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Leveraging health care reform to accelerate nurse practitioner full practice authority

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Abstract

Background and purpose: Since development of the nurse practitioner (NP) role, NPs have been advocating for policy allowing them to practice to the full extent of their training. The aim of this research was to determine whether passage of the Affordable Care Act (ACA) had an impact on expansion of NPs' scope of practice.

Methods: This was a retrospective descriptive study of NPs' scope of practice legislation from 1994 to 2016 using regulatory theory. Data sources included annual reports on NP legislation and state-level legislative and media coverage.

Conclusions: Eight states adopted full practice authority (FPA) from 2011 to 2016, representing a two-fold increase compared with the previous 10 years. Seven states adopted Medicaid expansion. Nursing interest groups and politicians shaped their argument in favor of FPA around the increasingly insured population because of the ACA, provider shortages, and rural health care access issues.

Implications for practice: Shaping the discourse of FPA beyond the benefits to the NP profession makes way for broader political interest and participation. Although the future of the ACA is unknown, as the 28 states without FPA continue to advocate for legislative change, they could benefit from the strategies of these newly adapted FPA states.

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Keywords

Advanced practice nurse; Affordable Care Act; full practice authority; health policy analysis; nurse practitioner; scope of practice

Introduction

Nurse practitioners (NPs) have been providing health care services across the continuum of care since the 1960s. Although nationally certified, scope of practice for NPs is determined at the state level with varying degrees of role enactment. Full practice authority (FPA) means that physician involvement is not required for NP practice, and NP practice is the sole authority of the state Board of Nursing. It assures that NPs can practice in accord with their educational preparation and provides an avenue for patients to independently access a qualified health care provider. Nurse practitioners offer a pathway to primary care, especially in underserved areas, remove delays in care, and allow patients to choose the health care provider they want to see (American Association of Nurse Practitioners [AANP], 2015).

The development of and need for the NP role to help meet the increased demand for primary care services started with the passage of Medicare and Medicaid legislation in 1965 (O'Brien, 2003). The first formal NP educational program was created in 1965 in Colorado and in 1971, Idaho was the first state to recognize the NP title in legislation. Initially, NP licensure did not exist, and there was no mechanism for direct reimbursement for NPs causing barriers to practice. As a result of these conditions, in the late 1980s and 1990s, NPs began to organize to advocate for professional advancement at the state level for expanded scope of practice legislation and at the national level for reimbursement of NP services. See Table 1 for a timeline of legislation and reports related to NPs.

As NPs continued to advocate for changes affecting their practice, major shifts in the health care delivery system were underway, including the passage of the Affordable Care Act (ACA) in 2010. The ACA is important because it provides increased access to health insurance, resulting in the need for more primary care providers to meet this demand. At the same time, the United States is experiencing an increasing number of people older than 65 years and because of increasing health needs, requires access to care. These two independent trends have led to a shortage of primary care physicians (Petterson et al., 2012). Nurse practitioners are recognized in the literature and by several national organizations as being able to provide quality and cost-effective primary care (Mundinger et al., 2000; Newhouse et al., 2011) and are seen as potentially part of the workforce to meet this increased demand (Federal Trade Commission [FTC], 2014; Institute of Medicine [IOM], 2011; National Governors Association [NGA], 2012). Although this confluence of events is recognized (i.e., increased agitation in the political sphere for NP practice and the passage of the ACA), it is not clear what effect these two factors have had on the status of NPs' scope of practice legislation.

Background

History of NP scope of practice.—Defining the scope of practice for health care providers is a state responsibility. Laws for the practice of health care were originally created to be expansive and to pertain to licensed physicians. The scope of practice laws for other health care providers were based on services nonphysicians could "carve out" of physician practice and perform (Safriet, 2011). This has caused variation in NPs' scope of practice definitions from state to state. State NPs' scope of practice is broadly categorized into three groups: (a) FPA: NP practice is under the exclusive licensure authority of the state board of nursing, and no involvement with an outside health discipline is needed for practice or prescribing; (b) reduced practice: "state law requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care or limits the setting or scope of one or more elements of NP practice"; and (c) restricted practice: state law "requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care" (AANP, 2017b).

National support for nurse practitioner scope.—Starting in the late 2000s, several practice and national organizations published recommendations with regard to NPs' scope of practice including the National Council of State Boards of Nursing (NCSBN), IOM, Robert Wood Johnson Foundation, NGA, and FTC. Cumulatively, they are supportive of NPs practicing to the full extent of their education and certification (Table 1).

Scope of practice and the Affordable Care Act.—Although the future of the ACA is uncertain, to date, it has insured 20 million more Americans (U.S. Department of Health and Human Services, 2016). Insuring more people does not assure that there is an adequate workforce to care for them. The demand for physicians is projected to grow faster than their supply. By 2025, the projected shortage of physicians will be between 61,700 and 94,700; with the lower estimate representing physicians delaying retirement and rapid growth of nonphysician clinicians (Association of American Medical Colleges [AAMC], 2016). Another major driver of the demand for provider services is an aging population, with the population older than 65 years growing 41% compared with the population younger than 18 years growing 5% by 2025 (AAMC, 2016). With this demand for provider services, there is a need to look beyond physicians for the provision of primary care.

Simply providing the funds for care will not meet the growing demands; change in how care is delivered is also needed. Nurse practitioners are masters or doctorally prepared and certified nationally. In particular, because primary care NPs are prepared to provide preventive care, as well as chronic disease management, this class of provider may be one key strategy to meeting these new national demands (NCSBN, 2008). However, NPs' ability to contribute in this way is driven by the state-level scope of practice legislation. Nurse practitioners' scope of practice is important because FPA has been shown to have an effect on the growth of NPs and improved utilization of their services (Xue, Ye, Brewer, & Spetz, 2016). For Medicare beneficiaries, more primary care provider NPs practice in FPA states (Kuo, Loresto, Rounds, & Goodwin 2013). Nurse practitioners seem to be more accessible in rural areas; however, pre-ACA, these areas had the highest rates of uninsured persons per

primary care clinician (Graves et al., 2016). If NPs in these reduced/restricted scope of practice states had FPA, it might influence their ability to provide a full cadre of services to these rural and vulnerable patients. In the year of the ACA passage, 13 states plus the District of Columbia allowed FPA for NPs (National Academies of Sciences, Engineering, and Medicine, 2015).

Theoretical framework—regulatory theory

Political scientist James Q. Wilson studied the politics of policy with a perspective that accounts for political motives and institutions that shape policy. From Wilson's perspective, policies have multiple causes and can be understood by their perceived costs and benefits. Costs and benefits are considered either widely distributed, affecting most people, or narrowly concentrated, affecting only a portion of the population or a specific group. Generally, political actors are "threat" versus "opportunity" oriented, meaning that they are more motivated to act when a legislative change could be perceived as a threat to their interests. In Wilson's matrix, a policy is considered regulatory when both costs and benefits are narrow. A regulatory policy determines who will be included or deprived based on a rule, for example, determining who may prescribe medications. Regulatory politics deals with groups or sectors, such as professions, and involves coalition forming based on common goals with regard to potential regulatory legislation (Wilson, 1984).

Regulatory theory and interest groups related to NPs' scope.—Interest groups are the key mode in which regulation of NPs' scope of practice is most influenced. Interest groups can broadly be defined as individuals, organizations, or institutions that attempt to influence public policy (Beyers, Eising, & Maloney, 2009). Participants of interest groups act in their own self-interest through the political process. Under this premise, legislators act to increase their likelihood for re-election, and interest groups may act to further their self-interests even at the expense of others. Interest groups advocate for legislators to create regulations that benefit the interests of their members (Elhauge, 1991).

The context of regulation of a profession extends be-yond dichotomizing costs and benefits to the profession and other interested groups, the discourse of the issues must also be considered. When groups in society (such as interest groups) define nursing, their definition becomes perceived truth about the profession. This can be constraining or liberating (Harvey, Driscol, & Keyzer, 2011).

Organized medicine: Medicine has long been a well-organized profession that developed and rose to prominence over the 18th and 19th centuries. Medicine gained professional authority during this time because of scientific advances in medicine, such as laboratory tests and diagnostic imaging (Starr, 1982). The American Medical Association (AMA), formed in 1847, has been a powerful interest group with regard to the scope of other health care professions. The AMA has strongly advocated at the national and state levels not to expand the scope of practice for NPs and has been successful in slowing legislation. In their 1969 Clinical Convention House of Delegates Proceedings in response to the recently developed NP program in Colorado, they acknowledge this workforce developed in response to shortages of physicians, and that in limited situations and settings could be useful. They

were concerned that physicians would not adequately be able to supervise these nurses and that they would eventually wish to expand their scope and level of independence (AMA, 1969). In the year the ACA was passed, with regard to independent nursing models, the AMA opposed state legislation that allowed for the independent practice by anyone who was not a licensed physician. They were supportive of physician-led integrative practices that included NPs but opposed the Centers for Medicare and Medicaid Services policy that allowed payment for physician services by nonphysicians who were unsupervised by physicians (AMA, 2010, p. 51).

Organized nursing: Modern nursing arose in the late nineteenth century in the United States when a group of upper-class women organized through the State Charities Aid Association to advocate for hygienic conditions in hospitals (Starr, 1982). In 1873, the first schools of nursing were established. There was concern among physicians that these educated nurses would not listen to physicians and a campaign followed to keep nursing in "its place," (Ehrenreich, 2002, p. xxxiv). In existence since 1896, the American Nurses Association represents the interests of all American nurses. Their activities include shaping public policy and workplace advocacy. In 1974, they developed the Council of Primary Care Nurse Practitioners, which helped to legitimize the role among health care professionals. To advance the NP profession, the American Academy of Nurse Practitioners formed in 1985 and with the goal to advance NP-specific policy, the American College of Nurse Practitioners was formed in 1995. These two organizations merged in 2013 to become AANP to promote health care through NP integrity, excellence, professionalism, leadership, and service. The AANP is the major national professional organization for NPs, which provides continuing education, professional practice standards, and legislative advocacy at the national and state levels. They advocate for improved access to care, more efficient care delivery, and decreased cost (avoid duplication of work) as major reasons to support FPA for NP. With regard to shaping the discourse around the discussion of NP practice, AANP encourages the use of the term "FPA" versus words such as "independent" or "autonomous" practice, which have caused mischaracterization of NPs by some as "lone ranger" clinicians practicing without any parameters (AANP, 2017a).

Purpose

We sought to determine whether the passage of the ACA had an impact on expansion of NPs' scope of practice by examining changes in state-level NPs' scope of practice laws from 1994 to 2016. The hypothesis was that scope of practice laws would be altered in response to the passage of the ACA, with an increasing number of states adopting FPA legislation from 2011 to 2016.

Study design and methods

This was a retrospective descriptive study of NPs' scope of practice legislation using regulatory theory. States were categorized by their scope of practice and those with recent (2011–2016) adoption of FPA were evaluated for reference to the ACA as influencing the legislative change.

Data description

A state NPs' scope of practice database was created based on annual legislative updates published from 1994 to 2016 in *The Nurse Practitioner* (Pearson, 1995; Phillips, 2017). The legislative update data were collected through survey of states' Boards of Nursing and NP professional association representatives (Phillips, 2017). Dates of passage of FPA legislation published in *The Nurse Practitioner* were corroborated by cross-referencing to state legislative records.

Sample.—The sample included all 50 states and the District of Columbia and data on annual legislative action on NPs' scope of practice from 1994 to 2016.

Measures.—An annual scope of practice category for each state was created and included full, reduced, or restricted. Full practice authority states were those that did not require physician involvement for NP practice, and NP practice was the sole authority of the state Board of Nursing. Reduced or restricted states were those where collaboration, supervision, delegation, or team-management by an outside health discipline was required for some elements of NP practice, such as diagnosing or prescribing (AANP, 2017b). Then, an overall scope of practice category was created to describe each state's scope over time. The categories included: (a) long-term FPA (pre-2000), (b) long-term reduced or restricted practice (pre-2000), (c) mid-range FPA adoption between 2000 and 2010, (d) newly adapted FPA (2011–2016), and (e) increased restrictions from 1994 to 2016. The 2011 cut point between mid-range and newly adapted FPA was chosen to reflect NP legislative change that occurred after passage of the ACA on March 23, 2010. Defining long-term for the FPA and reduced or restricted practice states as pre-2000 was meant to reflect states with a stable scope of practice over the study time.

Analysis

A case study approach using the regulatory theory was used to characterize these recently adopted FPA states to determine how the ACA may have played a role (Wilson, 1984). Data were collected from the public record for each of these states and examined for reference to the ACA. The ACA was considered to be a factor in the legislation if it was explicitly mentioned. Mentions of health care reform or expanded health care coverage were considered surrogates of the ACA. The mention of specific interest groups, party make up of the legislature and governor, and bill sponsorship were also included.

Results

Scope of practice categorization

Nine states (18%) plus the District of Columbia were categorized as long-term FPA (pre-2000), 29 states (58%) were long-term reduced/restricted practice (pre-2000), four states (8%) were mid FPA (from 2000 to 2010), eight states (16%) were newly adapted FPA (since 2011), and no states became more restricted over the study period. See Table 2 for individual state categorizations.

With regard to the region, 56% (five of nine) of North-eastern and 85% (11 of 13) of Western states were primarily long-term FPA or adapted FPA from 2000 to 2016. However, 94% (15 of 16) of Southern states and 67% (8 of 12) of Midwestern states were primarily long-term restricted/reduced NP scope of practice. All four regions were represented in each overall scope of practice category.

Scope of practice change and the Affordable Care Act

The newly adapted FPA states were Connecticut, Maryland, Minnesota, Nebraska, Nevada, North Dakota, Rhode Island, and Vermont. These eight states indicated an acceleration of states passing FPA legislation for NPs, compared with the previous decade when only four states passed similar legislation (Colorado, Hawaii, Idaho, and Washington). The newly adapted FPA states are detailed in Table 3. These eight states had a variety of law changes that resulted in FPA. North Dakota and Rhode Island eliminated physician collaboration for prescribing, whereas the other state laws created a practice and prescribing change.

With regard to the ACA's influence in these legislative changes, specific mention of the ACA, issues with access to health care providers, or increased demand for care (particularly primary care) was found in testimony and/or media coverage for six states. Arguments in favor of legislative changes across these states included concern over having enough primary care providers, health insurance reform as a result of the ACA, and adequate access to health care providers in rural areas (Becker, 2014; Senate Human Services Committee, 2011; Farmer, 2015; Health and Human Services Committee, 2015; Snyder, 2013; Taylor, 2015). No testimony or media coverage was found with regard to the ACA, access to care, or interest groups for the Rhode Island or Vermont legislation; so, the impetus or influencing factors for their law changes could not be ascertained. All states except Nebraska expanded Medicaid effective January 1, 2014 (Kaiser Family Foundation, 2016).

Party affiliation

Across all eight states, there was not a consistent make up of party control of the governors' offices or state legislatures. Three states had a Democratic governor and a Democratic majority in the state legislature. Two states had a Republican governor and a Republican majority in the state legislature. Two states had Republican governors and a Democratic majority in the state legislature. Vermont had a Democratic governor and split state legislature. Bill sponsors were solely Democratic in half of the states and bipartisan in the other half.

Interest groups

Support for the FPA law changes most frequently came from nursing professional organizations and legislatures themselves who saw the need for more providers. Opposition to NPs' scope of practice, changes came most frequently from state medical associations. Nebraska had the most diverse interest group representation in favor of FPA including AARP Nebraska, the Nebraska Association of School Boards, and Latino American Commission (Health and Human Services Committee, 2015).

Discussion

Regulatory theory and full practice authority legislation

We found a two-fold increase in states that adopted FPA for NPs post-ACA passage compared with the previous decade. As per the regulatory theory, the interest group who are able to be most influential are able to influence regulatory legislation in their favor. Organized medicine remains a strong interest group advocating against FPA for NPs. However, in this analysis, despite medicine's influence, eight states were able to make legislative changes, which resulted in FPA for NPs.

Medical organizations voiced many concerns over FPA. For example, the Connecticut Medical Society and Nebraska Medical Association opposed FPA because of concerns of decreased quality and consumer confusion over the type of provider seen (Becker, 2014; Health and Human Services Committee, 2015). The Nevada State Medical Association was concerned that elimination of collaborative agreements would result in NPs feeling isolated from physicians, leading to decreased teamwork in patient care (Snyder, 2013). The North Dakota State Board of Medical Examiners advocated for collaborative agreements because from their perspective, these documents ensured patient protection (Senate Human Services Committee, 2011).

Counters to organized medicine's objection came from nursing organizations, practicing NPs, and legislators in these states. For example legislators in Connecticut and Nevada cited work from studies on NP outcomes and data from their own states with regard to health care shortages to advocate for FPA for NPs (Becker, 2014; Snyder, 2013). It is important for NPs to harness support from elected officials, for example Connecticut's Governor, who felt that FPA was important for access to primary care for the state's constituents, or a legislator with a personal connection, such as Nevada's bill sponsor, who was personally cared for by an NP. In 2014, the Nebraska state legislature passed FPA legislation for NPs; however, the outgoing Governor vetoed the legislation citing that the mentored hours for NPs new to practice were not high enough. The following year with the new Governor's support, the legislation was proposed again and signed into law.

Affordable Care Act's influence on regulatory change

Nurse practitioner interest groups have advocated for FPA for many years before with incremental law changes occurring in many states. However, passage of the ACA allowed for an acceleration of states to pass FPA legislation. All but one newly adopted FPA state also adopted Medicaid expansion. In six states where testimony and/or media coverage was found, nursing and other supportive interests groups leveraged the influence of health care reform, access to care difficulties, and physician shortages as reasons to justify FPA. This driver for regulatory reform outweighed the influence of organized medicine in these states.

Advocating for NP FPA is not a new policy issue; nursing groups have been doing so for decades (Table 1). Framing the need for regulatory change and centering discourse beyond the benefits to the profession makes way for broader political interest and participation. Nurse practitioners, nursing interest groups, and politicians in states that attained FPA for NPs post-ACA created a discourse where FPA for NPs was part of the solution to an

increasingly insured population and health care provider shortages, particularly in rural areas.

Barriers to full practice authority

From 2008 to 2014 several key reports were published by national organizations all in support of NPs practicing to the full extent of their training and education (FTC, 2014; IOM, 2011; NCSBN, 2008; NGA, 2012). Yet, a gap remains between this national support and state-level legislative change. The advanced practice registered nurse Consensus Model recommended FPA for all NPs by 2015 (NCSBN, 2008). However, as of 2016 less than half of states allowed FPA for NPs (21 states plus DC), with the addition of South Dakota in 2017 (AANP, 2017b). Although there was acceleration in the passage of FPA legislation post-ACA, 29 states still require some type of physician involvement for NP practice as of 2017. Hurdles to FPA for NPs continue to be overcoming opposition from organized medicine and educating state legislators on how restrictions to NPs' scope limit their abilities to fully meet patient care needs (Tegler, 2015). By remaining organized as a profession and consistently framing the need for FPA with regard to patients' needs, NPs will continue to make progress in achieving FPA in all 50 states.

Limitations

This analysis was based on evaluation of electronically available written materials with regard to states where scope of practice law changed. One way to enhance this would have been to compliment it with interviews of key stakeholders to provide a richer view of the discourse, such as was used in previous analysis (Rigolosi & Salmond, 2014). This approach might have been helpful for smaller states, particularly, Rhode Island and Vermont, where the availability of written materials made it difficult to determine themes of their legislative changes. The analysis was limited to states that successfully passed FPA legislation; therefore, it is unknown what was similar or different in states where FPA legislation was proposed but did not pass.

Future research

An incidental finding was that six states' legislation included a requirement for new NPs to the state to have a period of formal collaboration or mentorship before being granted FPA; joining Maine and Colorado in this requirement. The length of this transition to practice varied from 18 months to 2 years or 2,000–2,400 practice hours. Since 2014, every state (five total) that has passed FPA legislation has done so with this transition requirement. However, this requirement's impact is not known with regard to the feasibility of NPs to form these required collaborative relationships or their impact on quality, patient access, and patient outcomes (Brassard, 2016).

The mechanism for change in NPs' scope of practice laws is an important area for continued research. Despite what happens with health care reform, the United States still faces a growing and aging population, and NPs can provide a cost-effective and quality source of care. To move the FPA policy forward in all 50 states, an analysis of states that remain reduced or restricted in scope or states where legislation was proposed but failed may also be helpful in understanding state-level dynamics that influence NP legislation.

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Table 1.

Timeline of key reports and legislation regarding nurse practitioners

Date	Item	Description
1965	NP role created	Loretta Ford, a nurse, partnered with a pediatrician, Henry Silver, to develop the NP role and created the first pediatric NP program in the country at the University of Colorado (Saver, 2015).
1971	First state to recognize NP title/role	Idaho was the first state to recognize NPs' scope of practice, which included diagnosing and treatment.
1977	Rural Health Clinic Act	Mandated that 50% of services in funded rural health clinics be provided by NPs, clinical nurse specialists, and physician assistants and that their services were to be reimbursed.
1985	American Academy of Nurse Practitioners formed	Goal to advance NP-specific policy and develop a national NP database.
1989	Omnibus Budget Reconciliation Act	Provided some reimbursement to NPs in rural areas who collaborated with a physician. Also created in this act was the Resource-Based Relative Value Scale, which calculated Medicare payments to physicians and was used to study reimbursement to nonphysician providers (including NPs).
1993	American College of Nurse Practitioners formed	The goal of this group was to establish a Washington-based NP advocacy group for NP-favorable health care reform as well as state-level legislation and opened up membership to State Organizational Affiliates (Sharp, 1995).
1994	5 states have FPA for NPs	States: Alaska, Iowa, Montana, New Mexico, and Oregon (Pearson, 1995).
1997	Budget Reconciliation Act	Allowed for reimbursement of NP services by Medicare
As of 2000	10 states plus DC have FPA for NPs	Additional states: Arizona, Maine, New Hampshire, Washington, and Wyoming (Pearson, 2001).
2005	11 states plus DC have FPA for NPs	Additional state: Idaho
2006	50th state grants prescriptive authority for NPs	Georgia becomes the last state to pass legislation granting prescriptive authority for NPs (Phillips, 2007).
2008	*Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*	Endorsed by 48 nursing organizations. This report published by the National Council of State Boards of Nursing APRN Committee and Advanced Practice Nursing Consensus Work Group defined national standards for the licensure, accreditation, certification, and education of APRNs with the goal of implementation by 2015.
2010	13 states plus DC have FPA for NPs	Additional states: Colorado and Hawaii.
2011	IOM published *The Future of Nursing: Leading Change and Advancing Health*	Recommended action steps aimed at changing public policies at all levels of government Its first recommendation was to remove barriers to full scope of practice and specifically that APRNs should "practice to the full extent of their education and training," (IOM, 2011, p. S-8).
March 23, 2010	The Affordable Care Act signed into law	
2012	NGA report: *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*	The NGA concluded that NP care is comparable to that of physician care and that "states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of incentivizing greater NP involvement in the provision of primary care," (NGA, 2012, p. 11).
2014	FTC's report Competition and the Regulation of Advanced Practice Nurses	Based on the literature and recommendations from other expert bodies concluding that APRNs are safe as independent practitioners the FTC report states that restrictions to APRN scope by mandating how APRNs work with physicians (such as supervisory agreements) may not be needed. Such restrictions prevent new models of health care delivery systems from being developed to meet the changing needs of consumers and new technology (FTC, 2014).
2016	21 states plus DC have FPA for NPs	Additional states: Connecticut Maryland, Minnesota, Nebraska, Nevada, North Dakota, Rhode Island, and Vermont (Phillips, 2017)

Date	Item	Description
2016	Consensus Model Adaption to date	18 states have fully implemented these recommendations

Note: APRN = advanced practice registered nurse; FPA = full practice authority; FTC = Federal Trade Commission; IOM = Institute of Medicine; NGA = National Governors Association; NP = nurse practitioner.

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Table 2.

Overall scope of practice categorization by state

Overall Scope of Practice Category	Description	Region	State	Year Full Practice Authority Passed
Newly adapted full practice authority	Full practice authority passed between 2011 and 2016	Midwest	North Dakota	2011
			Minnesota	2015
			Nebraska	2015
		Northeast	Connecticut	2014
			Rhode Island	2013
			Vermont	2011
		South	Maryland	2015
		West	Nevada	2013
Mid-range adapted full practice authority	Full practice authority passed 2000–2010	West	Colorado	2009
			Hawaii	2010
			Idaho	2004
			Washington	2000
Long-term full practice authority	Full practice authority (pre-2000)	Midwest	Iowa	n/a
		Northeast	Maine	
			New Hampshire	
		South	Dist. of Columbia	
		West	Alaska	
			Arizona	
			Montana	
			New Mexico	
			Oregon	
			Wyoming	
Long-term reduced/restricted practice	Reduced/restricted practice >15 years(pre-2000)	Midwest	Illinois Indiana	n/a
			Kansas	
			Michigan	
			Missouri	
			Ohio	
			South Dakota	

Overall Scope of Practice Category	Description	Region	State	Year Full Practice Authority Passed
			Wisconsin	
		Northeast	Massachusetts	
			New Jersey	
			New York	
			Pennsylvania	
		South	Alabama	
			Arkansas	
			Delaware	
			Florida	
			Georgia	
			Kentucky	
			Louisiana	
			Mississippi	
			North Carolina	
			Oklahoma	
			South Carolina	
			Tennessee	
			Texas	
			Virginia	
			West Virginia	
		West	California	
			Utah	
More restrictions	Scope of practice became more restricted between 1994 and 2016		n/a	n/a

Table 3.

Characteristics of states with newly adapted full practice authority for nurse practitioners (2011–2016)

State (Year Law Effective), Bill Number	Legislative Make up	Party Sponsorship of Legislation	Interest Groups Mentioned	Type of Change	Require Practice Hours Before Independence	Mention of ACA/ Access to Care (Medicaid Expansion)
Connecticut (2014), PA14–12	Gov.—D S—D H—D	Democratic	CT Medical Society	Practice and prescribing	Yes (2,000 hr)	Yes (yes)
Maryland (2015), HB 999	Gov.—R S—D H—D	Bipartisan	NP Association of MD MD Academy of Advanced Practice Clinicians MD Board of Nursing MD Nurses Association MD Department of Health and Mental Hygiene MD State Medical Association	Practice and prescribing	Yes (18 months)	Yes (yes)
Minnesota (2015), SF 511	Gov.—D S—D H—D	Bipartisan	MN APRN Coalition MN Medical Association MN Academy of Family Physicians MN Chapter of American Society of Interventional Pain Physicians MN Society of Anesthesiology	Practice and prescribing	Yes (2,080 hr)	Yes (yes)
Nebraska (2015), SF 107	Gov.—R S[a]—R	Democratic	AARP NE Friends of Public Health in NE Center for Rural Affairs Americans for Prosperity NE Association of School Boards Latino American Commission NE Nurses Association NE Medical Association	Practice and prescribing	Yes (2,000 hr)	Yes (no)
Nevada (2013), AB 170	Gov.—R S—D A—D	Democratic	NV Advanced Practice Nurses Association	Practice and prescribing	Yes (2,000 hr, if the NP will prescribe controlled substances)	Yes (yes)
North Dakota (2011), SB 2148	Gov.—R	Bipartisan	ND NPAssociation	Prescribing	No	Yes (yes)

State (Year Law Effective), Bill Number	Legislative Make up	Party Sponsorship of Legislation	Interest Groups Mentioned	Type of Change	Require Practice Hours Before Independence	Mention of ACA/ Access to Care (Medicaid Expansion)
	S—R		ND Medical Board			
	H—R					
Rhode Island (2013), HB 5656 and SB 614	Gov.—D	Democratic	None mentioned	Prescribing	No	Not found (yes)
	S—D					
	H—D					
Vermont (2011), HB 420	Gov.—D	Bipartisan	VT Board of Medicine	Practice and prescribing	Yes (2 years or 2,400 hr)	Not found (yes)
	S—D		VT Medical Society			
	H—R		VT Board of Nursing			
			Department of VT Health Access			

Note: A = Assembly; AB = Assembly Bill; ACA = Aordable Care Act; APRN = advanced practice registered nurse; Gov. = Governor; H = House of Representatives; HB = House Bill; PA = Public Act; S = Senate; SB = Senate Bill.

[a]Nebraska's legislature is a unicameral, consisting of only one house.