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CREATIVE CONTROVERSY

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COVID 19: An unprecedented opportunity for nurse practitioners to reform healthcare and advocate for permanent full practice authority

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Abstract

The coronavirus disease 2019 (COVID-19) pandemic ushered in a new era for advanced practice registered nurses, as emergency regulatory and policy changes expanded the nurse practitioner (NP) scope of practice. The legislative changes enabled NPs to bolster the national pandemic response by working to the full extent of their education and training. The changes are only temporary, and many have contemplated the permanent impact of COVID-19 when healthcare transitions to a postpandemic normal. NPs now have a unique opportunity to educate others about the merit of their role and advocate for permanent legislative changes. In this creative controversy manuscript, we build a case that national NP full practice authority increases access to care and is vital for a sustainable and resilient healthcare system that can react to future pandemic crises.

KEYWORDS
COVID-19, full practice authority, nurse practitioner, nursing, pandemic

1 | INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic has ushered in a new era for advanced practice registered nurses (APRNs), as emergency regulatory and policy changes expanded the nurse practitioner (NP) scope of practice and provided a pathway to national full practice authority.[1] Nationally, NPs met the pandemic response challenges by providing life-saving direct primary and acute care for COVID-19 positive patients.[2] Consequently, the COVID-19 pandemic increased public awareness of nursing's value and the integral role NPs have in optimal patient health.

The policy and regulatory changes are only temporary, and many have pondered the permanent impact of COVID-19 when healthcare transitions to a postpandemic normal.[3] Some medical organizations have historically opposed full practice authority and resisted efforts to increase access to licensed APRNs (e.g., APRN Compact legislation), under the guise of patient preference and safety.[4] NPs now have a unique opportunity to educate others about the merit of their role and advocate for permanent legislative changes. Therefore, this article aims to describe the merit of the NP role, review recent COVID-19 regulatory and policy changes, and recommend a progression towards a postpandemic national healthcare model where NPs gain full practice authority.

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2 | EDUCATING OTHERS: NPS PROVIDE QUALITY AND COST-EFFECTIVE CARE TO DIVERSE POPULATIONS

Nursing is not only a practice profession. It is a scientific discipline with a vast body of knowledge independent of medicine. Nursing has its own philosophical and theoretical foundation, which is bolstered by a comprehensive research base comprised of innovative practice frameworks, interventions, and care models. Thus, nursing provides great value in the provision of care in collaboration with other disciplines. NPs should not function ancillary to medicine, but in a collaborative way that leverages the unique training of each discipline to enhance the delivery of effective patient care.

More than 290,000 NPs in the United States provide high-quality, cost-effective, and patient-centered care.[5] Millions of U.S. patients choose NPs as their healthcare provider, comprising over 1.06 billion patient visits in 2018.[5] Certified NPs are one of the four recognized APRN roles, including certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists. NPs have advanced graduate or postgraduate education with certification and practice focused on direct patient care in at least one of six population concentrations: adult-gerontology, pediatrics, neonatal, women's health/gender-related, family/individual across the lifespan, or psych/mental health.[6]

Because NPs are registered nurses with advanced education, their care provided is deeply rooted in nursing's foundational principles. NPs offer a holistic and unique perspective to health, as they emphasize both care and cure by focusing on health promotion, education, and disease prevention.[7] NPs are the fastest-growing primary care provider professionals.[5] They are vital to the delivery of patient-centered primary care for many U.S. patients, as more than 75% of NPs provide primary care services.[8] Furthermore, NPs care for diverse patient populations and are more likely to practice in rural and medically underserved areas than physicians.[9,10]

A large body of research supports that NPs provide equivalent or higher-quality care than their physician colleagues,[11] with improved patient satisfaction rates.[12] Kurtzman et al.[13] conducted a retrospective analysis of over 30 million patient visits and determined NPs provided largely comparable care to patients compared with physicians in similar populations on quality, utilization, and referral patient measures.[13] In the study, patients seen by NPs were more likely to receive recommended health education/counseling services and smoking cessation counseling as compared with patients seen by their physician counterparts.[13] NPs have consistently provided cost-effective care in multiple settings, with studies concluding NPs deliver care at a 29% reduced cost compared with primary care physicians.[14]

Before the COVID-19 pandemic, 22 states (including Washington, DC), the Veterans Administration, and the Indian Health Service passed legislation to grant NPs full practice authority.[15] Full practice authority is granted under the licensing authority of the state boards of nursing and authorizes NPs to “evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments—including prescribing medications.”[16] In the 28 states that limit practice authority, NPs must have a collaborative practice agreement with physicians outlining their practice privileges and oversight by the state medical board.[16] Restrictive scope of practice regulations are a barrier to optimal NP primary care utilization, reduce efforts to ameliorate racial and ethnic health disparities, and limit access to care for many medically underserved areas.[10]

3 | THE RISE OF COVID-19 AND THE RELAXATION OF REGULATIONS GOVERNING NP SCOPE OF PRACTICE

The COVID-19 pandemic stressed the U.S. healthcare system and threatened to overwhelm regions where the disease burden was high and resources were low.[17] The pandemic exposed weaknesses in the U.S. healthcare system, including severe shortages of hospital beds, equipment, medication, supplies, and personal protective equipment.[18,19] Furthermore, the pandemic response presented challenges to frontline clinicians' well-being, including risks to their physical and mental health.[20,21] To meet COVID-19 response challenges, many healthcare workers endured extended work hours and were at higher risk for compassion fatigue from providing care to patients with severe health complications.[22]

The COVID-19 pandemic also highlighted structural vulnerabilities in the U.S. health system, including inequities in care for minority and rural populations.[23,24] Rural residents are at an increased risk for morbidity and mortality once diagnosed, as rural hospitals have fewer specialized providers, limited or no acute care capabilities, and are less resilient to staffing shortages and financial hardship.[24]

Although the total long-term impacts of the global pandemic are unknown, the negative impacts on the U.S. healthcare workforce's vitality are evident. COVID-19 exposure exacerbated healthcare staffing shortages and increased workload for unexposed clinicians.[24] COVID-19 infected thousands of U.S. healthcare workers[21] resulting in the mortality of over 800 frontline clinicians.[25] Thus, many hospitals instituted Contingency and Crisis Capacity Strategies to mitigate staffing shortages and maintain patient and staff safety.[26]

As government officials anticipated further shortages of healthcare workers, they urged retired NPs, doctors, nurses, and other medical professionals to return to the workforce and assist frontline staff.[27] At the request of federal and state governments, many nurses and NPs traveled to assist besieged hospitals with the COVID-19 response.[28] The COVID-19 disruption led to numerous primary care clinic closures and dramatic decreases in patient load. Reduced primary care appointment volume and cancellations of millions of elective surgeries enabled clinicians to shift to critical frontline areas to aid in the pandemic response.[29] To meet actual or potential patient demand, many APRNs received additional training to care for mechanically ventilated patients. Their flexibility and adaptability enabled them to provide life-saving support to emergency and critical care areas.[30] Thus, some NPs shifted their focus from specialty areas to provide acute care for patients diagnosed with the virus.

To bolster the national COVID-19 reaction plan, the US government relaxed long-standing regulations and implemented policies to

empower hospitals and healthcare systems with expanded treatment capacity.[31] The U.S. Department of Health and Human Services Secretary urged immediate executive action by all governors to modify state laws and regulations to extend the healthcare workforce's capacity and "ensure health professionals maximize their scopes of practice."[32] Under the direction of the Trump Administration, the Centers for Medicare & Medicaid Services (CMS) made sweeping regulatory changes to, among other things, strengthen an overburdened workforce, expand telehealth delivery and reimbursement, and lessen administrative burdens.[31] The waivers issued by CMS enabled hospitals to use NPs to their fullest extent under state emergency preparedness plans.

One change from the Coronavirus Aid, Relief, and Economic Security Act or the "CARES Act" (H.R. 748) permanently authorized NPs to order and provide care for Medicare-eligible home health patients.[33] The CARES Act promoted timely access to home health services and potentially reduced the virus's spread, as medically stable COVID-19 positive patients are discharged into the home setting to reduce risk. Additionally, all but seven states limiting APRN practice have partially or fully waived collaborative practice agreement requirements.[1] Depending on state law, NPs can perform services such as ordering tests and medications that previously required a physician's order. The broad and sweeping changes by federal and state governments enabled maximum flexibility for health systems to rapidly hire nurses to meet pandemic needs, and progressed NPs closer to full and independent practice authority. As federal and state laws and regulations change in response to pandemic concerns, we recommend visiting the COVID-19 policy and practice updates at the American Association of Nurse Practitioners (AANP) website (https://aanp.org).[1]

4 | OPPOSITION TO FULL PRACTICE AUTHORITY AND HIERARCHY IN HEALTHCARE

The landmark Institute of Medicine (IOM) report titled: *The Future of Nursing: Leading Change, Advancing Health* recognized the role of nursing in a transformed healthcare system, stating "Nurses should be full partners, with physicians and other health professionals, in redesigning healthcare in the United States."[6] However, nurses are not full partners with physicians and are frequently met with opposition when proposing efforts to reframe nursing professional identity and capabilities.

The existing barriers limiting APRN practice are outdated and from a bygone era, when physicians occupied a higher position in the healthcare hierarchy and undervalued were nursing's contributions and status within the healthcare system. Physician groups such as the American Medical Association (AMA) have historically opposed full practice authority for NPs and other APRNs under the guise of patient safety. Motivated by healthcare market competition and concerns of losing healthcare dominance, physician groups work vigorously to impede nursing workforce mobilization by opposing APRN multistate licensure compacts.[4] Furthermore, the AMA is leading efforts to reverse the pandemic policy changes and restore physician oversight.[34] The AMA and over 100 physician organizations requested the CMS and federal and state governments sunset the temporary waivers when the pandemic concludes.[34]

The narrative that NPs and other APRNs need physician oversight to provide safe, timely, effective, and efficient care is erroneous, particularly when considering empirical data in the 22 states with full practice authority. Multiple studies show that NPs provide equitable care as compared with their physician colleagues.[11–13] Ultimately, the practice barriers prevent the NP workforce's full utilization and decrease access to care for many U.S. healthcare consumers.[35]

Furthermore, the terms used to describe the NP role, created by some physician groups and medical organizations, are inaccurate and perpetuate hierarchy. Antiquated job titles pervasive in the workplace for NPs such as "midlevel provider," "physician extender," or "nonphysician provider" are misleading and do not fully capture the prominence of nursing. In many states, NPs are licensed, independent practitioners and do not "extend" physicians' care. The terms midlevel and nonphysician provider confuse healthcare consumers and connote care that is substandard or lower than provided by physicians. Just as physicians would deem the titles "non-nurse practitioner" or "nurse practitioner extender" as inappropriate, nurses should advocate for titles that accurately describe their role as the most trusted healthcare professionals.[36] Thus, the AANP has a position statement against the use of any term besides "nurse practitioner" to describe this unique and important role.[8] In an era where physicians occupy most senior-level positions in healthcare and governing boards,[37] progressing toward full practice authority and removing title ambiguity for the NP role would elevate nursing and potentially promote collaborative relationships with physicians.

5 | PROGRESSING TOWARD NATIONAL FULL PRACTICE AUTHORITY AMID COVID-19

The COVID-19 pandemic exposed major flaws and weaknesses in the U.S. healthcare system, including severe shortages of providers to meet anticipated patient surges.[24] Thus, the pandemic highlighted the importance of a healthy and robust provider workforce to manage patient care in crises. As frontline providers, NPs and other APRNs showed they were vital to bolster healthcare and aid the national pandemic response. More than 290,000 NPs stand ready and willing to provide safe care in acute, chronic, and community settings and meet the critical provider staffing needs during current and future pandemics and crises.

The recent temporary federal and state regulatory orders are just that—temporary. However, it does pose the question—Why did it take a pandemic to expand NP scope of practice regulations? Nevertheless, many organizations support a national call to remove all barriers to full practice authority, including the National Governors Association (NGA),[38] the Federal Trade Commission (FTC),[39] the American Nurses Association (ANA),[40] the Bipartisan Policy Center,[41] the IOM,[6] and many others. We now have an opportunity to reform and improve a flawed healthcare system that exacerbated the COVID-19 pandemic. For the

United States to progress towards a sustainable and resilient healthcare system that can react to future pandemic crises, methods to increase providers and improve access to quality healthcare are paramount. To maximize access to care in the United States, especially in rural or primary care health professional shortage areas, NPs need to practice to the full extent of their education and training.[10]

The regulatory authority for NPs and other APRNs varies from state to state, creating an inconsistent and confusing patchwork in which boards of nursing have the sole regulatory authority or share authority with boards of medicine. The patchwork of state-specific regulations limits NP workforce mobility and is confusing for clinicians and consumers of healthcare. States with NP regulatory oversight by boards of nursing typically have less restrictive regulations on consumer access to NPs and increased professional autonomy.[42] For advanced practice nursing to grow as a truly independent discipline, nurse leaders and policymakers must strive for professional oversight by boards of nursing and limit the influence of outside professionals.

A national and permanent full practice authority would not fundamentally change the unique NP approach of providing patient-centered, holistic care. NPs have a proven track record of delivering high-quality care in the 28 states with full practice authority before the pandemic. However, a national full practice authority would potentially improve APRN provider supply and salaries, reduce racial and ethnic disparities, and increase access to care.[43] The results from a recent survey concluded that 87% of Americans reported that nurses were indispensable during the COVID-19 pandemic, and 89% desire the same level of care from nurses postpandemic.[44] Nurses should harness the momentum in public opinion to revolutionize healthcare and advocate for policy changes that increase nursing influence in healthcare.

Advocating for full practice authority is not only an APRN issue, as all nurses benefit from advancing the nursing profession. Nurses can elevate the nursing profession through political advocacy and support changes that improve health outcomes and patient experience. An essential first step in advocacy is to understand the core issues which influence nursing care on the national and state levels. The ANA[45] and AANP[46] websites have extensive advocacy resources, including position statements, policy updates, and state maps of regulations and policies that influence nursing care delivery. Nurses can advocate for full practice authority by supporting efforts to amplify nursing's voice within healthcare, including initiatives by the ANA,[45] AANP,[46] and NursesEverywhere.[47]

Nursing's collective body of knowledge from academia to clinical practice, as well as their long history providing care to patients in urban and rural regions, provides unique insight to shape healthcare policy and prepare the United States for the next pandemic. Thus, the general public and policymakers must acknowledge the critical role NPs have in healthcare delivery and optimal health across the lifespan. Echoing previous calls for APRNs and other nurses to reform healthcare,[48] we advocate for nurses to push for the U.S. healthcare system's modernization, including permanent removal of APRN practice barriers. An ideal postpandemic normal for NPs includes legislation establishing full practice authority in all 50 states, and a nationwide approval of the APRN Compact Legislation. These two essential initiatives will increase access to care for millions of U.S. healthcare consumers and enable NPs to seamlessly mobilize to future areas of the country overburdened by future crises.

6 | CONCLUSION

Emergency regulatory and policy changes expanded the NP scope of practice to meet national healthcare needs during a pandemic crisis. The legislative changes enabled NPs and other APRNs to bolster the national pandemic response by working to the fullest extent of their education and training. Thus, the COVID-19 pandemic provided a watershed moment for NPs to redesign U.S. healthcare in a sustainable and resilient manner, educate others about the merit of their role, and advocate for permanent and national full practice authority.

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