UTILIZING THE NURSE PRACTITIONER: RETHINKING STATE-LEVEL REGULATORY STRUCTURES TO INCREASE ACCESS AND QUALITY OF HEALTHCARE

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I. INTRODUCTION

In 2020, it is estimated that there were over 325,000 nurse practitioners (NPs) licensed to practice in the United States.[1] NPs are registered nurses with "advanced training," typically a master's degree,[2] who provide comprehensive services to patients by combining clinical training in diagnostics and the treatment of health conditions, with disease prevention and health management.[3] Over the last decade, the demand for health care, specifically primary care, has increased. This increase results from several factors—one being newly insured Americans—but it is largely due to population growth and aging, which accounts for 81% of the change in demand from 2010 to 2020.[4] The current number of physicians will not meet this growing demand.[5] And marginalized populations and rural areas will be the most impacted, because physician shortages are particularly severe in these areas.[6] Without addressing the physician shortage, access to primary care will become more delayed and widespread in underserved rural and urban areas. Medically underserved populations may face economic, cultural, or language barriers to health care.[7] One suggestion to

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[1] *More Than 325,000 Nurse Practitioners (NPs) Licensed in the United States*, AM. ASS'N OF NURSE PRAC. (May 4, 2021), https://www.aanp.org/news-feed/more-than-325-000-nurse-practitioners-nps-licensed-in-the-united-states.

[2] Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH L. 21, 21 (2008).

[3] *What's a Nurse Practitioner (NP)?: Discover Why Americans Make More Than 1.06 Billion Visits to NPs Each Year*, AM. ASS'N OF NURSE PRAC., https://www.aanp.org/about/all-about-nps/whats-a-nurse-practitioner (last visited Aug. 20, 2022).

[4] Joy L. Austria, *Urging a Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Nurse Practitioners*, 17 DEPAUL J. HEALTH CARE L. 121, 122 (2015).

[5] Within the next twelve years, the U.S. will face a projected physician shortage of up to 124,000 physicians. Andis Robeznieks, *Doctor Shortages are Here—and They'll Get Worse if We Don't Act Fast*, AM. MED. ASS'N (Apr. 13, 2022), https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act.

[6] An additional 180,400 physicians would currently be needed "[i]f marginalized minority populations, people living in rural communities, and people without health insurance had the same health care use patterns as populations with fewer barriers to access." Press Release, Ass'n of Am. Med. Colls., AAMC Rep. Reinforces Mounting Physician Shortage (Jun. 11, 2021).

[7] A medically underserved population is a group living in an area designated as having a shortage of personal health services. 42 U.S.C. § 300e–1(7).

expand access to health care in these areas, and close this physician gap, is to enlist the services of NPs.

A significant increase in NPs in the last decade has sparked debate among health care professionals and state licensing boards about issues related to diagnosis, evaluation, and treatment of patients—and what NPs' scope of practice should be.[8] Scope of practice refers to the actions a health care professional can perform under their state licensure.[9] NP scope of practice varies by state; some states allow full independent practice, and some significantly restrict it.[10] Massachusetts, New Jersey, and California demonstrate three different approaches to NP scope of practice regulation. Looking at the different training requirements, education models at universities, and state licensure requirements, this variation makes perfect sense. But with looming physician shortages, increased access to affordable health insurance,[11] and deficiencies revealed by the COVID-19 pandemic, states should consider implementing less restrictive scope of practice laws. Additionally, NP private accrediting agencies should consider enforcing a standardized curriculum nationwide. And while no state has the perfect solution, Massachusetts has begun to address these issues proactively by allowing NPs to have a larger scope of practice. Other states should follow Massachusetts' approach to allowing NPs to have full practice authority while continuing to regulate these professionals.

This Article makes two contributions to the discussion about regulating NP scope of practice. First, the article explores the different types of practice authorities in the United States for regulating

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[8] In 2010, there were approximately 140,000 NPs in the United States. *Historical Timeline*, AM. ASS'N OF NURSE PRAC., https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/historical-timeline (last visited Aug. 20, 2022).

[9] Barbara A. Cuccovia et. al., *A Policy Analysis of Nurse Practitioner Scope of Practice in Massachusetts*, 34 J. AM. ASS'N. OF NURSE PRAC. 410, 411 (2022).

[10] *See, e.g.*, MASS. GEN. LAWS ch. 112, § 80E (2021); N.J. ADMIN. CODE § 13:37-6.3 (2016); CAL. BUS. & PROF. CODE § 2835.7 (West 2023).

[11] Since the Affordable Care Act was enacted in 2010, an estimated twenty million Americans have gained access to health insurance. Nicole Rapfogel et. al., *10 Ways the ACA Has Improved Health Care in the Past Decade*, CTR FOR AM. PROGRESS (Mar. 23, 2020), https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade.

NP scope of practice. Drawing on various studies and examining three example states, the Article discusses how permitting full practice authority[12] can lead to better health care outcomes and access to care in underserved areas, and how reduced or restricted practice authority can lead to greater health care disparities, higher costs of care, and higher chronic disease burden. Second, having established the benefits of granting full practice authority, the Article considers how best to achieve this. It begins with a brief overview of the history of NPs and what the current standard is for education, training, and licensure. Then, it analyzes the costs and benefits of standardizing NP curriculum in order to address concerns surrounding NPs' ability to practice to their full scope of practice. The Article looks at the varying models of education and the challenges they create for NPs looking to acquire licensure in different states. At the same time, it discusses how standardization can threaten academic freedom and the individual cultures and missions of universities. Lastly, this Article explains the new NP curriculum criteria issued by the National Task Force on Quality Nurse Practitioner Education and argues why these new standards do not go far enough to help NPs achieve independent practice across the United States.

II. STATE PRACTICE ENVIRONMENTS FOR NURSE PRACTITIONERS

There are no uniform laws or regulations that define an NP's duties and responsibilities. Rather, all fifty states and the District of Columbia have their own licensure and regulatory requirements,[13] including scope of practice laws that "address the capacity for healthcare professionals to exercise independent judgment in clinical patient management."[14] There are three

[12] Discussed extensively below, full practice authority is commonly understood as an NP's "ability to utilize knowledge, skills, and judgment to practice to the full extent of his or her education and training." *ANA's Principles for Advanced Practice Registered Nurse (APRN) Full Practice Authority*, AM. NURSES ASS'N . 1 (2020), https://www.nursingworld.org/~495dca/globalassets/docs/ana/ethics/principles-aprnfullpracticeauthority.pdf (last updated Feb, 2020).
[13] *State Practice Environment for Nurse Practitioners*, CAMPAIGN FOR ACTION (Mar, 28, 2023), https://campaignforaction.org/resource/state-practice-environment-nurse-practitioners/.
[14] Austria, *supra* note 4, at 121.

types of practice environments that a state can adopt: (1) full practice; (2) reduced practice; and (3) restricted practice.[15]

A. Full Practice Authority

Currently, twenty-seven states and the District of Columbia have adopted a full practice authority regulatory structure for NPs.[16] Practice and licensure laws under a full practice environment permit NPs to "evaluate patients; diagnose, order[,] and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing."[17] Full practice authority structures further require NPs to "meet educational requirements for licensure; maintain national certification and consult and refer to other health care providers, when warranted by patient needs."[18] This ensures that NPs will deliver a nationally set, high level of care, as they are held responsible to both the public and the state board of nursing.[19] NPs in these states are not required to maintain contracts with physicians or other health care providers; they may practice independently.[20] In states where NPs have full practice authority, their careers overlap significantly with physicians, yet there are some important distinctions.[21] For example, while physicians are able to choose from more than 160 specialties and subspecialties, NPs only have 6.[22] Furthermore, NPs can perform certain invasive procedures,

[15] *State Practice Environment*, AM. ASS'N. OF NURSE PRACS. https://www.aanp.org/advocacy/state/state-practice-environment (last updated Oct. 2022).
[16] *Id.*
[17] *Id.*
[18] *Issues at a Glance: Full Practice Authority*, AM. ASS'N. OF NURSE PRACS. https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief (last updated Mar. 2023).
[19] *Id.*
[20] *Id.*
[21] NPs and physicians' patient care responsibilities overlap in several areas including examining and taking patients' histories, diagnosing illnesses, developing treatment plans, and ordering laboratory work. *What's the Difference Between an MD, a PA, and an APRN?* AMA MEDICAL GROUP, https://amamedicalgroup.com/whats-the-difference-between-an-md-a-pa-and-an-aprn/ (last visited May 9, 2023).
[22] *Specialty Profiles*, ASS'N OF AM. MEDICAL COLLS., https://careersinmedicine.aamc.org/explore-options/specialty-profiles (last visited Mar. 19, 2023); *Types of Nurse Practitioner Specialties*, AM. NURSES ASS'N, https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/types-of-nurse-practitioner-specialties/ (last visited Mar. 19, 2023).

although they are not qualified to perform complex surgeries.[23] Additionally, the median salary for physicians in 2020 was $208,000, which is substantially higher than the median salary of $117,670 for NPs.[24]

Granting full practice authority has helped states build their health care workforce and meet access goals, without sacrificing quality. Studies have shown that there is an increase in NPs practicing in rural and medically underserved areas, NP workforce recruitment has improved, and NPs consistently meet the highest care quality and safety standards in full practice authority states.[25] A U.S. Department of Health and Human Services study concluded that "NPs in full practice and prescriptive authority states had a predicted probability of working in a rural area 6 percentage points higher than NPs in restrictive states."[26] This is just one example of how adoption of full practice authority can improve quality and access to care.

1. Massachusetts

Massachusetts is one of many states that have adopted a full practice environment for NPs. The licensure requirements in Massachusetts include: (1) registered nurse license; (2) graduate degree from an advanced practice registered nurse education program; and (3) completion of an examination to obtain an advanced practice certification.[27] Massachusetts has only recently become

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[23] *Nurse Practitioner vs. Doctor: What's the Difference?*, INCREDIBLE HEALTH (May 15, 2021), https://www.incrediblehealth.com/blog/nurse-practitioner-vs-doctor/; *Nurse Practitioner Scope of Practice*, GRADUATE NURSING EDU, https://www.graduatenursingedu.org/nurse-practitioner-scope-of-practice/ (last visited Aug. 1, 2023).
[24] *Id.*
[25] *Issues at a Glance: Full Practice Authority*, *supra* note 18.
[26] WESTAT, IMPACT OF STATE SCOPE OF PRACTICE LAWS AND OTHER FACTORS ON THE PRACTICE AND SUPPLY OF PRIMARY CARE NURSE PRACTITIONERS: FINAL REPORT 42 (2015).
[27] *See generally* MASS. GEN. LAWS. ch. 112, § 80B (2021) (requiring registered nurses applying for advanced nursing practice to submit documentation of a graduate degree from an approved program and documentation of current certification in advanced nursing practice); 244 MASS. CODE REGS. 4.00 (2021) (establishing the criteria for granting a registered nurse authorization to practice as an advanced practice registered nurse); 244 MASS. CODE REGS. 9.04 (2021) (outlining the standard of conduct applicable to licensed nurses with advanced practice authorization); COMMONWEALTH MASS. BD. OF REGISTRATION IN NURSING, Licensure Policy 00-01 (2021) (assessing the "good moral character" of applicants for authorization as advanced practice registered nurses).

a full practice authority state; the revised statute went into effect on January 1, 2021.[28] As part of the revision, an NP will have independent practice authority if they complete two years of "supervised practice" following certification.[29] NPs with less than two years of supervised practice will still need to be supervised by a health care professional who meets minimum qualification criteria, but this now includes an NP who already has independent practice authority.[30]

In the past, legislation attempted to remove NP scope of practice restrictions in Massachusetts, but was met with resistance from physician advocacy groups that argued NPs lack the proper training and education requirements to practice without physician supervision.[31] Before the new legislation, restrictions on NP scope of practice were temporarily removed due to the COVID-19 pandemic.[32] NPs showed they were competent to practice independently during this time.[33] The real push for the legislation, however, came as a result of physician shortages in medically underserved populations. In Massachusetts, 49% of communities are classified as "rural."[34] There has long been a need to increase NP scope of practice in Massachusetts, so that NPs are able to practice independently in these underserved areas and increase access to care.[35]

Massachusetts has already seen changes since adopting full practice authority. In Massachusetts, limiting NP scope of practice led to delays in care and higher health care costs.[36] A brief from the Massachusetts Health Policy Commission found a 9% decrease on medical care

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[28] *Nurse Practitioners in Massachusetts Granted Full Practice Authority*, CREDENTIALING RES. CTR. (Jan. 6, 2021), https://credentialingresourcecenter.com/articles/nurse-practitioners-massachusetts-granted-full-practice-authority; MASS. GEN. LAWS ch. 112 § 80E (2021).
[29] MASS. GEN. LAWS ch. 112, § 80E(a) (2021).
[30] *Id.*; *Frequently Asked Questions about Full Practice Authority for MAN NPs*, MASS. COAL. OF NURSE PRACS., https://mcnp.enpnetwork.com/page/37450-faqs-about-fpa-for-ma-nps (last visited Aug. 20, 2022).
[31] Cuccovia, *supra* note 9, at 410.
[32] *Id.*
[33] *Id; see, e.g.*, Monica O'Reilly-Jacob & Jennifer Perloff, *The Effect of Supervision Waivers on Practice: A Survey of Massachusetts Nurse Practitioners During the COVID-19 Pandemic*, 59(4) MED. CARE 283, 284-85 (4th ed. 2021) (discussing the affect of temporarily waiving Massachusetts' NP scope of practice restrictions during the initial surge of the Covid-19 pandemic).
[34] Cuccovia, *supra* note 9, at 411.
[35] *Id.*
[36] *Id.* at 416.

spending when an adult's primary care provider was an NP rather than a physician, demonstrating that health care costs have already begun to decrease.[37] The brief also showed that "Massachusetts NPs are more likely to provide care for underserved populations" compared to physicians.[38] And studies have shown that after states adopt full practice authority, there is an increase in the total number of NPs,[39] which implies that Massachusetts will likely see an uptick in the number of NPs practicing in underserved areas.

B. Reduced and Restricted Practice Authority

Today, twelve states have adopted a reduced practice and eleven states have adopted a restricted practice regulatory structure for NPs.[40] In both practice environments, "the ability of NPs to engage in at least one element of practice" is reduced or restricted by licensure laws.[41] In reduced practice environments, state laws require a "career-long *regulated collaborative agreement*" between the NP and another health care provider.[42] In restricted practice environments, various state laws require "career-long *supervision* . . . by another health care provider for the NP to provide patient care."[43]

States that impose limitations on NPs' practice capabilities through restrictive licensure authority, demonstrate a stronger correlation to "geographic health care disparities, higher chronic disease burden, primary care shortages, higher costs of care and lower standing on national health rankings."[44] A 2015 report showed that there are fewer NPs in rural areas as compared to urban

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[37] *Id.* at 415.
[38] MASSACHUSETTS HEALTH POL'Y COMM'N, THE NURSE PRACTITIONER WORKFORCE AND ITS ROLE IN THE MASSACHUSETTS HEALTH CARE DELIVERY SYSTEM 5 (2020).
[39] Ying Xue et al., *Impact of State Nurse Practitioner Scope-of-Practice Regulation on Health Care Delivery: Systematic Review*, 64 NURSING OUTLOOK 71 (2015).
[40] *State Practice Environment*, *supra* note 15.
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Issues at a Glance: Full Practice Authority*, *supra* note 18.

areas, but NPs were reported to be a large portion of the providers in rural areas.[45] The report explained that in states with reduced or restricted practice authority, it can be difficult to meet the requirements for physician collaboration due to physician shortages—especially in rural areas.[46] This can lead to a migration of NPs to urban areas where physicians are more readily available.[47] Another recent study found that "[scope of practice] regulation was one of the most important determinants of staff composition in federally funded community health centers."[48] And community health centers—which are essential for medically underserved populations—are less likely to hire NPs if located in states with restrictive practice environments.[49]

1. New Jersey

New Jersey has adopted a reduced practice environment for NPs. The fundamental licensure requirements in New Jersey include: (1) registered professional nurse license; (2) master's degree in nursing; and (3) completion of an examination in an advanced practice nursing specialty.[50] In New Jersey, N.J. ADMIN. CODE § 13:37-6.3 is a joint protocol that requires NPs to work with a collaborating physician in order to practice. New Jersey made attempts in 2012 to expand its NP scope of practice laws by introducing a bill—the New Jersey Consumer Access to Healthcare Act—which would remove the need for a collaborative agreement.[51] The bill was opposed by the Executive Committee of the New Jersey Board of Medical Examiners due to three concerns: (1) "under certain circumstances a physician should be brought in to give treatment"; (2) "the [b]ill could result in raised medical malpractice insurance premiums for physicians"; and (3) "consumers should be

[45] Westat, *supra* note 26, at 23.
[46] *Id.*
[47] *Id. at 24.*
[48] Xue, *supra* note 39, at 81.
[49] *Id.*
[50] N.J. ADMIN. CODE §§ 13:37-7.1, 13:37-7.2 (2022).
[51] A.J. Barbarito, *The Nurse Will See You Now: Expanding the Scope of Practice for Advanced Practice Registered Nurses*, 40 SETON HALL LEGIS. J. 127, 141 (2015).

advised as to who . . . is actually providing healthcare."[52] As to the first complaint, the Committee believed that situationally, only a physician can decide on the most suitable treatment plan.[53] But the act does not preclude physician consultation, and moreover, it is the duty of NPs to refer when necessary, so physicians have no reason to be concerned about the act.[54]

Regarding the second objection, the Committee had concerns that the elimination of the collaborative agreement would cause malpractice carriers to raise premiums.[55] This claim seems to be without merit. The National Bureau of Economic Research demonstrated that more liberal scope of practice laws for NPs lead to no change in malpractice premiums.[56] As to the last objection, the Committee stressed that it is crucial consumers are aware of both the scope and identity of who they are receiving health care from.[57] While healthcare consumers have a legitimate interest in understanding their provider's qualifications, the American Medical Association's "Truth in Advertising" campaign seeks to inform patients about who is providing care while also working to punish nurses who lay claim to the title "Doctor."[58]

In thirteen of twenty-one counties in New Jersey, there is a major issue with access to primary care.[59] Removal of the physician collaboration requirement could ameliorate this issue in counties with poor health outcomes.[60] Specifically, counties with lower income levels—and relatedly, "lower health factor and outcome rankings"—have fewer physicians per capita.[61] This emphasizes the need

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[52] *Id.* at 142.
[53] N.J. BD. OF MED. EXAM'RS, OPEN BOARD AGENDA, 2 (Jan. 13, 2013), http://www.njconsumeraffairs.gov/bme/Agendas/bmeage_010913.pdf.
[54] Barbarito, *supra* note 51, at 142.
[55] N.J. BD. OF MED. EXAM'RS, *supra* note 53, at 2.
[56] *See* Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 L. & ECON 261, 261-65 (2016).
[57] N.J. BD. OF MED. EXAM'RS,, *supra* note 53, at 3.
[58] Barbarito, *supra* note 51, at 143. *See generally* AM. MED. ASS'N, "TRUTH IN ADVERTISING" CAMPAIGN (2018).
[59] Edna Cadmus et al., *Access to Care in New Jersey: Making the Case for Modernizing Legislation*, 11 J. NURSING REG. 36, 36 (2020).
[60] *Id.*
[61] *Id.* at 37.

for removal of New Jersey's joint protocol to ensure primary care access for the most vulnerable populations.[62] And yet, New Jersey is still lagging in modernizing its NP legislation. New Jersey should be particularly concerned, as its surrounding states all adopt full practice authority. NPs could migrate out of New Jersey towards those states, further increasing the provider shortage.[63]

2. California

California follows a restricted practice regulatory structure. The licensure requirements in California include: (1) registered nurse license; (2) a graduate degree in nursing or a similar field; and (3) completion of a nurse practitioner education program or a national certification from an accredited organization.[64] Unlike the previous two states, California does not require NPs to take a national certification exam.[65] Like New Jersey, California has attempted to expand its NP scope of practice laws. And also like New Jersey, the California Medical Association—which represents physicians—spent upwards of one million dollars to oppose the bills.[66] A recent study in California found that "physician supply will meet less than half of the demand for primary care by 2030."[67] Another study showed that the projected growth of NPs in California can fill this anticipated gap in care.[68]

There are more than eleven million people, the majority of whom are Latino/x, who live in health professional shortage areas in California.[69] And nearly one in five Latino/x Californians report

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[62] *Id.*
[63] *Id.* at 38.
[64] CAL. CODE REGS. tit. 16, § 1482 (2023).
[65] *Id.*
[66] Colin Goodman, *Nurse Practitioners: Comparing Two States' Policies*, 23 ANN. HEALTH L. 168, 172–73 (2013).
[67] Alex Montague, *Expanding Scope of Practice for Nurse Practitioners in California: AB 890 Compromises to Permit Independent Practice*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION (Dec 15, 2020), https://sourceonhealthcare.org/expanding-scope-of-practice-for-nurse-practitioners-in-california-ab-890-compromises-to-permit-independent-practice/.
[68] *Id.*at 2.
[69] *HPSA Find*, HEALTH RESOURCES & SERV. ADMIN., https://data.hrsa.gov/tools/shortage-area/hpsa-find (last visited Nov. 29, 2022).

having no regular source of health care.[70] NPs in California have the ability to provide care where it is most needed; more than sixty percent of NPs surveyed in California report they always or almost always work with underserved populations.[71] But unless scope of practice laws are reformed to stop limiting the tasks that NPs can perform, NPs will not be able to fully meet the need for care.[72]

California has recently attempted to grant NPs full practice authority. Similar to Massachusetts, due to the COVID-19 pandemic, the governor of California signed an executive order that eased restrictions of the scope of practice of NPs temporarily.[73] Following the pandemic, a California assemblymember introduced AB 890, which goes further than the temporary waiver and offers NPs two "categories" of practicing independently.[74] The first category, under § 2837.103 ("103 NPs"), allows NPs to practice independently if they work in the same setting as another practicing physician.[75] Alternatively, under § 2837.104 ("104 NPs"), NPs may practice independently under the same settings as 103 NPs, but if they meet additional criteria—such as having practiced as an NP in good standing for at least three years—they can practice in additional settings, such as opening their own practice.[76] NPs who meet either set of requirements will be allowed to practice to the entirety of their training and breadth of their practice.[77] NPs would be able to: (1) "[c]onduct an advanced assessment"; (2) "[o]rder, perform, and interpret diagnostic procedures"; (3) "[e]stablish primary and differential diagnoses"; (4) "[p]rescribe, order, administer,

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[70]Megan Thompson et. al, *Health Disparities by Race and Ethnicity in California*, CAL. HEALTH CARE ALMANAC 2 (Oct. 2021).
[71] JOANNE SPETZ ET AL., 2017 SURVEY OF NURSE PRACTITIONERS AND CERTIFIED NURSE MIDWIVES 58 (2018).
[72] Montague, *supra* note 67, at 2.
[73] *Id.* at 4; *see also* MASS. DEPT. OF PUB. HEALTH, ORDER OF THE COMMISSIONER OF PUBLIC HEALTH AUTHORIZING INDEPENDENT PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES (2020).
[74] Montague, *supra* note 67, at 4.
[75] *Id.*; CAL. BUS. & PROF. CODE § 2837.103 (2023).
[76] CAL. BUS. & PROF. CODE §§ 2837.103-04 (2023).
[77] Montague, *supra* note 67.

dispense, procure, and furnish therapeutic measures"; and (5) "[d]elegate tasks to a medical assistant."[78]

C. Benefits and Costs of Unrestricted Practice

States that have not already adopted a full authority scope of practice for NPs should consider doing so. Giving NPs full practice authority will have numerous benefits. First, it will greatly improve access to medical treatment—especially in urban and rural regions with limited health care resources.[79] According to a study from researchers at the University of Rochester School of Nursing, between 2010 and 2016, in communities with the highest proportion of low-income residents, the average number of NPs increased from 19.8 to 41.1 (for every 100,000 people).[80] At the same time, in rural communities, the average number of NPs increased from 25.2 to 41.3 (for every 100,000 people).[81] Second, it will streamline care and make care delivery more efficient.[82] Specifically, the collaboration requirement is "an inefficient use of primary care resources."[83] This is because the relationship between the physician and the NP "is not one of mere collegial consultation."[84] Rather, these scope of practice laws require NPs "to seek approval and consent of a physician prior to providing a new type of care."[85] Third, adopting full practice authority can decrease costs.[86] In regulatory schemes that require physician oversight of NP practice, there can be duplication of

[78] CAL. BUS. & PROF. CODE § 2837.103(c)(1-4), (6) (2023).
[79] *Issues at a Glance: Full Practice Authority*, *supra* note 18, at 2.
[80] Ying Xue et al., *Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016*, 321(1) JAMA 102 (2019).
[81] *Id.*
[82] *Issues at a Glance: Full Practice Authority*, *supra* note 18.
[83] Austria, *supra* note 4, at 131.
[84] *Id.*
[85] *Id.* (quoting Lauren E. Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH. U. L. REV., 1127, 1128 (2010)).
[86] Heather M. Brom et al., *Leveraging Health Care Reform to Accelerate Nurse Practitioner Full Practice Authority*, 30(3) J. AM. ASSOC. OF NURSE PRACS. 120, 124 (2018).

services and billing costs.[87] Further, the collaboration requirement increases total costs for practices that hire NPs.[88] Certain state laws place statutory limits on the total number of NPs a physician may oversee, thus requiring clinics to hire more physicians in order to maintain compliance, which in turn increases provider costs.[89] Estimates from Massachusetts studies have shown "that with full practice authority of NPs, there will be savings of $4.2 to $8.4 billion in health care costs" over the next ten years.[90]

1. Growth of the Nurse Practitioner Workforce

One reason for adopting full practice authority for NPs is an increase in the total number of NPs. Studies demonstrate that the number of NPs and general growth of the NP workforce is substantially higher in states that have the greatest practice authority.[91] Additionally, "four studies showed that states with more favorable work environments ha[d] higher per capita NPs."[92] In line with these studies, states that allowed NPs independent practice had a 30% increase in enrollment in advanced practice registered nurse programs.[93]

Even if the increase in NPs does not fully close the physician gap, NPs are still a viable substitution for physicians, as they are able to provide high-quality, cost-effective care.[94] The American Association of Nurse Practitioners maintains a list of peer-reviewed, independent research that demonstrates and supports their quality care claims.[95] Physician groups, however, continue to

[87] *Id.*
[88] Austria, *supra* note 4, at 131.
[89] *Id.* at 131–32.
[90] Cuccovia, *supra* note 9, at 413.
[91] Xue, *supra* note 39, at 73.
[92] *Id.* at 74.
[93] *Id.* at 74.
[94] Austria, *supra* note 4, at 125; Chuan-Fen Liu et al., *Outcomes of Primary Care Delivery by Nurse Practitioners: Utilization, Cost, and Quality of Care*, 55(2) HEALTH SERVS. RSCH., 178, 178 (2020).
[95] *See generally* Catherine M. DesRoches et al., *The Quality of Primary Care Provided by Nurse Practitioners to Vulnerable Medicare Beneficiaries*, 65 NURSING OUTLOOK, 679 (2017); *Quality of Nurse Practitioner Practice*, AM. ASSOC. OF NURSE PRACS., https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice (2020).

criticize the quality of care patients receive from NPs.[96] One Doctor, who is a member of Physicians for Patient Protection, points out that all of these studies have been performed while NPs have been supervised, and it would be a leap to say the care will be the same unsupervised.[97] Yet substantial evidence has shown that NPs are able to expand the availability of care while still delivering high quality care and states that have adopted broader practice authority "have experienced no deterioration of care."[98] To be sure, NPs are still subject to the same quality control rules as other health care providers, including medical malpractice laws, which will help to ensure high quality of care.

2. Opposition to Expansion of Scope of Practice for Nurse Practitioners

Expansion of NPs' scope of practice has not come without resistance. The American Medical Association (AMA) states it "vigorously defends the practice of medicine against scope of practice expansions by nonphysicians that threaten patient safety."[99] The AMA reports they have obtained over one hundred state legislative wins "stopping inappropriate scope expansions of nonphysicians."[100] Additionally, research performed by the AMA has shown that even with the increase in the number of NPs across the country, health care shortages still exist.[101] Further, they report that NPs are more likely to practice in the same geographic location as physicians, and thus are not expanding access to care.[102]

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[96] Austria, *supra* note 4, at 125.
[97] Todd Shryock, *Quality vs. Quantity*, 99 MED. ECON. J. 22, 23 (2022).
[98] Austria, *supra* note 4, at 125 (quoting Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL'Y, POLS., & NURSING PRAC. 241, 244 (2008)).
[99] *AMA Successfully Fights Scope of Practice Expansions That Threaten Patient Safety*, AM. MED. ASS'N, https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten (May 15, 2023).
[100] *Id.*
[101] *See, e.g., id.*
[102] Andis Robeznieks, *Why Expanding APRN Scope of Practice is Bad Idea*, AM. MED. ASS'N (Oct. 30, 2020), https://www.ama-assn.org/practice-management/scope-practice/why-expanding-aprn-scope-practice-bad-idea.

NPs strongly disagree. NPs maintain that the medical community, including organizations such as the AMA, has made "a concerted effort to limit their professional occupation and business dealings" and are restraining trade.[103] A restraint of trade is "a limitation on business dealings or professional occupations . . . intended to eliminate competition, create monopolies or otherwise adversely affect the free market."[104] Physicians' view is that their intentions are to protect patients and "the public from the unauthorized practice of medicine" because of the potential harm that could occur.[105] But physicians are also aware that NPs impact the medical establishment's ability to reap financial rewards from their centrality in the primary care market, bringing their intentions into question.[106]

In order for NPs to help medically underserved populations gain access to quality healthcare, NPs must be granted full independence under the law in every state. Opposition to this expansion is backed by inaccurate statements that a larger scope of practice for NPs will result in diminished quality of care, despite well-documented research showing the opposite.[107] The health care system is overdue for a new provider to materialize and fight against the widespread inaccessibility within the health care system, provide care to the growing number of insured Americans since 2014, and manage the lingering impacts of the COVID-19 pandemic. State governments have to shift their mindsets to recognize NPs as independent providers, and wipe out restrictions on NP scope of practice, in order to close the physician gap and make health care accessible for all.

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[103] Austria, *supra* note 4, at 129.
[104] *Id.* (quoting BLACK'S LAW DICTIONARY (9th ed. 2009), Westlaw).
[105] Austria, *supra* note 4, at 129.
[106] *Id.*
[107] *See* DesRoches, *supra* note 95, at 684.

III. LACK OF A NATIONAL STANDARD FOR NURSE PRACTITIONERS

NPs who wish to provide independent care often face policy and legal challenges due to state governments implementing restrictive scope of practice laws, diminishing NPs' ability to practice to their full training and capacity. These restrictive laws—and opposition to expansion of these policies—stems from a lack of understanding of what NPs' credentials truly reflect, including education requirements, hands-on training, and general skills and competence. More so, inconsistencies in NP licensure requirements from state to state have brought about excessively restrictive NP-physician joint protocols and confusion surrounding NP scope of practice. One suggestion to persuade law makers to ease up on these restrictions is to adopt a national curriculum for NPs. It is important to achieve standardization first, before expanding full practice authority, as this would help address inconsistencies in licensure requirements and alleviate legal and policy challenges faced by NPs. This section begins with a brief overview of the history of the NP and NP curriculum, and then identifies challenges to adoption of a national curriculum and offers a possible solution.

A. Deviation from a National Standard

The NP profession is self-governing, and NPs can seek accreditation through a number of private agencies, including the American Association of Nurse Practitioners and the American Nurses Association.[108] And the NP requirements are stringent; the American Nurses Credentialing Center requires individuals to have either a masters, post-masters, or doctorate from an accredited program.[109] Graduate programs tend to require individuals to have a bachelor of science in nursing and have a valid nursing license.[110] The purpose of graduate school is to prepare NPs to "[identify]

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[108] Austria, *supra* note 4, at 126.
[109] *Id.* at 126.
[110] *Id.* at 126-27.

a disease or condition by a scientific evaluation of physical signs, symptoms, history, laboratory test results, and procedures."[111]

1. History of Nurse Practitioners

The University of Colorado School of Nursing developed the first NP program in 1965 following a physician shortage.[112] Despite the shortage significantly affecting rural areas, the introduction of the first NP program was heavily resisted.[113] There were concerns that the title "Nurse Practitioner" would mislead the public and the medical community.[114] Within the medical community, there was resistance from health care providers who believed that NPs were not qualified to provide the same type of medical care as a physician, unless under the supervision of a physician.[115]

During the 1970s and 1980s, there was a push from NPs to legitimize themselves and their practice.[116] This included conducting studies to show the increase of the availability of primary care to patients.[117] During this same period, NPs created eleven professional membership organizations across the United States and NPs were able to take certification exams for the first time.[118] And though NPs were continuously expanding their scope of practice, they "did not have provider status in the eyes of the government" during the late 1980s.[119] Because of this, services provided by NPs had no set monetary value, as did similar or identical services when provided by physicians, and were not eligible for reimbursement.[120] It was not until the Omnibus Reconciliation Act of 1989 was

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[111] *Id.* at 127 (quoting DOUGLAS M. ANDERSON, MOSBY'S MEDICAL NURSING & ALLIED HEALTH DICTIONARY 80 (2002)).
[112] Goodman, *supra* note 66, at 169.
[113] *History of Nurse Practitioners in the United States*, SIMMONS UNIV., https://online.simmons.edu/blog/history-nurse-practitioners/.
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.*
[120] *Id.*

signed into law that NPs received limited reimbursement, and then through the Balanced Budget Act of 1997 NPs were able to gain direct reimbursement.[121] Private insurance companies' reimbursement processes are separate from Medicare and Medicaid and can require a credentialing process.[122]

2. Where Did the Variation Come from?

Today, NPs provide care to patients across the United States in various settings, with 70.3% of NPs certified in family primary care.[123] Nationwide, the criteria for NP education, program accreditation, and board certification conform seamlessly with established national benchmarks.[124] Two primary organizations offer NP program accreditation: (1) the Accreditation Commission for Education in Nursing, Inc.; and (2) the Commission on Collegiate Nursing Education.[125] Together, "these organizations ensure that specific standards in nursing education are being met and that students receive a quality education."[126] Even with these national standards in place, how state laws and legislative bodies authorize NP practice is inconsistent.[127] In the 1970s, this variability surfaced "when states started to regulate NPs beyond their registered nursing license."[128] Within recent decades, however, this disorder among practice authorization has created substantial challenges, not only for NPs, but also for their patients and the health care delivery system.[129]

B. Varying Education Models among Nurse Practitioner Programs

1. The Current Standard

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[121] *Id.*
[122] Reimbursement Task Force and APRN Work Group, *Reimbursement of Advanced Practice Registered Nurse Services: A Fact Sheet*, 39 J. WOUND, OSTOMY AND CONTINENCE NURSING S7, S9 (2012).
[123] *NP Fact Sheet*, AM. ASS'N. OF NURSE PRACS., https://www.aanp.org/about/all-about-nps/np-fact-sheet (Nov. 2022).
[124] *Issues at a Glance: Full Practice Authority*, *supra* note 18.
[125] Ann Feeney, *Nurse Practitioner Programs*, NURSE J., https://nursejournal.org/nurse-practitioner/np-programs (Jan. 31, 2023).
[126] *Id.*
[127] *Issues at a Glance: Full Practice Authority*, *supra* note 18.
[128] *Id.*
[129] *Id.*

Health experts are becoming increasingly concerned with the lack of standardization and education quality of NP programs.[130] To be sure, accreditors provide general guidelines—and do require some benchmarks—but programs can use different teaching methods and measures of student performance.[131] In most cases for a registered nurse to become an NP, they must complete a two-year Master of Nursing program.[132] These programs usually include a combination of classroom lectures and patient-facing clinical hours.[133] The varying models of education, however, may leave students under-prepared for the rigor of NP practice and ultimately put patients at increased risk.[134] Additionally, the different state practice environments that schools operate under can make it challenging for students to find NP programs that will afford them licenses in different states.[135] This can make it difficult for colleges and universities to keep abreast of the requirements each state has.[136]

2. Should Nurse Practitioner Curricula be Standardized?

The American Association of Colleges of Nursing, as well as other nursing associations, create a "uniform starting point" for an NP education program, but there is no standardized curriculum.[137] Though all schools use this as the foundation for their programs, adding various school missions and visions to the design results in more than 400 curricula across the nation.[138] In comparison, over a century ago, medical schools universally embraced a standardized curriculum,

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130 Megan Luther & Lee Zurik, *Nurse Practitioner Field Grapples with Question of Whether to Standardize Curriculum Nationwide*, WITN (Nov. 4, 2020), https://www.witn.com/2020/11/04/nurse-practitioner-field-grapples-with-question-of-whether-to-standardize-curriculum-nationwide/.
131 *Id.*
132 *Id.*
133 *Id.*
134 *Id.*; Roberta Proffitt Lavin et al., *Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments*, 12 J. NURSING REGU. 50, 59 (2022).
135 Luther & Zurik, *supra* note 130.
136 *Id.*
137 Donald Gardenier et al., *Should the NP Curriculum be Standardized?*, 14 J. NURSE PRAC. 140, 140 (2018).
138 *Id.*

which has provided patients with greater transparency regarding their physicians' training.[139] A family physician has a highly structured education path that requires four years in a doctoral program that includes 2,700 lecture hours and 3,000 study hours.[140] A nurse practitioner, by contrast, can complete a master's program that ranges in length from one and a half to three years.[141] The requirements within these varied programs also have a wide range: between 800 and 1,600 lecture hours and between 1,500 and 2,250 study hours.[142] There are concerns that standardization of NP curricula would threaten academic freedom, but public administration literature has shown that standardization "brings efficiency and lowers costs, which in turn should improve outcomes and allow flexibility and interchangeability."[143]

Further, standardization could sway legislators to lift restrictions on NPs' scope of practice across the U.S.[144] Today, there are three different NP program accreditors with three different accreditation standards, which causes concern for lawmakers that NP educational preparation may not align with their practice.[145] Studies have demonstrated that there is a priority to reform curriculum, to address the variability in education preparation, before being able to address the inconsistencies in state licensure and scope of practice laws.[146] Until this variability is resolved, it is likely that many states will continue to operate under a reduced or restricted practice environment.

Proponents of preserving existing variation in NP curricula believe that colleges and universities are so unique to the communities they serve, that standardization would ultimately do a disservice.[147] Specifically, "[i]dentification of community needs prompts assessment and application

[139] *Id.*
[140] Primary Care Coalition, *Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners*, https://tafp.org/media/default/downloads/advocacy/scope-education.pdf.
[141] *Id.*
[142] *Id.*
[143] Gardenier, *supra* note 137, at 140.
[144] *Id.*
[145] Lavin, *supra* note 134, at 53.
[146] *Id.* at 59.
[147] Gardenier, *supra* note 137, at 140.

of suitably matched concepts and skills."[148] Customized NP programs provide an opportunity for the curriculum to reflect the culture and character of the university and the community.[149] Graduate faculty are given the academic freedom to create innovative teaching methods while still adhering to the national standards.[150] Additionally, standardization across schools at present makes it hard to alter curriculum in the future, since future modifications would interfere with consistency.

3. Proposed Solution

An affiliation of nineteen national nursing organizations, known as the National Task Force on Quality Nurse Practitioner Education ("NTF"), recently developed new criteria designed to ensure quality in NP graduate programs.[151] The new standards are titled *2022 Standards for Quality Nurse Practitioner Education (6th Edition)* and will be used nationwide by nursing colleges and universities.[152] The goal is to "better prepare graduates for contemporary NP practice."[153] Some notable changes include: (1) increasing the clinical hours to 750 direct patient care hours;[154] (2) requiring the NP faculty to matriculated student ratio not to exceed twenty-four NP students;[155] and (3) placing an emphasis on diversity, equity, and inclusion in NP programs.[156] The transition to the new NTF standards is expected to take three to five years.[157] Accrediting agencies including the American Association of Nurse Practitioners and the American Nurses Credentialing Center have

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[148] *Id.*
[149] *Id.*
[150] *Id.*
[151] Press Release, Am. Ass'n of Colls. of Nursing, Nat'l Nursing Orgs. Endorse New Quality Standards for Nurse Prac. Programs (Apr. 7, 2022) (on file with author).
[152] *Id.*
[153] *Id.*
[154] The purpose of this increase is to enhance the caliber of NP education and ensure that NP graduates are equipped with the necessary skills to begin practice immediately. *The National Task Force Standards FAQ*, NAT'L TASK FORCE ON QUALITY NURSE PRAC. EDUC. (Jun. 16, 2022), https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/2022/ntfs_/20220616_ntfs_faq_.pdf.
[155] This requirement is aimed at having a favorable faculty workload, which in turn will increase the quality in NP student education. *Id.*
[156] The added emphasis will help to ensure that the NP education prepares students to incorporate consideration of the social determinates of health into their practice. *Id.*
[157] *Id.*

adopted the evaluation criteria into their accreditation standards.[158] While this new set of standards may be a step in the right direction, it is still only having education and training programs meet certain standards, and is not a *standardized* NP curriculum.

Physician organizations across the United States will continue to oppose broadening NPs' scope of practice.[159] And while these groups have various reasons and motivations for doing so, one reason that continues to spark heated debates among legislators is the variation in educational preparation across NP programs.[160] The NTF's new set of standards certainly heightens the base line requirements—bringing them more in line with the requirements of physicians—but still leaves room for individual programs to have variation.[161] NP private accrediting agencies should move to a fully standardized curriculum. It is likely that only the standardization of curriculum can promote nationwide consistency and quality of NP educational programs, to ensure uniformity among NPs. Only then will there be a shift in mindset towards NPs' independent practice, and NP organizations can move legislative initiatives forward.

IV. CONCLUSION

This Article comes at a crucial time for NPs. With the impacts of the COVID-19 pandemic still present, and with the ongoing issue of physician shortages, NPs are needed now more than ever to create access to adequate healthcare. Many states are considering expanding their laws and

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[158] *See generally* NAT'L TASK FORCE ON QUALITY NURSE PRAC. EDUC., STANDARDS FOR QUALITY NURSE PRACTITIONER EDUCATION 1 (6th ed. 2022).
[159] *See AMA Successfully Fights Scope of Practice Expansions That Threaten Patient Safety*, AM. MED. ASS'N, https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten (May 15, 2023).
[160] *See, e.g.*, Letter from James L. Madara, MD, CEO, Am. Medical Ass'n, to Members of Louisiana State Senate (May 7, 2021) (on file with the American Medical Association) (opposing NP scope of practice expansion due to "difference[s] in education and training between [NPs and physicians]").
[161] *See generally* NAT'L TASK FORCE ON QUALITY NURSE PRAC. EDUC., *supra* note 158.

regulations to allow NPs to expand their scope of practice.[162] Those reforms will rely crucially on weighing the costs and benefits of granting full practice authority.

Recognizing the importance of utilizing NPs, this article seeks to do two things. First, it explains the three different state practice environments and their individual implications. Second, building on that framework, it analyzes the risks and benefits of creating a nationalized curriculum, to best prepare NPs to work to their full scope of practice in a full practice authority state. This discussion demonstrates that creating a nationalized curriculum would have its own challenges but highlights why the current standard may not prove effective in training NPs—especially compared to the nationalized curriculum of physicians.

Nurse practitioners have become—and have been—a crucial part of the health care system. Today, medically underserved populations have high health care demands and greater health disparities.[163] Increasing the number of primary care clinicians in these areas would help start to remove barriers to healthcare. Adopting full practice authority will ensure that more Americans have access to quality health care, which will help them lead healthier, longer lives.

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[162] *See, e.g.*, S.B. 1700, 2023 Leg. 88th Sess. (Tex. 2023) (allowing primary care NPs to practice without physician supervision).
[163] *See* Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers* KAISER FAMILY FOUND. (Apr. 21, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.