

Ranking State NP Regulation: Practice Environment and Consumer Healthcare Choice

Nancy Rudner Lugo, DrPH, NP;
Eileen T. O'Grady, PhD, RN, NP;
Donna R. Hodnicki, PhD, APRN,BC, FNP, FAAN; and
Charlene M. Hanson, EdD, RN,CS, FNP, FAAN

This study measured and ranked the regulatory environment for nurse practitioner (NP) practice and consumer healthcare choice in each of the 50 states and the District of Columbia (DC). An expert panel examined the state rules and regulations in three dimensions: (1) the environment affecting consumer access to NPs as providers, (2) the environment affecting reimbursement and NP patients' access to related healthcare services, and (3) the environment affecting NP patients' access to prescription medications. Scores in each of these domains were calculated for each state and DC, which were then ranked by the composite scores of the three domains. Findings suggest that wide variations exist in state regulation of NP practice, indicating the strong likelihood that, in some states, NPs cannot reach their full capacity to meet patients' needs. This wide variation also



suggests that regulations for NP practice are not evidence based, have no patient-safety foundation, and appear arbitrary. The study results can be used as an advocacy tool for NPs working with policy makers to identify

their state's or district's standing relative to the rest of the nation and to propel reform for modernizing nurse practice acts to align with improved consumer choice and evidence-based patient-safety principles.

Overview

The dense regulatory patchwork for NP practice described in the Institute of Medicine's (IOM's) 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,¹ persists in 2007. With national statistics indicating an increasing shortage of both nurses and primary care physicians, state regulation continues to restrict the full scope of practice for NPs.^{2,3} Extensive research validates that the care NPs provide is safe, cost-effective, and needed.^{2,6}

Despite these findings, state regulation still erects barriers to the full scope of care that NPs can provide. Regulation of NP practice exists on a continuum ranging from exceedingly restrictive language requiring supervision by healthcare professionals from another discipline to language allowing unimpeded autonomous practice within the scope of the profession. Much of the regulation governing NPs appears to lack an evidence base. For example, in one state, NPs are required to "intern" with a physician or *dentist*, whereas in other states, NPs with national certification established by the NP profession can practice autonomously. Variability of the regulation is such that some states require permission from a healthcare professional from another discipline for NPs to prescribe more than 7 days of medication, other states mandate an on-site physician 10% of the time, and still other states mandate a physician's order for physical therapy. These highly variable practice environments are not based on evidence and continue to hamper the ability of NPs to provide their full scope of care while impeding patient access and safety.

In order to develop a framework to understand the diversity of regulations governing NP practice, the authors evaluated the 50 states and DC in terms of (1) the multiple components of NP regulation, (2) the practice environment, and (3) the effect of each state's regulation on patients' access to NPs and related services. These findings highlight the states that are in the greatest need of significant revision in regulation or legislation to improve the context in which patients receive health care from NPs. In this way, the entire nation can achieve the goal of facilitating patients' access to continuous, timely, and efficient care and services.

Review of the Literature

Many papers have been written over the years assessing the diversity of state regulation on NP practice and its impact on health services.⁷⁻¹² Since 1989, *The Pearson Report*[®] has provided an annual descriptive, detailed compendium of state rules and regulations affecting NP practice. The 2007 version of *The Pearson Report* (<http://www.webnp.net/ajnp.html>) concludes that although some progress has been made in this regard, significant state reforms are still needed. Since 1999, the total number of NPs in the United States has increased by 83%, from 76,306 to 139,520, whereas regulations remain varied regarding prescriptive authority, physician involvement, ability to dispense medication samples, and ordering of diagnostic tests and physical therapy for patients.

Sekscenski and colleagues evaluated state practice environments for NPs, physician assistants, and certified nurse midwives, as well as the relationship between practice

environment and the supply of these providers in each state.¹³ The authors' practice environment scoring system consisted of three primary measures: legal status, reimbursement, and prescribing. The authors found wide variation among states in both practice environment scores and practitioner/population ratios. Favorable environments were associated with a greater supply of these providers.

Many voices have called for uniform NP regulation across the states and DC. Cooper et al reviewed "state practice prerogatives" for autonomy, scope of practice, and prescriptive authority for 10 professions, including the NP profession.¹⁴ These authors found a wide range in regulatory oversight and scope of practice, and posited that such variation could further fragment the US healthcare system, leaving more regions without adequate healthcare providers.

Safriet examined how unnecessary restriction of non-physician providers affects access and quality of care.¹⁵ Safriet, along with the Pew Health Professions Commission,¹¹ emphasized the need for regulation to be evidence based, consistent, and protective of patients instead of being directed toward serving the economic interests of physicians. Regulations that are "barriers serve no useful purpose and contribute to our healthcare problems by preventing the full deployment of competent and cost effective providers who can meet the needs of a substantial number of consumers."¹⁵

Wing, O'Grady, and Langelier assessed changes in the legal practice environment of NPs from 1992 to 2000.¹⁶ An NP Professional Practice Index was built on Sekscenski's earlier work, and used the same categories of legal

authority, reimbursement, and prescriptive authority. The authors found that although NPs had increased in number and, in many states, had expanded their scope of practice between 1992 and 2000, they were still greatly underutilized because of variable regulatory limits on autonomy, entry into practice, reimbursement, and scope of practice relative to their skill and potential contribution.

The IOM report, *Crossing the Quality Chasm*,¹ acknowledged that state practice acts that limit non-physician providers, e-health, and multidisciplinary teams act as a barrier to innovative health care—innovations that can enhance care for patients across settings and over time. *Crossing the Quality Chasm* recommends greater coordination and communication among professional boards both within and across states as the patchwork of advanced practice nursing (APN) regulation is resolved over time. The report also recommends that regulators create an infrastructure to support evidence-based practice, facilitate the use of information technology, align payment incentives with quality initiatives (eg, payment for group patient visits), and prepare the workforce to better serve patients in a world of expanding knowledge and rapid change. The report stresses that if innovative programs are to flourish, regulatory environments will need to foster innovation in organizational arrangements, work relationships, and use of technology. The 21st-century healthcare system described in *Crossing the Quality Chasm* cannot be achieved in the current environment of regulation and oversight. The report summarizes the current patchwork of regulatory frameworks as inconsistent, contradictory, duplicative, outdated, and counter to best practices.

To date, no studies have shown an adverse effect on consumers when care is delivered by an NP. In fact, the opposite is true—many studies have shown the favorable effects on healthcare outcomes when care is delivered by NPs.^{4,6,17-19}

The National Council of State Boards of Nursing (NCSBN) Advanced Practice Advisory Panel is developing a vision paper, *The Future Regulation of Advanced Practice Nursing*. This vision paper articulates a regulatory model, developed in collaboration with other stakeholders, that will set a standard for APN regulation and credentialing across the states. The NCSBN posits that regulation of NPs must be based on the “fundamental principle of protection of the health, safety, and welfare of the public.” The NCSBN recommends that state boards of nursing have sole authority over APNs, and that APNs’ practice must be independent, with no supervision requirements by healthcare providers from other disciplines. No evidence indicates that onerous requirements for NP practice such as supervisory or collaborative agreements enhance patient health, safety, or welfare. As geographic boundaries between states become obsolete with advances such as e-health and multi-state employers, there exists a significant need for NP licensure to evolve toward an interstate compact (mutual recognition). This compact will improve access to qualified NPs. However, in order for the compact to become a reality, the enormous variation between the state practice acts governing NPs must be eliminated.¹²

The Study

Purpose—The study was conducted to provide quantified data

about the 50 states and DC that might help in the creation of a coherent national regulatory framework for NPs. To facilitate this effort, the study presents a ranking of the multiple components of NP state regulation and compares practice environments for NPs across the 50 states and DC.

Method—An expert panel of four doctorally prepared NP researchers conducted a secondary analysis of the regulatory environment data contained in *The Pearson Report 2007*, which reflects state and DC regulations as of December 1, 2006. *The Pearson Report* data provide summary descriptions on the regulatory and practice environments of all 50 states and DC. The researchers identified key components of NP regulation, based on the NCSBN vision paper and previous studies of state regulation of NPs.

Content analysis of the data explored 12 specific measures of each state’s or district’s regulatory environment that affect patients’ access, care, and safety. The 12 specific measures were conceptually configured into three dimensions of the regulatory environment (Table 1). The first dimension, *Environment Affecting Consumers’ Access to NP Providers*, is defined as the environment that regulates and authorizes NP to provide health care to the public. This dimension is composed of three measures: (1) NP governance solely by the state board of nursing (BoN) or shared with another profession, (2) NP requirements for entry into practice, and (3) professional autonomy for NP practice. The second dimension, the *Environment Affecting Reimbursement and NPs’ Patients’ Access to Related Health-care Services*, is defined as the environment that allows NPs to be

reimbursed for services rendered and to order needed testing and related services. The five measures that comprise this dimension are NPs' abilities (1) to practice in an environment free of onerous requirements that are not evidence based, (2) to obtain hospital privileges, (3) to order laboratory testing or physical therapy, (4) to be named as primary care providers (PCPs), and (5) to receive reimbursement for services rendered.

The third dimension, *Environment Affecting NPs' Patients' Access to Prescription Medications*, describes the environment that allows NPs to write prescriptions for medications and provide drug samples. The four measures comprising this dimension are NPs' abilities (1) to write for appropriate amounts of legend or controlled drugs, (2) to write prescriptions without involvement of providers from another discipline, (3) to be clearly

identified as the prescriber on all prescription bottles, and (4) to receive and dispense drug samples. These three dimensions reflect the extent to which state regulations (1) allow the nation's almost 140,000 NPs to provide care according to their level of education, competence, and experience; (2) allow these same NPs to practice within the context of basic patient safety principles and consumer choice; and (3) ensure that

TABLE 1 STATE REGULATORY ENVIRONMENT DIMENSIONS AND MEASURES AFFECTING NP PRACTICE

Environment Affecting Consumers' Access to NP Providers—30 points

Governance of NP profession (10 pts)	Board of Nursing has sole state authority over NPs
Entry into practice (10 pts)	Requirements to enter into NP practice facilitate availability of safe, professionally qualified NPs and are not excessive
Professional autonomy (10 pts)	Scope of practice is congruent with NPs' education and professional ability; practice is not encumbered by members of any other profession

Environment Affecting Reimbursement and NPs' Patients' Access to Related Healthcare Services—40 points

No onerous, unreasonable requirements (10 pts)	Practice environment is free of onerous requirements imposed on NPs; NPs have authority to diagnose and treat without cumbersome oversight requirements, which can raise the cost of care (eg, required practice hours, practice agreements, limiting protocols, chart review, frequent filing of collaborative agreement)
Hospital privileges (4 pts)	State has no legislative prohibitions against NP hospital privileges
Access to diagnostic and other services (9 pts)	State has unencumbered laboratory testing, diagnostic testing, and physical therapy policies for patients of NPs
Primary care providers (7 pts)	State authorizes NPs to be recognized as primary care providers
Payment (10 pts)	Legislative language permits NP reimbursement by 3rd party or HMO

Environment Affecting NPs' Patients' Access to Prescription Medications—30 points

Prescriptive authority (8 pts)	NPs' prescribing is within scope of expertise unfettered by other professions (eg, protocols, practice agreements)
Prescriptions (10 pts)	NPs' patients have full access to prescriptions
NP name on bottle (7 pts)	Patients' prescription medication bottle is required to have NP's name
Receiving and dispensing samples (5 pts)	NPs are authorized to receive and dispense pharmaceutical samples for patients

NP = nurse practitioner; HMO = health maintenance organization.

TABLE 2 CONSUMER CHOICE RANKINGS OF STATE NP REGULATION, 2006

Rank	State	Legal Capacity	NP Patients' Access to Services	NP Patients' Access to Prescriptions	State* Score	Ranking Category
	<i>Maximum points</i>	30	40	30	100	
1	ARIZONA	30	40	30	100	Grade A: State is exemplary for patient choice
2	WASHINGTON	30	40	28	98	
3	WYOMING	30	37	30	97	
4	DISTRICT OF COLUMBIA	30	35	30	95	
5	NEW HAMPSHIRE	30	40	25	95	
6	MONTANA	27	37	30	93	
7	OREGON	27	36	30	92	
8	NEW MEXICO	27	40	25	91	
9	CONNECTICUT	24	37	27	88	Grade B: State partially supports patient choice
10	RHODE ISLAND	24	37	27	88	
11	UTAH	19	40	27	87	
12	IOWA	24	37	25	86	
13	ALASKA	21	37	27	85	
14	NEW YORK	21	37	27	85	
15	IDAHO	25	35	22	82	
16	NEW JERSEY	19	37	25	81	
17	KENTUCKY	21	37	22	80	
18	WEST VIRGINIA	24	33	21	79	Grade C: State confines patient choice
19	PENNSYLVANIA	24	31	22	78	
20	DELAWARE	16	37	25	77	
21	WISCONSIN	24	28	25	77	
22	VERMONT	24	28	25	77	
23	NORTH DAKOTA	22	30	25	76	
24	CALIFORNIA	18	32	25	75	
25	MINNESOTA	17	33	25	75	
26	TENNESSEE	17	33	25	75	
27	KANSAS	21	30	22	73	
28	NEVADA	17	29	27	73	
29	MAINE	18	33	22	72	
30	OHIO	18	33	20	71	
31	ARKANSAS	19	25	24	68	Grade D: State restricts patient choice
32	COLORADO	21	30	18	68	
33	INDIANA	13	30	22	65	
34	MISSISSIPPI	17	26	22	65	
35	TEXAS	18	28	19	65	
36	SOUTH DAKOTA	14	27	22	63	
37	OKLAHOMA	24	20	19	63	
38	LOUISIANA	18	25	19	62	
39	NEBRASKA	10	23	27	61	
40	VIRGINIA	17	28	15	60	
41	SOUTH CAROLINA	14	26	19	59	Grade F: State severely restricts patient choice
42	MARYLAND	13	24	20	57	
43	NORTH CAROLINA	13	25	19	57	
44	MICHIGAN	22	24	12	57	
45	MASSACHUSETTS	17	24	15	56	
46	HAWAII	13	33	9	55	
47	ILLINOIS	11	25	19	55	
48	GEORGIA	12	26	16	53	
49	FLORIDA	13	20	16	49	
50	MISSOURI	13	18	5	36	
51	ALABAMA	17	13	5	35	
	Average	20	31	22	73	
	Standard Deviation	5	6	6	15	

*Composite state score may not be the exact sum of the three dimension scores (legal capacity, NP patients' access to services, NP patients' access to prescriptions) because of rounding.

patients of NPs have access to needed services and prescriptions.

Each of the 12 measures was assigned a weighted numerical score by each of the four experts. Next, concordance on the weight was reached on each measure. Content analysis of the data was completed in three steps. In step 1, data on each state and DC were individually evaluated by each researcher. In step 2, the researchers formed pairs to reach consensus on the study data. In step 3, the four researchers as a group came to concordance on all state data and rankings. These three steps provided reliability to the study findings.

States were ranked by the total overall score that was determined by the individual scores on the three dimensions. Higher-ranked states have the most favorable environment for NP practice and consumer choice, whereas lower-ranked states restrict NP practice and patient access to safe and effective care by NPs.

Results—Table 2 provides subscores, composite scores, and ranking of the states. Rankings ranged from 38 to 100 (maximum, 100 points). Composite scores were divided into deciles and assigned letter grades to reflect the regulatory environment for patient choice and access. States with lower total scores showed variation among the three dimensions. For example, in Hawaii, South Carolina, and Nevada, the legal environment governing patient access to NPs, including NP entry into practice, is relatively restrictive, although once NPs in these states are in practice, patients' access to services and prescriptions is less limited.

Environment Affecting Consumers' Access to NP Providers. In 28 states and DC, the NP profession is governed solely by the BoN

in that state. In 23 states, governance of the profession is shared by the BoN and another non-nursing entity, typically the Board of Medicine. Requirements for entry into practice vary widely. New Hampshire, like 4 other states and DC, requires that NPs be nationally certified by their profession and does not place other restrictions on entry into practice. By contrast, Maine requires recent NP graduates to practice under physician supervision for the first 2 years.

Practicing NPs' professional autonomy also varies greatly. In 9 states (Arizona, Idaho, Montana, New Hampshire, New Mexico, Oregon, Washington, and Wyoming) and DC, NPs' scope of practice is congruent with NP educational preparation and professional ability, and is independent of or in collaboration with, not controlled by, another profession. By contrast, other states require specific written relationships between NPs and members of other professions; these relationships range from general collaboration to more specific protocols or written collaborative agreements, with or without direct on-site supervision. Predominately rural South Dakota requires direct on-site personal contact between the NP and collaborating physician for 10% of the time. South Carolina requires that a supervising physician or dentist be readily available for consultation. A few states authorize podiatrists and optometrists to serve in the role of supervisor to NPs. South Carolina arbitrarily requires increased scrutiny of applications when more than 3 NPs practice with 1 physician or if the NP practice site is more than 45 miles from the supervising physician's site. It is noteworthy that even when the BoN is the sole authority, a state can

still be restrictive. For example, in Oklahoma, the state BoN regulates the profession, but the state scores relatively low in measures of patients' access to NP services and prescriptions.

Environment Affecting Reimbursement and NPs' Patients' Access to Related Healthcare Services. Once an NP has met state requirements for practice, the scope and authority to practice varies across a continuum from independence to a requirement for follow-up or on-site supervision for selected populations. In Missouri, when an NP sees a new patient or a patient with major changes in diagnosis or treatment plan, a physician must see the patient within 2 weeks after the NP contact. Texas requires a physician to review 10% of the charts of patients seen by NPs in medically underserved and alternative practice sites; however, no review is required in the more affluent, mainstream settings. In many states, NPs' ability to order laboratory tests for patients is limited to those tests spelled out in a written protocol or collaborative agreement. Some states do not permit NPs to prescribe physical therapy. Other states require that a physician be on-site a certain percentage of the time, be within a limited geographic radius, and co-sign charts. Some states require frequent revisions of detailed collaborative agreements. These varied requirements have not been shown to improve quality of care but, rather, to raise the cost of care and impede patient access to health care.

Environment Affecting NPs' Patients' Access to Prescription Medications. State regulatory approaches to NP prescribing range from no authorization for prescribing (in Georgia, 2006 legislation passed which recognized NPs as prescribers, but the rules have not

been approved at the time of this writing) to unencumbered prescriptive authority (Arizona, DC, Montana, Oregon, Washington, and Wyoming). NPs in 47 states can prescribe controlled substances, although some states limit the quantities prescribed or place other restrictions on NPs' prescribing. In 4 states (Alabama, Florida, Hawaii, and Missouri), NPs' ability to prescribe is limited to legend drugs (no controlled substances), with or without restrictions. In 42 states, the NP prescriber's name must be on all medication bottles, whereas in 6 states, regulation does not permit the prescribing NP's name to be on the label. This latter situation creates a patient safety violation because neither the pharmacist nor the patient can easily access or identify the prescriber.

Limitations of the Study

These study findings are empirically supported. Limitations of this research are associated with the analysis of secondary data and the high degree of intra- and interstate variation in NP regulation. The researchers had early and exclusive access to 2006 data collected for *The Pearson Report 2007*. The *Pearson Report* data collection process relied on several different methods. Data were gathered from reviews of state legislation, reviews of state rules and regulation, interviews with personnel from state boards of nursing, and interviews with state nursing leaders. The varied sources of data could result in variable accuracy across states, depending on the level of expertise of the responder. Lack of an a priori system used to rank the data collected poses another limitation. Finally, the 51 nurse practice acts lack any coherent framework or congruence

among themselves, making it extremely difficult for analysts to develop a ranking rubric.

Implications of the Findings

These findings are important to practicing NPs, as well as to educators, certifiers, and regulators who license and credential the NPs. In essence, this ranking could be used as a tool to move outdated nurse practice acts onto the political agenda. With current shortages of nurses and PCPs, a window of opportunity may be opening to look at the barriers that are present in state legislation and regulations that are impeding consumer access to healthcare services. NPs are viable providers of safe, cost-efficient health care. Changes in health policy and legislative reforms can be instituted. Examples of possible solutions in terms of state reform measures and favorable political circumstances are noted in the *Crossing the Quality Chasm Report*, which recommends reform and pay-for-performance initiatives. Findings of the present study could serve as a powerful advocacy tool to strengthen the regulatory environment to provide consumer access to qualified NPs at a time when access to healthcare providers is becoming more limited.

This analysis of state regulation underscores the need for policymakers and legislators to understand that these restrictions on consumer choice are *not* based on patient-safety concerns or on evidence. Some state lawmakers have recognized the favorable impact of NPs on health care and have developed policies to increase the number of NPs available to meet their state's healthcare needs. For example, as governors of California and Pennsylvania develop plans to expand access to care in their

states, they propose removing barriers to NP practice.

Policy issues can be moved to the top of the policy agenda when highly relevant research is published under the right political circumstances. State and national NP associations, as well as grassroots NPs, could use these findings to encourage change strategies. Each state policymaker could be given a copy of the ranking table depicting where his or her state stands in relation to the others, with a letter from the state NP association listing specific items that need to be changed to work toward a nurse practice act that reflects modern practice. Higher-ranking states should receive recognition for their forward thinking and leadership advocacy, whereas lower-ranking states could be given a specific list of concerns that must be addressed and conditions that must be modernized. Individual NPs could engage the public by writing letters to newspaper editors and by alerting the media in their state to their state's rankings. NPs can also educate persons in the media about how NP practice affects their community and how regulatory barriers harm patients.

Further research could use the elements of the NCSBN vision paper to measure and rank the progress of state reform for NP practice. Annual rankings could assist NP organizations in exerting continuous pressure on state policymakers to align their state nurse practice acts with the NCSBN model to improve and standardize the regulatory environment. Until states use an evidence-based approach to regulating NP practice, an interstate compact for NP licensure will be elusive and NP regulation will be based on the whims and political leveraging of

interest groups rather than on patients' needs or safety.

However, opportunities for policy change can be realized *only if* NP organizations display a high degree of political competence. Policymakers do not typically read nursing and NP journals. It is critical that NPs and nurse leaders communicate these findings in arenas where policy is being developed. Table 3, Translating Research to Policymakers, provides strategies for disseminating this information.

NPs must demand change in the state regulatory environments because this dense and varied landscape of laws can be harmful to patients. Calls for regulatory reform need to be focused on solutions to the larger problems faced by the state and on consumer access to safe, cost-efficient care that can be provided, at least in part, by NPs. As health care is increasingly delivered within national corporate structures, and as telehealth grows, these outdated, arbitrary, overly complicated, and confusing regulations across states must evolve as geographic boundaries become obsolete. Modernizing state nurse practice acts can result in improved patient safety in multiple ways. Patient safety is enhanced when NPs can order an appropriate course of medication for a presenting problem. Safety is improved when the NP prescriber's name is easily identifiable to both patient and pharmacist on the medication label. Patient outcomes are improved when NPs are able to order timely, necessary tests and services on behalf of their patients.

Conclusion

The findings of this study of the 50 states and DC clearly present the effects of the current arbitrary

approach to regulation of NP practice. The states and DC approach NP regulation on a continuum ranging from independent practice to strict oversight by the medical profession and in some cases other professions. In order for NPs to meet the needs of patients and of the healthcare system, they must unapologetically seek regulatory environments that foster innovation and protect the public. This patchwork of regulations impedes NP practice and narrows the scope of practice for which they are educationally prepared and professionally certified. Clear and focused NP leadership is required to reframe the regulatory patchwork across the United States into a sound, evidence-based, coherent vision, with a strong patient safety orientation, expressed in the NCSBN vision paper. ■

The authors are editors and columnists for NP Communications, publisher of The American Journal for Nurse Practitioners and NP World News. They saw a need for a ranking of state regulations described in The Pearson Report to depict the patchwork of laws and rules governing NP practice. Nancy Rudner Lugo, from the 49th state according to this ranking, is the president of NR Consulting, Inc, and a faculty member at the University of Central Florida in Orlando. Eileen T. O'Grady, who writes about NP and health policy issues, resides in the state of Virginia, which ranks 40th. Donna R. Hodnicki is a professor of nursing and MSN Program director at Georgia Southern University in Statesboro, Georgia, a state that ranks 48th. Charlene M. Hanson, who also hails from the 48th state, is professor emerita at Georgia Southern University. The authors state that they do not have a financial interest in or other relationship with any commercial entity named in this article.

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This full report, all Tables, and *The Pearson Report 2007* can be downloaded from the NP Communications website: <http://www.webnp.net/ajnp.html>

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TABLE 3 TRANSLATING RESEARCH TO POLICYMAKERS

■ **Link research to specifics of the state.**

- Show example: "State X has an uninsured rate (and/or cite state health indicators) of Y% and a broken Medicaid budget, yet a highly restrictive state practice act for NPs; with improved regulation, NPs can be a big part of the solution."
- Make highly specific recommendations for regulatory change that will benefit patients and payors. Link changes to improved patient access and quality.

■ **Encourage NP professional organizations to provide leadership.**

- Focus governmental affairs and policy priorities toward modernizing state nurse practice acts.
- Organize state and local nursing and NP groups to develop policy solidarity by developing a strong, cohesive policy message and strategy.

■ **Educate the public.**

- Write letters to newspaper editors depicting the state ranking and what the state legislature must do to modernize regulation.
- Alert regional media to inform the public about the ranking and how restrictive NP regulation can harm patients by limiting access to qualified healthcare providers.
- Invite the media to "follow an NP" for a day to generate public interest stories.

■ **Inform policymakers about research findings.**

- Create awards and recognition strategies for forward-thinking states, congratulating them for supporting NP practice and patient access to qualified safe healthcare providers.
- Summarize and distribute relevant research, including your state's ranking, with a customized, highly specific action list (1-2 pages) for your state legislators.

■ **Include reference to the National Council of State Boards of Nursing (NCSBN) vision paper for the future of APN regulation.**

- Develop model language for state legislatures to work toward in states that impose restrictions on NP practice.
- Invite policymakers to visit NPs in clinics.

■ **Refer to the nurse practice acts in the higher-scoring states and the NCSBN vision paper.**