes untapped potential of nurse practitioners where regulations on practice are more limited. So, let's go back to the beginning as you kind of brought up Florence Nightingale already. How did the NP role come about? In, in doing some reading for this podcast, I read something about the official NP role in this country goes back to the 1960s?

PACK: Yeah, yeah, that's correct, actually. The first advanced practice curriculum and training was developed by Loretta Ford, a nurse practitioner, in collaboration with Dr. Henry Silver, a medical doctor at the University of Colorado in 1965. Dr. Ford actually was a member of public health nursing faculty at the University of Colorado, their school of nursing, and was active in many of their higher education nursing organizations. And so while she was working actually, to identify some advanced content for their clinical master's curricula, for the public health school and the maternal child school, psychiatry, and such, she became aware that one of the health conferences had identified a major difficulty in staffing local clinics.

And so from there, she reported that she saw this as like an opportunity for nursing and worked with, with, yeah, with the pediatrician, Dr. Silver, to formulate a model of care and curriculum drawn from her experience, in rural Colorado and then from Dr. Silver's pediatric experience. So her idea, for the curriculum development was to pilot a concept, I guess, or content, prior to embedding it into the actual curriculum. I think she said, instead of putting in the curriculum, people sit around and talk all the time. So, she was like, “Hey, let's do it!” I can appreciate that.

MORALES: There you go!

PACK: Yeah. And, and so the new model actually that is now known as the pediatric nurse practitioner role was devised to improve the health and wellbeing of those children to increase access to providers that were educationally prepared to provide such care and prepared at the university. I think one of the biggest things to remember, Maria, is that, remember what happened here. Dr. Ford recognized a need both within her community and within her own practice, and as a result, she created opportunity. Her contributions have led the way towards advancing nursing scope of practice and the development of various advanced practice roles that we have today (Berg, 2020).

MORALES: I'm glad to hear that background. All right. So, we know once we have a new role then comes the organizational change and the rules and the regulations. Once this NP role was established and began to grow, can you tell us more information about the beginnings of regulating and then legislating this professional NP role or scope of practice in general?

PACK: Yes, of course. I guess according to the National Council of State Boards of Nursing, they're also called the NCSBN, and the Federation of, uh, State Medical Boards. Scope of practice is defined as “a set of rules, regulations, and boundaries within which a fully qualified NP may practice” (Kleinpell et al., 2012). So early on, NPs actually created self-imposed regulations emerging from what was once a certificate program, which is now, requires graduate level degree. In addition, they adopted a uniform core requirements for all NP training, and met, uh, nationally vetted education and accreditation standards. These advancements were made in conjunction with nursing regulatory groups, uh, who were responsible for monitoring an oversight of NP practice to ensure public safety.

Yet despite these efforts to self-govern and standardize the APRN's preparation, APRN meaning advanced practice registered nurse, role cross border recognition and scope of practice varies from state to state for nurse practitioners. This is actually unlike any other of their allied counterparts because, it isn't such for RNs, MDs, and PAs (Kleinpell et al., 2012). So, if we dig a little deeper into the legislative process, state regulatory boards were established in the seventies or eighties, I'd say. The purpose of these regulatory boards is to protect the public and to ensure licensed professionals comply within their scope of practice. In this instance, scope of practice is the defined set of rules about the actions that can be performed under a professional state licensure.

So, across the country, each state has a regulatory board whose members are in good standing and primarily of the same profession. They are responsible for developing the content of the scope of practice for licensed individuals. State legislators then approve the content created by these regulatory boards, which in final draft is brought forth by the state's board of nursing. And then once approved, these statutes are then referred to as what many people know as practice acts.

MORALES: Ah ha! So, you mentioned the legislation. So, we know from earlier you have some familiarity with the legislative aspect of, uh, public health policy and the advocacy side of nursing. We, we know that nurses in general are advocates for patients. So, please explain some more about the advocacy role that you and other nurse practitioners provide within this legislation and public health policy realm.

PACK: Yes, that's absolutely true! Nurses are often instinctually advocates. Historically it's been primarily utilized for the health and wellbeing of our patients. However, just as our patients' needs, professional practices, and healthcare landscape change over time. Uh, so have the roles and responsibilities of advocacy and nursing.

So, within legislative and policy realm, there are numerous ways in which nurses can participate and advocate to impact, public health policy. Would you like me to name a few examples, Maria?

MORALES: Yes, please go for it!

PACK: Okay. So, grassroots efforts, you can join your professional organization. Often many only join their national organization, but it is essential that they be active in their state organization as well. Remember they have different agendas: One, federal law, the other state law. And as many know, we are often, more often impacted by our local and state governance daily compared to federally or nationally speaking. You could ...

MORALES: Oh, I'm so glad you said that. Yes, that is a great point. You're right, sometimes we're very nationally focused, but not so much locally and, and that really impacts exactly where we are!

PACK: Right, right. At home every day. Yes. I guess another example could be meeting and contacting your representative. There are user friendly tools available to help guide your advocacy efforts with confidence. I know sometimes it's like, "Oh, I don't wanna reach out. They're a senator, or they have all these letters." Or, and, and that's not the case. And, these tools actually do, do help.

And what also would help is educating yourself in the legislative process, knowing who your representatives are. Making yourself known by contacting them on a, on a frequent basis. Attending town halls are another good idea. Believe it or not, they're just like you and me! I recently attended one, for a delegate locally, and she looked like me, talked like me, was the same age as me, had long green nails! Right? I mean, you know, we put, we put these people on a pedestal sometimes, and they're just like you and me. So, they represent us and, and it's important that we communicate our needs to them. I, I think one of the biggest things, Maria, that I've learned in advocacy is documenting the stories of impact. They, meaning your representative, want to hear how you impact your community or what is going on in your community. And, if you don't want to directly impact or directly communicate with your legislator, you know, you can shoot your email to a professional organization (even if you're not a member). They actually want to know the barriers, and they're there to help. Joining a board is a good idea, and ultimately you could run for public office.

We recently had, uh, two people that are nurse practitioners that are in office in Virginia. One currently is running in a very controversial race in the Senate for a federal seat. So, it can happen, and it does happen, and we're moving towards that. So those are just a few ways.

MORALES: Yeah, that's great. You know, within the nursing community, we always talk about representation and things. It's always great to have nurses, uh, have a seat at some of these tables.

PACK: Absolutely.

MORALES: You know, they, they've been there. They know what the issues are and, and what it feels like.

PACK: Right.

MORALES: Let's talk a little bit about the lobbying part. Um, you have had some experiences with collaborating with lobbyists for promoting the advancement of nursing practice. So, educate us about the lobbying part.

PACK: Ah, lobbying! Okay, so, let me give you the definition of lobbying. So, a Merriam Webster (n.d.) definition. The phrase "to lobby" or the term lobbyist dates as far back as the 1640s. It actually has been used to reference

people or the action of people who met in a gathered area, like a lobby or a legislative hall, to discuss the issues with or influence the decision-making of their elected officials.

And although politics have certainly changed since the 19, or rather the 1640s, the need for lobbyists in an official capacity actually has not. And, most state and national professional organizations work with lobbyists to effectively move their organization's agenda forward. Lobbyists are well versed and experienced in the, in the legislative arena. They are graduate prepared. They often have a background in law, health policy, or, or healthcare administration. Their primary agenda, remember, is to navigate the complexities of policy-making and to advocate on behalf of their client's interest.

So, in the NP organization world, this is quite helpful, as we often do not have the time or legal expertise it takes to do so. We have other things that that are taking up our time. Let me give you an example of how a lobbyist would help me. If my NP organization wanted to put forth legislation to obtain full practice authority, the lobbyists will assess the political climate, report back to the organization's leadership and government relations committee regarding an ideal strategy for the best outcomes for the upcoming legislative session.

They also draft the written bill. They help find a congressional representative in either the House or the Senate to sponsor the bill. If bipartisan sponsorship can be obtained or there is a large amount of congressional support or sponsors for the bill, the better our chances are for the bill to be addressed during the session or actually passed into law.

MORALES: Okay. That was good. That helps me put the picture together a little bit and see how these things move. Back to NP scope of practice. Okay, so the pandemic was interesting! It ushered in some expanded practice possibilities or allowances, you know, because we <u>needed</u> it. So, is there a way for you to explain kind of where we were before the pandemic? And then the next question would be, you know, about changes to allow an expanded scope of practice for some nurse practitioners.

PACK: Okay, so one way to determine this is to look back at how the state's practice environments were defined by leading nursing organizations such as the American Association of Nurse Practitioners, or as we like to call AANP. Um, so prior to, and even now, in many states, the NP scope of practice is reduced or restricted. That means that the set of rules mandated by that state in some way limit the NP to work exclusively under the nursing board or to the full extent of their training and expertise. National nursing organizations have categorized the practice environments of each state into one of three categories, and many listeners may be familiar with AANP's map of the U. S. that color codes these states in red, yellow, or green categories (AANP, 2022, State Practice Environment).

So, the three categories, okay, are restricted, which are red states, and that means that they have state laws that restrict the ability of NPs to engage in at least one element of NP practice. This state law requires career long delegation or team management by another healthcare provider in order for that NP to provide care.

So reduced practice, which is the yellow states on that map, they have practice, state practice and licensure laws that reduce the ability of the NPs to engage in at least one element of nurse practitioner practice. So, the state law requires a career long regulated collaborative agreement with another healthcare provider in order for the NP to practice, or it limits the setting of one or more elements of the NP's practice.

And then lastly, we have the green state, which is the goal for our leading nursing organizations. And that is the full practice state or full practice authority, which means that these states' practice and licensure laws actually permit all NPs "to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments" including "prescribing medications" and controlled substances (AANP, 2022, Issues).

And, this is the key under the exclusive licensure authority of the state board of nursing. So, let me give you an example, Maria. Virginia is considered a restricted practice state, because it requires a five-year physician practice agreement. It is not under the exclusive license authority of the state board of nursing, but rather the joint boards of medicine and nursing. And to note in the states without full practice authority, Virginia actually has a five-year requirement for autonomous licensure, which is a major outlier compared to similar states with a mean of two years.

MORALES: All right. So, prior to the pandemic, how many states, in how many states were nurse practitioners in some way limited in their ability to deliver patient care?

PACK: So, as of 2019, there were 28 states that limited nurse practitioners, in a variety of ways. So, for example, many states require nurse practitioners to work under the supervision of physicians, through contracts called collaborative practice agreements, where physicians determine which exact services NPs are allowed to offer and restrict the ones they believe NPs lack the training to deliver. Uh, let's see. In Florida, it's required that NPs practice 25 miles or less from their supervising physician's office, or 75 miles within a county that is neighboring to that physician's office. In Missouri, NPs were prohibited from practicing more than 75 miles from their supervising physician.

And some mandate, uh, nurse practitioners practice under physician supervision for a minimum period of time. And, uh, additional education before a collaborative agreement is required. For instance, Minnesota NPs must work 2080 hours under the supervision of a physician before they can practice autonomously. Illinois nurses must work 4,000 hours under a supervision of a physician, um, and then complete 250 additional hours of continuing education.

SOUNDBITE OF MUSIC

MORALES: Okay, the 2080 is sticking out to me. I think we might talk about that later. I think that's bit controversial.

PACK: It is!

MORALES: ... whether you can just graduate and start working or you need these hours, but the time has gone by quickly! So, I think it's already time to conclude episode one of this podcast. Thanks to everyone for joining us. Please return for episode two as we continue discussing this topic. A sincere thank you to Dr. Alysia Pack. This is Maria Morales for Colibri Healthcare.

SOUNDBITE OF MUSIC

Episode 2 – NP Practice: Professional Issues

SOUNDBITE OF MUSIC

MORALES: Hello and welcome back for episode two of our series, Nurse Practitioner Regulations and Practice Issues: Pandemic to Future Considerations. Let's jump back into the conversation. So, before we were talking about some limitations on nurse practitioner practice. During the pandemic changes occurred, which paved the way for states to choose to allow for an expanded scope of practice, like during the timeframes of the pandemic and states of emergency. Um, there were decreased regulatory restrictions in those states without full practice authority. That's FPA, right?

PACK: Right.

MORALES: How did some of this work out and impact nurse practitioner practice?

PACK: Uh, Right. So, as we know, the end of 2019 brought a new global healthcare crisis, and, and NPs were called upon to care for the nation's COVID-19 stricken patients, communities, and, and healthcare systems. In some states, scope of practice restriction was limiting the APRN's full contribution as providers. Primarily their requirements for physician oversight, which was exacerbating the issue of access to competent healthcare providers. So on March 24th, 2020, Health and Human Services Secretary, Alex Azar urged the states to lift their practice barriers, on APRNs, so that they can increase access to care.

So as a result, restricted and reduced practice states moved in some fashion or another towards suspending the restrictive practice laws, which ultimately expanded the nurse practitioner or APRN scope of practice. So, for example, in the states that remained without FPA or full practice authority, 13 states temporarily waived select practice agreements and five suspended all practice agreement requirements (Moore et al., 2020; AANP, 2022, March 31 COVID-19). West Virginia for example, suspended the co-signature requirement on refilled prescriptions by nurse practitioners for meds that were initially prescribed by the physician, just to name a few.

MORALES: It sounds like NP practice was and is regulated by the state level related to state boards of nursing and state law. You said something about that earlier, and this is bringing it back to that state level.

PACK: Yes. Yeah, you're correct. So, NP scope of practice laws are generally established by the, the state boards of nursing, and that's in one of three ways. They endorse a nationally vetted standards of practice statement established by a national organization that represents NPs. They craft state specific standard of practice statements based on stakeholder input, or they use a combination of national statements with state specific guidelines added to further clarify or provide clarity or restriction (Kleinpell et al., 2012). So, which in this case it appears, many states choose the latter gathering input from both national and state stakeholders to determine and clarify the new scope of practice laws for their states.

MORALES: That makes sense. We talked about the full practice authority. Please tell us more, remind us more about full practice authority for nurse practitioners.

PACK: Okay, so remember it is the practice model recommended by the National Academy of Medicine, formally called the Institute of Medicine, and the National Council of State Boards of Nursing. It requires that state practice and licensure laws to permit all NPs “to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments” including “prescribing medications” and controlled substances. Remember, under the exclusive licensure authority of the state board of nursing (AANP, 2022, Issues).

MORALES: Hmm. Okay, so this seems to be like something that there's a lot of opinions about. Particularly in the medical community, there have been different opinions for and against expanding nurse practitioner practice. So, where do we kind of stand today?

PACK: So as of July this year, 2022, there are 26 states or territories to include the District of Columbia, whose NPs have been granted with full practice authority. You know, Maria, there will always be differences.

MORALES: Haha, right.

PACK: However, I will say the scientific community, as a scientific community, these opinions do not outweigh the decades of evidence-based research that has demonstrated that NPs provide safe and effective care. They positively impact health outcomes, increase access to care, and whose services are utilized by every major national healthcare system across the nation.

MORALES: Good point!

PACK: Yeah. Yeah. I mean, in addition, opinions can't shrug off the reality that in the next 10 years, the United States will have 122,000 fewer physicians that are required to care for the patient population (Association of American Medical Colleges, 2019).

MORALES: That's a large number.

PACK: Yeah, it is. And so when practice authority is restricted in states, it severely limits the number of available providers. Let me give you an example. We talked about this: Limiting the distance that NPs can provide care or that NPs can practice prevents patients actually who live far from the physician's office to be cared for. Hmm. As a result, I will say Kaiser Family Foundation reported that over 80% of all Americans, who face primary care shortage, roughly 63 million individuals live in states that restrict access to NPs! (Van Vleet & Paradise, 2015; Kaiser Family Foundation 2022)

MORALES: Wow!

PACK: That's pretty, that's pretty significant! Yeah.

MORALES: Yes.

PACK: In addition, states that enact full practice authority have demonstrated decreased hospital use. It's reduced emergency room visits, increased the availability of healthcare provider follow ups, and expanded access to rural and underserved communities. There was a 2019 executive summary by the Americans for Prosperity report and, and it stated, that in states that implement full practice authority, they “spend 17 percent less per-capita on outpatient care, 11 percent less on prescription drugs, and 15 percent less on pediatric preventive care” compared to states that restrict access to nurse practitioners (Katebi, 2019, para 3). So that, that's significant economically as well.

MORALES: No, that, that's great! I mean, we're always talking about cost effective healthcare and how to provide, you know, better care for more people. There's the evidence right there!

PACK: Right, right, exactly.

MORALES: So let's say in the past few years, or in this time of the pandemic, do you think medical support, particularly for nurse practitioners has changed?

PACK: Yes, Yes, absolutely! There are many professional communities and providers that support the APRN role and the value that's added by their practice. This includes physicians whose scientific underpinnings are founded in the medical model. So, a prime example of how support has changed in the federal government was in 2016 under the Under Secretary of David Shulkin. They granted advanced practice registered nurses, including NPs, full practice authority to deliver care to veterans without the supervision of a physician. After lengthy review and controversy of veterans who were not being properly cared for, it was determined that the VA had the capacity “to provide timely, efficient, effective and safe primary care” via “making the most efficient use of APRN staff capabilities” and how it “provides a degree of much needed experience to alleviate the current access challenges that are affecting the VA” (U. S. Department of Veterans Affairs, 2016)

MORALES: They were able to, to really mobilize and increase their use of advanced practice nurses. Okay. well, while we're discussing this, sometimes there can be a question that comes up from those unfamiliar with the differences between, let's say, nursing and medical models of care, and the differences between the four major professional designations. So we have the nurse practitioner, which of course is a specific type of advanced

practice registered nurse, the physician assistant, and the nurse. And then of course we have the physicians. So, we have different roles. While many listeners from a nursing background may already know these differences and be extremely familiar, maybe you can provide some concise explanations that healthcare professionals in general can use to explain the differences to patients, clients, or even the public, to help avoid some of the stigmatizing or the misinterpreted language that some in the public realm use. I still hear things like, “What's a nurse practitioner?” Or, you know, the nurse practitioner … “Oh, is that the PA?”

PACK: Right, exactly.

MORALES: You know how it goes!

PACK: Yes. Yes. That's a million-dollar question, Maria, for sure! Or, and you know, and explaining those differences between those that, that aren't healthcare providers can be quite confusing. I totally get it. And, and there's so many different types, but, in speaking to your question in regards to the misinterpretations, I gather you were talking about the controversy or misperception that APRNs (and specifically speaking against the nurse practitioners) are trying to practice as physicians. And, and that is not at all the case. APRNs practice advanced practice nursing. Remember that. They do not intend or desire to practice as a physician as they weren't trained under the medical model to be physicians. And although the healthcare arena in which APRNs practice is often referred to as the world of medicine, um, that does not mean it is exclusive to physicians or those trained under the medical curriculum model.

MORALES: Well said.

PACK: Ah, I’d say furthermore, like personally speaking, when I am asked, so what's the difference between you or a PA or you and a doctor? I note that while yes, there is overlap in many of the services that we provide, there are distinct differences in our educational foundations, training requirements, the practice approaches, and pathways that we provide care. My own, being founded in scientific and theoretical underpinning of nursing or what people call the nursing model, and physicians and PAs are trained under the medical curriculum model. I am always clear to explain my scope of practice, expertise, training, and licensure capabilities.

MORALES: I like the way you said that. Yeah, that was very good. Unless you're very familiar or you've been to nursing school or medical school, yes, I think the lay public in general doesn't always understand there, there's two different disciplines here, but we work together to provide the best care. Okay, so going back to these states of emergency what does it look like now that states of emergency are being allowed to expire or many states have already let their states of emergency expire. For states that allowed a significant change in nurse practitioner practice during the pandemic, is it as simple as like, “Here today, gone tomorrow?” Like, you know, “Oh yeah, we changed everything, and now we're going back to the way it was.”

PACK: Yeah. Yeah. To much surprise, it is as simple as that to many’s dismay. I'll tell you, Gale Adcock, she's a family nurse practitioner and an American Association Nurse Practitioner Fellow. … is a fourth term North Carolina House of Representatives who recently reported, that “In the almost three decades since New Mexico passed the nation's first ‘independent practice’ bill” which meant that they launched “the state-by-state pursuit of unrestricted NP practice” (Adcock, 2022). Only “certain kinds of crisis” such as “unremitting provider shortages” or “widening health disparities” and “escalating numbers” of underserved “have provided enough of a compelling backdrop to give FPA” or full practice authority “momentum” (Adcock, 2022). When she spoke about her own state (though similar in many other restricted states), she noted that, and I quote “Political context, a political form of preexisting conditions, was too powerful for even a pandemic to overcome” (Adcock, 2022).

MORALES: Ah.

PACK: Yeah. Yeah. In March of 2020, the North Carolina legislature passed a 70-page corona bill that included some waivers for two of their most cumbersome senseless NP regulations, but it has since, been in legislation and, and not yet passed. So, she was speaking to how frustrating that was.

So, so far, three states, Delaware, Kansas, and New York, have achieved full practice authority during the pandemic but not because of it. So that's where we are today.

MORALES: Okay. Let's jump over to talking about the CARES Act, the Coronavirus Aid Relief and Economic Security Act. What impact did this act have for APRNs or NPs specifically?

PACK: Yes. So, the CARES Act was legislation implemented by the federal government under the previous presidential administration to provide the nation with, uh, additional funding and, and vital resources that was needed during the pandemic. So, for example, it provided funding for personal protective equipment, what we call PPE. It allowed NPs to provide care across the nation without new licensure. It permitted interstate telehealth care to be provided and reimbursed … and increased seniors access to care by authorizing NPs to certify and re-certify home healthcare services for Medicare patients. In many ways, uh, APRNs were extremely impacted by the CARES Act. As their scope of practice actually was expanded through these emergency regulatory and policy changes. But more importantly, the health of our country was significantly impacted. … as these advanced practice providers were actually able to strengthen the nation's response to the pandemic by working to a fuller extent of their education and training (AANP, 2020, March 27).

MORALES: Okay. And you are based in the state of Virginia.

PACK: I am.

MORALES: Are there any scenarios or regulations related to Virginia that you could share with us just to help us get, you know, a real-life example kind of picture of how nurse practitioner practice changes or evolves based on current events or changing laws? You used that word evolves earlier?

PACK: Yeah, sure. So, uh, one example would be that Virginia is a state that requires five years of full-time practice or 9,000 hours until NPs are allowed to practice without a collaborative physician agreement. At the beginning of 2020 pandemic, this was changed to be a two-year requirement until NPs could apply for autonomous practice licensure.

Like North Carolina, when there was a light at the end of the tunnel, the pandemic tunnel, opposition from organized medicine used their lobbying weight during the 2022 legislative session to persuade state legislators to reject a sunset clause provision that was proposed which would have allowed permanent statute of the two-year requirement.

As of July, 2022, it reverted back sadly, to five years. Coincidentally though, those who did obtain their autonomous licensure during the pandemic were not required to surrender it. Just no one else between the practice years of two and five could apply for it. So, we currently have a wide range of NPs in Virginia with more or less than five years' experience without any evidence of downside detriment. So, the data moving forward should, should look good!

MORALES: Yes. Okay. And then what about some other states? Did they respond in a different manner related to the emergency authorizations for this independent practice?

PACK: Yeah. So as I mentioned earlier, to date, there are zero states that ultimately granted full practice authority as a result of the pandemic emergency authorizations. However, there is much more data coming down the line to support its potential. For example, a recent report from Massachusetts Health Policy Commission demonstrated that the impact of NPs had on lowering healthcare costs and servicing individuals in underserved areas of the state.

During the pandemic restrictions of that state, the scope of practice were temporarily removed, which allowed the commission to realize that if NPs can practice independently during a pandemic, then they certainly are competent to practice independently after or at other times! So, you know, as a result, there are calls for the reassessment of NP scope of practice to allow for full authority within this state and nationwide (Cuccovia et al., 2022).

MORALES: Ah, excellent. Let's talk about the geographic location stuff and the APRN consensus model and then also the APRN compact. That's very interesting! Cause you know, the RN compact, that's pretty huge, but it seems like the APRN compact isn't quite as huge yet. So many nurses are familiar with the nurse licensure compact for non-APRNs, and most states have entered the practical/registered nurse compact program since around 2018. Uh, can you tell us about the APRN Consensus and compact and some of the factors that have delayed its adoption?

PACK: Sure, sure. Yeah. It, it's not that it's not popular to those within nursing!

MORALES: Okay. Fair enough!

PACK: Right, as it would be quite beneficial to both patient and nurses, but rather it's controversial among those outside of nursing and more in the political world. Remember, the consensus model provides guidance for states to adopt uniformity and the regulation of the APRN roles, in their licensure, their accreditation, certification, and education. So although there has been significant progress in the implementation of those components of the consensus model, there are many jurisdictions in states that have not adopted all of the elements of the APRN regulation. You know, it, it makes sense to ensure that all licensed APRNs were, were held to the same regulatory standards, right?

MORALES: Yes, it would make sense.

PACK: However, that would mean that participating states would lose a good amount of regulatory control over NP professional practice, and that doesn't sit well with organized medicine or bureaucrats who report their necessary oversight, as a way to protect the public or prevent nursing's expanded scope of practice.

MORALES: Okay. Okay. Do you think if more states get on board with the APRN Compact that, that would help encourage this further advancement or allowing APRN practice to advance more independently or not, not really. Do you think it's connected or not so much?

PACK: Well, it certainly would, would make it a lot easier for NPs who desire to practice, in more than one state and increase the amount of available healthcare providers across the nation. The APRN Compact was adopted in 2020, and it allows advanced practice registered nurses to hold more than, or hold one multi-state license, with a privilege to practice in other compact states. There are specific requirements though for eligibility such as the most recent, and controversial, addition of the 2080 practice hours to be eligible.

MORALES: Oh yeah. There it is.

PACK: There it is.

MORALES: Yeah, yes.

PACK: Uh, yeah. This recent addendum to the compact, it was actually opposed by the AANP. However, the National Council of State Boards of Nursing defended its position saying that it was due to the political climate (NCSBN, 2020) of the 20 restricted practice states. And, it was more of a compromise that would gain traction and help it be more successful for the compact to become enacted. And, once the APRN compact is enacted, it would require actually seven states to have adopted the legislation (NCSBN, 2020).

MORALES: So you talked about the AANP and then the National Council of State Boards of Nursing. I was surprised to find there are a lot of organizations that have issued statements of some sort saying, you know, that they'd rather not have to deal with that extra requirement of the 2080 hours. So I think the idea behind that is they're saying if an NP graduates and completes all of their requirements to, you know, be awarded the credential, they should be able to start practicing. In other words, don't add on more requirements afterwards. So, is that the gist of the differences in opinion?

PACK: That is the gist. Exactly.

MORALES: Okay.

PACK: It is exactly the gist. And I think the NCSBN or, or it's not I think, what they've documented and reported is that there was several reasons why these changes were necessary, and they weren't stating necessarily that they aren't competent, but more so it was a compromise ...

MORALES: Ah.

PACK: ... due to the political environment of these restrictive states, and they needed to move along the, the likelihood that the compact would be enacted and quicker. And some of these reasons were due to the COVID-19, because it increased the demand for telehealth and education. It demonstrated an urgent need for this compact to happen.

Without the 2080 hours in 2020, that is, only 14 states, would've ever been eligible to join the compact, because they had already had independent practice and prescriptive authority for all the four roles, the APRN roles, and just needed like minor modifications. I thought what was most interesting of what NCSBN said is, despite this requirement, an estimated 92% of all APRNs would be eligible to apply for multistate license from day one of the implementation of the compact. So, looking at it overall, it, it seemed to be beneficial for the majority.

MORALES: Okay. All right. So we know there's geographic inequities in terms of APRNs and specifically NPs. So we talk about a nursing shortage, but then it's like, well, there's not a nursing shortage in like every area of the country. So, along those lines, do you know if there are certain areas with fewer practicing nurse practitioners or certain areas that are really pro-expanding nurse practitioner practice?

PACK: Right. Yeah. So like you said, we know population of the practice of NPs has grown exponentially. However, in building its workforce, we remain kind of stymied by the lack of educational funding limiting clinical trading sites and barrier legislation as we've talked about. As we established in our previous discussion, there is evidence that NPs are more likely to provide care in areas where they are needed the most, such as geographically rural areas where their scope of practice is not diminished by, you know, unnecessary regulatory barriers, such as collaborative agreements requiring them to pay to play, I should say, and/or the distance from oversight physicians' offices. Economically speaking, without such barriers, there are greater advantages and increased opportunities to become entrepreneurs. And as a result, positively impact state and federal revenue in, in addition to unemployment rates. So, so there is a, a positive impact for having decreased regulations. As

far as an example to provide you, let's use the example of the regulation that only MDs are allowed to provide collaborative agreements and oversight to NPs until they are eligible at five years for autonomous practice.

In Virginia, for example, the Appalachian region is one of the well-known … beauty of hardworking communities … small, and it is also a community at the heart of the opioid epidemic with minimal access, they have, to healthcare and where poor health and low income is prevalent. Remember, this is the same area that was highlighted in the recent movie Dopesick. So, if you can relate to … this is the area. Alright. So, in this community resides the Everheart primary care clinic. It was established by a mother and daughter nurse practitioner team. They have, um, or had rather, the mother has passed, since passed, but a combined experience of over 30 years. Okay. Uh, this clinic has provided many of preceptorships to nurse practitioner students, and it actually has resulted in many of the nurse practitioners wanting to stay and work there after they board certify. However, with the limited access of area physicians or the money that's required to pay a physician for a collaborative agreement, it remains difficult to staff and therefore by default limits its potential outreach in a needed area.

SOUNDBITE OF MUSIC

PACK: Alternatively, if the well experienced NPs working there were allowed to provide this collaboration to their newly employed NPs, it would increase access to services, impact overall health outcomes, and decrease the health provider shortage.

MORALES: All right. That's a very real situation that gets to the heart of the matter right there. There are solutions …

PACK: There are.

MORALES: … and can we have the environment to allow the solution to come forth? Wow. Okay. We have more to discuss! So, we'll head into episode three. This is Maria Morales for Colibri Healthcare with Dr. Alysia Pack.

SOUNDBITE OF MUSIC

Episode 3 – NP Practice Authority and Scope of Practice

SOUNDBITE OF MUSIC

MORALES: Welcome back everyone to episode three. We were talking about some differences in nurse practitioner practice with regard to geographic locations. So continuing under this topic, some organizations seem to be more NP-friendly or at least very willing to hire nurse practitioners. For example, there was a 2021 article titled COVID 19: An Unprecedented Opportunity for Nurse Practitioners to Reform Healthcare and Advocate for Permanent Full Practice Authority. And, this 2021 article by Stucky et al. describes how prior to COVID, the Veterans Administration and the Indian Health Service allowed more nurse practitioners to practice fully. Can you describe some information for us about this, the VA, and the Indian Health Service?

PACK: Sure. Yes. I, I know we discussed a little bit about this earlier, but this was an amazing triumph, uh, not only for NPs, but for some of the most deserving and underserved population across our nation. The VA administration recognized and validated the public outcry in its outstanding and immediate need to resolve its deficiencies in providing quality, affordable, and accessible services to its veterans. One of the efforts to resolve this matter was in 2016, when it permitted full practice authority of APRNs to provide care for the VA system. You know, bottom line, Maria, is our federal government saw a great need, knew there was a professional body of providers well-equipped and ready to help. And after a thorough review and investigation of the evidence, their ultimate decision was not based on politics but rather decades of evidence-based research.

MORALES: Okay. Okay.

PACK: Absolutely. So to add to that, the, the VA has paved the precedence for NPs across the system to autonomously practice and collaborate with the patient healthcare team to the full scope of their abilities, preparation, and education. They, in essence, removed an additional layer of bureaucratic red tape, let's say, to allow delivery of healthcare to our veterans by another set of qualified professionals.

MORALES: Fantastic! Knowing that these large organizations allowed full practice in the federal sector, are there other organizations that support nurse practitioner practice and this expanded scope of practice?

PACK: Yes. Yes, actually there is. And if we speak specifically to the APRN Compact that we were talking about, there are national organizations such as CVS and Walmart. Think about it, Minute Clinic, you know, it does benefit them as well. Right?

MORALES: Yes, huge.

PACK: … the American Association of Retired Persons (the AARP), the National Academies of Sciences, Engineering, and Medicine, Robert Wood Johnson Foundation, just to name a few of many of those who have publicly recognized their support.

MORALES: Okay. Oh Yeah, that's good to hear. All right, we've been talking about this a lot, the scope of practice and practice authority, but explain some more to us about the meanings and differences between that terminology.

PACK: Okay, so scope of practice is what you're allowed to do. Okay. So, beyond the differences in practice environment, a wide range of policies and regulations that impact NPs have been adopted at the state level. …from impacting NPs' authorizations to prescribed medications, signing for disability parking, placards, death certificates, ordering home health services, and as simple as authorizing access to diabetic shoes for their patients.

These policies can vary drastically from state to state. So, full practice authority, remember, is the authorization of nurse practitioners "to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments" including "prescribing medications" under the exclusive licensure authority of the state board of nursing (AANP, 2022, Issues).

In FPA states, NP licensure is not contingent on unnecessary contracts or relationships with the physician or oversight by the state medical board. So, studies have shown that in, in FPA states, NPs are more likely to practice in rural and underserved areas and have improved NP workforce recruitment while meeting the highest care quality and safety standards.

States that restrict or reduce NPs' ability to practice by limiting licensure authority are more closely associated with, uh, geographic healthcare disparities, higher chronic disease burden, primary care shortages, increased costs of care, and lower standing on national health rankings (AANP, 2022, Issues).

MORALES: So I know you've been sharing some of that information from the AANP, but they really, they've been really putting out some great info. I mean, recent info. I mean, that info you were talking about, I think was from 2022 from this year, so …

PACK: Absolutely, they're on it, and they're providing the tools that we need.

MORALES: Yes! Yes! Can you help by explaining the differences in prescriptive license authority? Is this like an “add on privileges” that certain nurse practitioners can obtain and others can't? Like what's this special designation?

PACK: Okay. Well, again that depends on the state's scope of practice and the regulatory laws. We go back to that.

MORALES: Oh, okay, okay.

PACK: Yeah. For some states, additional prescriptive licensure is required in addition to the national DEA license required by all prescribers. So, the unnecessary hoops and barrier regulations can add up actually when considering that the DEA licensure already costs over $800 that has to be renewed every couple of years.

In other states such as West Virginia, prescriptive authority is limited to certain medications. In other states, such as Virginia, where there was once an additional licensure required for prescriptive authority, is no longer the case. … as regulatory bodies have deferred such oversight to employer institutions and DEA.

MORALES: Okay. Yeah, there's a lot of, lot of differences. All right, well, let's keep rolling with the terminology. Autonomous practice licensure.

PACK: So autonomous practice licensure … well, some people would like to say it's called independent practice, but rather it means such licensee has met the state requirements to practice without a collaborative physician to the full extent of their state's individual nursing practice act. But to be clear, this still does not signify full practice authority for such a practitioner. Remember, FPA refers to the state's nursing practice act, allowing practice to the full extent of training without the antiquated red tape or regulation. Remember, such as having the physician sign the home health order or things that delay care, or the mandatory relationship between the physician and the NP, or oversight by the medical state board. FPA or full practice authority states are exclusively governed by the state board of nursing (AANP, 2022, Issues).

MORALES: The landmark 2010 to 2011 publication, the famous publication, The Future of Nursing: Leading Change, Advancing Health by The Institute of Medicine, as it was called at that time, in collaboration with the Robert Wood Johnson Foundation, that yielded a lot of information about nursing as a profession, you know, frequently cited document. Even then, yeah, even then, it was noted that regulations prevented advanced practice registered nurses from being able to practice to the full extent of their education and training in some cases. It was also acknowledged that physician training is different than APRN training, as you were talking about before, and how some care should be provided by physicians and not advanced practice registered nurses. However, many APRNs might be able to be used in a further capacity if state regulations allowed. So, it sounds like, again, we are just still in this, like this web.

PACK: Right. And they're all different, and there's no uniformity, which goes back to why we want that compact enacted, but then there's controversy within the compact. So, it, it can never be simple. Right?

MORALES: Wow! No, no. It is not simple.

PACK: Yeah. Yeah. But to speak to your recent comments, APRNs should only provide care within the scope of their training, their education, and their expertise. You know, as we discussed earlier, APRNs and MDs have different models of education and curriculum. For example, APRNs are not surgeons and therefore would not practice as if they are trained to do so. In addition, increasingly complex patients with multimorbidities and/or rare diseases would require specialized health provider oversight and therefore may not fall under the scope of, you know, an APRN's educational preparation or licensure. Again, you know, APRNs are not requesting

permission to practice this unknown, but rather to the full extent of what they have already been educated for and trained to do.

MORALES: Okay. Makes sense. Good description. So, let's talk about pros and cons then, the positives and negatives, advantages, disadvantages. Do you see any disadvantages or speed bumps for advancing nurse practitioner practice in areas where it is still quite restricted?

PACK: Hmm, that's a good question, Maria. So no, I do not see disadvantages for the advancement of nursing practice in any region. Nursing is quite capable of self-governing, prioritizing patient safety, and delivering the highest quality of evidence-based care possible. We are the most trusted profession, after all.

As far as speed bumps. Off the top of my head, I can think of two. One being, as I mentioned earlier, the opposition found within the political landscape. And number two, I think as NPs, we must get out of our own way. We need to incorporate not only patient but political advocacy into our daily practice. Uh, we must assist policy makers in decisions that impact our community and our profession. Otherwise, someone less considerate for our best outcomes will do it for us.

MORALES: Uh huh, yeah. That's a good way to word that. Okay. That makes sense. All right. And what are some of the benefits and opportunities for more states allowing a fuller practice authority for NPs? Now, you've, you've addressed some of this, you know, as we've been talking, but let's go ahead and address that again.

PACK: Right, so we, we've talked about the increased access to care. We've talked about the economic savings, the fulfilling of a provider shortage, opportunities to put care in geographically rural areas. I mean, the sky's the limit. We, we've discussed.

MORALES: Yes. That's good. All right. I found another interesting article from the AANP, specifically addressing use of the term nurse practitioner rather than other descriptors or other titles. The article said calling a nurse practitioner a mid-level provider or a physician extender or other names was incorrect, and it was even misrepresentation. So, I'd love for you to speak about this. It seems this is an important part of the NP professional practice conversation about what do they prefer to be called, and, and what they should be called, or what they shouldn't accept being called.

PACK: Oh, this is good, Maria. You know, I even correct my students if they, if they put mid-level on their papers. I am a “anti” this, this term, kind of faculty. In regards to this article, you know, it, it talks about the IOM and the NCSBN and the AANP recommendations that NPs are full practice partners of the patient healthcare team and their desire to eliminate outdated terms (which are necessary to ensure clarity and public understanding of the title of nurse practitioners).

The article kind of goes on to explain that the names mid-level provider and physician extender, or really any other inappropriate rendering when used to reference nurse practitioner is, and I quote, “inaccurate and misleading” (AANP, 2022 Use of terms …) They say the terms were created, decades ago by organized medicine and bureaucracies, and most certainly aren't interchangeable with, you know, nurse practitioners or the use of the title nurse practitioner. They say it fails to recognize the education, the scope of authority of the NP role in addition to, quite frankly, being confusing to the public as it's got vague overtones: “mid-level.” What exactly is that? Who do you belong to? You know? You know, simply put, NPs are not less than in the clinical hierarchy but rather a critical team component, you know, to patient care. Remember, we are independently licensed with well-established patient outcomes. And definitively our scope of practice is not, you know, designed, dependent, or an extension of the care that's “rendered by a physician” (AANP, 2015). You know, my favorite part, I think about the article, Maria, and it might just be because it's funny and I get it, is that it says as it would

be “inappropriate to call physicians non-nurse providers, it is similarly inappropriate to call all providers by something that they are not” (AANP, 2015). And I love that, because …

MORALES: They flipped the script! That makes you think about it!

PACK: … uh, yeah, why don't you call your non-nurse provider? I mean, it just, you know. Yeah, it doesn't …

MORALES: That would not be well-received.

PACK: Right, Exactly. So, best practice is clearly to inform our patient that the provider call them by their individual title, their designated title, and they call on actually employers and policy makers and health organizations and providers to do so as well (AANP, 2015).

MORALES: Okay. So moving forward, we make sure that we're using better terminology and considering your state laws and what does your state board say and all that. So, how do we support and encourage an environment where patients have increased access to healthcare providers, and nurse practitioners can practice to the full extent of their education, their training, their licensure, you know, within the bounds of what they're allowed to do. How, how do we kind of foster and encourage that?

PACK: I anticipate that the road forward will continue to be a little bit of a bumpy one. In states that have more recently obtained full practice authority like Kansas and New York, there hasn't been exactly a magic method or a common denominator that pushed them to the break to become full practice. The one consistency that was found is that NPs kept pushing. They were persistent in pushing their agenda forward, again and again, year after year. As an NP or an advocate of NPs, I challenge you to actively engage in activities that support NP practice autonomy. Call your legislator. They want to hear stories that impact your community. Call for adopting multistate licensing reciprocity. Call for the lifting of scope of practice restrictions. Call for the elimination of clinical practice mandates and the supervision of joint boards in those states that require medical board oversight of nursing practice, a practice they are not trained in. And lastly, continue to deliver or support the delivery of advanced practice nursing care and its highest levels of quality and safety. These are all key to overcoming many of the professional practice barriers facing NPs and the patients that they care for within today's healthcare environment.

SOUNDBITE OF MUSIC

MORALES: All right. Thank you so much. Well, it's time to conclude this episode. I wish we could just keep talking more, but we're nearing the end.

PACK: Thank you for having me, Maria.

MORALES: Oh yeah, definitely, I'm glad you could, I'm glad you could join us. I loved hearing about how nurse practitioners provide a specialized and unique practice that is different from the standard medical community. And our discussion is not saying better or worse, but we need all the partners, you know, to play their role so that everybody can contribute what they have to offer. So an NP is not a physician helper or a mid-level provider. Nurse practitioners are partners with physicians and with the healthcare team and provide advanced nursing care that is unique to nursing. I, I like how we talked about that. They are skilled and highly trained to provide nurse practitioner care from a nursing background, which brings a special contribution to the healthcare team. And, uh, talking about regulations and legislative stuff, you know, getting all deep into the weeds and all that. Sometimes that can be very dry. But thank you. You made, you brought life to it. This was interesting.

Thank you everyone, all of our listeners. Another sincere thank you to Dr. Alysia Pack for putting together information and enlightening us today and explaining some things. This is Maria Morales for Colibri Healthcare.

SOUNDBITE OF MUSIC