Impact of Health Care Reform Law on APRN Scope of Practice

Rebecca Bryan

Marianne Buzby

Ann O'Sullivan

University of Pennsylvania

Abstract

We are facing a kairos moment in advanced practice nursing: a time when current events align in such a way that significant and rapid change is possible as our profession continues to evolve. Our numbers have reached critical mass, research repeatedly demonstrates our competence, and we are newly recognized by the Patient Protection and Affordable Care Act (PPACA) as well as the Institute of Medicine as qualified health care providers. Multiple professional organizations call for the removal of all barriers to our full scope of practice so that we may indeed be part of the solution to the looming primary care provider shortage predicted for the year 2014. This article articulates our scope of practice, which includes healthcare service leadership in the 21st century, as well as a call to action for all Advanced Practice Registered Nurses (APRNs).

Keywords: advanced practice registered nurses/aprns, consensus model, ncsbn aprn model rules and regulations, accountable care organizations, scope of practice, primary care shortage

Impact of Health Care Reform Law on APRN Scope of Practice

We are facing a kairos moment in advanced practice nursing; a time when current events align in such a way that significant and rapid change is possible. A professional turf battle is raging as to who is qualified to lead future health care delivery models (i.e. healthcare homes) and to autonomously provide primary care, thanks in large part to the passage of health care reform, the 2010 Institute of Medicine (IOM) publication, *The Future of Nursing: Leading Change, Advancing Health* and our numbers reaching critical mass. Some physicians insist that healthcare leadership remains their sole domain; APRNs, emboldened by federal legislative recognition and years of research evidence, believe they are qualified to lead as well. Is this just a turf war, or does APRN scope of practice in fact enable safe and effective clinical leadership? We will argue that APRNs have the potential to provide equal, if not superior care as we move to the coordinated, community-based health care models envisioned by both the Patient Protection and Affordable Care Act (PPACA) and the Institute of Medicine (2010).

Concept of Scope of Practice

Scope of practice is a phrase used by regulatory boards that defines the procedures, actions, and processes permitted for licensed individual in a specific profession (http://en.wikipedia.org/wiki/Scope_of_practice). The scope of practice is

limited to that which the individual has received education and gained experience, and in which he/she has demonstrated competency. Each state has specific regulations based on entry education.

Certified nurse practitioners (CNPs) are registered nurses who are prepared beyond the initial nursing education in a graduate level program to provide advanced care directly to patients. The profession originated in the mid-1960's in response to shortages of physicians. Legal scope of practice, based on education requirements and certification mechanisms, are decided at the state level and vary considerably (Christian, Dower, & O'Neill, 2007). CNPs, as well as certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and clinical nurse specialists (CNSs) are advanced practice registered nurses (NCSBN, 2008, July).

Regulators, employers and professional organizations have each developed definitions of scope of nursing practice, at times independent of one another. There is overlap, inconsistent terminology, and more often than not, limitations set more narrowly than what APRNs are professionally prepared to practice. Scope of practice needs to be a dynamic document that is able to respond, after careful consideration, to changes in the health care environment; overlapping scopes of practice are a reality (NCSBN, 2009).

Definitions by Legal and Professional Bodies

Scope of practice as defined by state regulation.

Physicians were the first practitioners to have legislative recognition of their practice (aka scope of practice) in the 1880's. Their scope was broad and made it illegal for others to perform activities related to diagnosing, treating, prescribing, curing, and

any activity otherwise known as practicing medicine. In the mid to late 1930's licensure for nurses became mandatory and State Nurse Practice Acts emerged. These acts began to describe the legal regulation of nursing practice. Many state Nurse Practice Acts define requirements for graduate education and additional recognition to basic licensure, as well as the requirements for physician collaboration or supervision, licensure renewal, disciplinary action and requirements of graduate educational programs (NCSBN, ad 11) **MEMBER BOARD PROFILE – NEW REFERENCE**.

There is significant variability in state laws around the degree of physician involvement required, as well as in prescriptive authority, and reimbursement (Stringer, 2010; Phillips, 2011). According to the 23rd Annual Legislative Update by Phillips (2011), 24 states have no statutory or regulatory requirements for physician collaboration, delegation, direction, or supervision; 21 states require collaboration to diagnose and treat; 3 states require physician supervision, and in 3 states the scope of CNP practice is overseen by both the State Board of Nursing (SBON) and the State Board of Medicine (SBOM). Similar diversity is present in state regulations focused on CNP prescriptive authority. Since the Consensus Model for APRN Regulation (approved July 2008) and the NCSBN APRN Model Act/Rules and Regulations (approved August 2008) there has been a concerted effort to minimize this diversity across the nation.

Scope of practice and federal regulation.

CNP scope of practice is also impacted by the rules and regulations for state and federal health care reimbursement programs. PPACA (2010) recognizes CNPs as primary

care practitioners eligible to receive grants, primary care bonus payments, with no mention of collaboration or supervision requirements (Grady, 2010).

Scope of practice as defined by professional organizations.

Professional certification organizations are a self-regulatory mechanism for the nursing profession to ensure competency of nurses at basic and advanced levels of practice. This is done by certification examinations focused on measuring a minimum level of competence for the APRN entering practice. The majority of states have incorporated professional certification into the state nurse practice act as a requirement for CNP licensure (Phillips, 2011).

National professional nursing organizations such as the American Nurses Association (ANA, 2011) have broadly defined the scope of practice for all APRNs. The ANA relies upon specialty nursing organizations to define specific scopes of practice for each type of APRN. Both national and regional organizations lobby at the federal, state and local levels to influence legal decisions impacting the ability of APRNs to provide the health care necessary to the nation. In contrast to regulatory scope of practice definitions, these organizations' definitions often represent the broadest view of scope. While the state nurse practice act is responsible for protecting the safety of the states' citizens, the professional nursing organizations take responsibility for informing the public about the services available from APRNs. These professional definitions of APRN scope of practice create the basis for influencing the regulatory scope of practice. In some instances, the scope of practice written by the profession is more flexible and

responsive to changes in practice and health care issues when compared to scope of practice definitions by regulators.

Scope of practice as defined by employers.

Scope of practice as defined by employers describes the services that the APRN will provide in a facility. While the employer may restrict scope of practice, it may not expand the scope of practice beyond the state nurse practice act.

Scope of practice as defined by NCSBN.

The National Council of State Boards of Nursing (NCSBN) collaborated with a consortium of six professional regulatory organizations representing physicians, nurses, social workers, physical/occupational therapists and pharmacists. It produced a guide to assessing scope of practice proposals for state legislators, acknowledging, "It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others." It calls for changes "that reflect the evolution of abilities of each health care discipline" recognizing what we have all known for a long time, that there is – and should be – overlap in scope (NCSBN, 2009, p. 3).

Consequences – Good and Bad - of Overlapping Scopes of Practice

For the past twenty years scholars of state licensing laws that define scopes of practice for health care professionals have commented on the workforce issues of misdistribution, shortages and barriers to full, independent practice based on education and credentialing. Two such scholars are Catherine Dower and Barbara Safriet, both of whom were involved with the PEW Health Professions Commission (1995) which stated more than fifteen years ago that:

> The varying objectives and levels of practice specifically found in different professions 'scope of practice' are more than frustrating; they have encouraged a system that treats practice-acts as rewards for the profession rather than a national mechanism for cost effective, high quality and accessible service delivery by competent practitioners (p. 10). States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills (p. 9).

Sadly an unintended consequence of deciding who can be reimbursed for a particular skill or procedure has often defined a profession's scope of practice. The current overlap of professional domains does not fit into this schema; organizations and institutions need to keep this in mind as we move forward in this century. Medicare beneficiary rules prohibit CNPs from ordering durable medical equipment, ultimately increasing the cost of services since the physician must then also be involved in the ordering. In response to barriers to practice such as this, the Center for Medicare and Medicaid Services (CMS) often adds waivers or writes program memoranda to clarify polices and provide the soundest interpretation for services provided by CNPs. Additionally the Department of Public Welfare and/or the Association of Medical Supplies also interpret language of federal regulations and deny provision of services by CNPs to Medicaid and Medicare beneficiaries.

Barriers to APRN Expanded Scope of Practice

"The potential for expansion of non-physician scope of practice has important implications for policymakers… (T)he potential of nurses and physician assistants to help

redress such imbalances will depend partly on the resolution of current tensions over their scope of practice" (Cunningham, 2010). The challenge of any new law is that just because it is signed into being doesn't mean the specifics, or regulations, are spelled out immediately. With scope of practice varying from state to state, and indeed by facility, it is difficult for legislators to grasp our potential. Barriers to functioning at our fullest potential obscure the picture as well: the requirement of collaborative agreements in many states limits our ability to have an independent license. Lack of consistent reimbursement across states has kept us largely invisible or at best minimizes the quantity/quality of care we currently provide. Title variation by state (APN?, CRNP?, APRN? ARNP?) increases confusion. And reduced Medicare reimbursement for APRN primary care services, which is already low, makes financial solvency difficult.

As we move forward with expanding the scope of practice of APRNs we will have to resolve regulatory issues, due to language that specifically states "physician" as provider, that have unintended consequences such that an APRN can order prosthetics, orthotics, dentures, eye glasses and medications like Oxycontin but are not able to order diapers or a walker. Hopefully, in the near future we can move to more neutral language in regulations such as *physicians or other licensed healthcare practitioners of the healing arts within the scope of practice as defined by State law of that professional*, or simply, *prescriber* (Nurse Practitioner Roundtable, 2009).

If our society wanted to prevent our citizens from full access to safe, quality services in order to cut costs, we would have a very good reason to limit expanding scope of practice for qualified practitioners. If physicians did not want to make health care

delivery services available to their clients, or legislators wanted to decrease use of services by their constituents, then and only then, should our country prevent the independent licensing of APRNs.

Impact of Health Care Reform Law on APRN Scope of Practice

March 23, 2010 was the day that many APRNs had long awaited: President Obama signed The Patient Protection and Affordable Care Act (PPACA) into law. The language of this law finally recognized, on a federal level, the authority of APRNs as health care providers. We are listed as one of the Accountable Care Organization Professionals (along with physician assistants and physicians) for Medicare, which will hold us accountable for coordination of quality, cost effective care. Indeed, we are specifically mentioned as eligible recipients for a 10% bonus payment under Medicare for primary care providers (PPACA, 2010). And there is more money behind this federal recognition: $50 million available in grants for Nurse Managed Health Clinics and an additional $1.5 billion to expand primary care in the community. Since 85% of CNPs are certified in primary care, this has specific implications for our profession (HRSA, 2011).

Increased Demand for Primary Healthcare Providers

PPACA markedly increases the number of Americans who will now be able to afford healthcare, beginning immediately and increasing until 2014, when there will be an estimated 32 million additional patients. With this coverage expansion, along with population growth and aging, demands for more primary care providers increases exponentially. There are already an insufficient number of physicians trained to provide primary care, and their numbers continue to fall (IOMa, 2010) APRNs are one safe, cost-

effective and efficacious solution to this challenge. But do legislators – and the public - comprehend this?

Impact of the IOM: Future of Nursing Report

> Recall that Clara Barton neither asked for permission nor sought direction before she headed into the front lines of the Civil War. This experience inspired her to campaign fiercely and successfully to create the Red Cross. In the spirit of Clara Barton …the IOM *Committee on the Initiative on the Future of Nursing*… recommends an action-oriented blueprint for the future of nursing (Grady, 2011).

Citing statistics such as nursing representing the largest sector of the health professions, numbering at 3 million in the United States, as well as the reputation of our profession as having "a steadfast commitment to patient care, improved safety and quality, and better outcomes", *The Future of Nursing: Leading Change, Advancing Health* (IOMa, 2010) broke with tradition to recommend removal of all barriers preventing nurses from practicing to the full extent of their education and training. Kathleen Potempa, president of the American Association of Colleges notes that while some have interpreted this report as calling for the expansion of APRN scope of practice beyond that which they already do, in reality it is an affirmation of APRN effectiveness, and a call to address areas where regulatory framework is lagging (Devi, 2011). The IOM is a well-respected, unbiased institution that has a reputation for providing evidence-based recommendations. *The Future of Nursing: Leading Change, Advancing Health* (IOMa, 2010) recognizes unique attributes of the nursing profession, including our adaptability, close proximity to patients and our scientific understanding of care

processes. Additionally *The Future of Nursing: Leading Change, Advancing Health* (IOMa, 2010) notes the broad continuum of care our profession provides, "from health promotion, to disease prevention, to coordination of care, to cure – when possible – and to palliative care when cure is not possible" (p. 4). In exchange for this recognition, the IOM charges our profession with achieving higher levels of education and training with the goal of having increasing numbers of graduate level prepared providers. "Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States" (IOMa, 2010, p. 4).

Evidence based solution to Professional and Public Perception

Meanwhile medical professional organizations have been vehemently guarding their turf, which historically (rather than logically) encompasses all of health care provision (Safriet, 2002), asserting without evidence that non-physician health care providers are under qualified. Perhaps in the past physicians were the best educated and prepared to be the leaders in health care, but APRN education and skill levels have increased with the consequent broadening of scope of practice in all 50 states. Research repeatedly demonstrates our safety, parity and cost-effectiveness and the Cochrane Collaboration found us to be superior providers with regard to communication skills and patient satisfaction (Laurant, Reeves, Hermens, Braspenning, Grol, & Sibbald, 2008). *Scope of practice is not based on precedent,* as medical professional organizations would have us believe. Case in point: there was a time that only physicians used a thermometer to assess a patient's temperature and the nurse held a velvet box that held the thermometer safely. Today parents routinely check temperatures at home! But at one time

temperature taking was the sole domain of a physician, not a nurse or parent. It is in the best interest of public health and safety to have all competent primary care providers empowered to provide care to the fullest extent of their license and certification.

Medical economist Jeffrey Bauer, PhD, states that the drive behind health care reform is to "slow the relentless growth as a relative portion of the gross domestic product" (2010, p. 228). He goes on to recognize the ability of APRNs to provide cost-effective care without diminishing quality, stating, "…economic and clinical gains can be realized by allowing APRNs to be independent caregivers and delivery team leaders for a large number of health services in a wide variety of settings" (Bauer, 2010, p. 228). Bauer (2010) estimates that APRNs can be substituted for physicians in 90% of primary care.

Changing the Thinking of Entrenched Health Care Professionals, Legislators and Consumer Advocates

Historical Perspective

Prior to PPACA many states already felt the impact of a primary care provider shortage. Often these states were rural or had large urban regions that were designated as federally underserved areas for delivering primary health care. Consequently physicians in these areas, who cared more about their clients than what their professional medical associations dictated, began to support the expansion of scopes of practice to qualified non-physician healthcare providers (NCHCPs). These physician-visionaries worked with state legislators, health care regulators and professional provider organizations to provide an additional work force for their states' consumers who would be properly educated, certified and licensed to provide needed primary care services. Concomitantly as

physician residency training requirements evolved and the hours of service were sharply curtailed physicians began to use qualified APRNs to enhance the workforce and provide needed services in settings other than traditional primary care.

This attitude of putting client needs before professional medical association dictates will be crucial in this time of healthcare reform, regardless of regional demographics. Less than one-third of our states are ready for the transition to universal healthcare because the position of medical professional organizations prevents APRNs and others from practicing to the full scope of their education and certification.

Promoting Misperception

APRNS and other NPHCPs (including physician assistants, dental hygienists, optometrists, pharmacists, physical therapists and psychologists) have an uphill battle. In 2006, the American Medical Association (AMA) established a coalition of national medical organizations and state medical societies called the Scope of Practice Partnership (SOPP). Stating its mission was to protect the public from under-trained practitioners, this partnership developed a clearinghouse of information about NPHCPs called the Scope of Practice Data Series. The series consists of modules that provide in-depth analysis of the education, certification and licensing of various NPHCPs, according to the AMA. Another project of AMA-SOPP has been geographic mapping that visualizes practice location for physicians versus NPHCPs to allow state legislators to see for themselves if NPHCP's will actually improve access to care (AMA, 2009). Sadly, both of these initiatives have been challenged by all NPHCPs for containing numerous factual

misrepresentations and misleading conclusions. (Nurse Practitioner Roundtable, 2009, Engebretson, 2010, English, 2010).

Incongruent Policies

The AMA's own policies recognize that a particular profession is responsible for determining the criteria for education and credentialing that drive that profession's scope of practice; yet the AMA-SOPP repeatedly publicly promotes the perception that NPHCPs are not fully qualified nor working within legally established scopes of practice. The AMA-SOPP coalition also demonstrates its need to protect turf by deterring NPHCPs with professional, non-medical doctorates from calling themselves "doctor." If they would call themselves "physicians" distinguishing them from many other professional doctors who deserve to call themselves "doctor," this issue would cease to exist.

Health Care Regulatory Boards and Legislators Can Make the Difference For Consumers Through Collaboration

Health Care Reform arrived in 2010 even without much collaboration between our political parties. But the implementation of this reform cannot succeed without the collaboration of all healthcare stakeholders, including regulatory boards, state legislators, professional licensing committees, health profession committees independent regulatory review boards and insurance committees, hospitals and nursing home institutions, and consumer advocacy groups. Many groups outside of nursing are supporting the full scope of practice of APRNs for the 21st century: AARP (2010), Brookings Institute (2009), CATO Institute (2008), Citizen Advocacy Center (2010), FTC ( ), IOM (2010), Josiah

Macy Jr. Foundation (2010), PEW Health Professions Commission (1995), RAND Health (2009).

Where to begin? Facilitating discussions around common issues is a place to begin. Evidence of this is already beginning: At a state level last year, Basil Merendes, Commissioner of PA Bureau of Professional and Occupational Affairs was promoted to Secretary of State and one of his first acts was to bring together all of Pennsylvania's Healthcare Board Chairs and Executive Directors. Issues were shared and quarterly meetings were scheduled to continue the dialogue. Other states have done this as well, with Minnesota having created the Council of Health Boards in 2001 (LeBuhn & Swankin, 2010).

And at the federal level, The Federal Trade Commission (FTC) wrote a letter in March 2011, which voiced support for a bid to lift Florida's restrictions on full practice for APRNs. Not only did the FTC agree with a Florida Department of Health report that found that reducing supervision requirements for CNPs would increase access to healthcare, they went to the next level by lambasting the 2006 Legislature, which applied the physician-driven restrictions in the first place (Ward, 2011).

Finding Common Ground

Both APRNs and other NPHCPs would like to work in partnership with their physician colleagues (as they do now in 14 states) to address the real health care needs of our consumers. One group trying to move the agenda towards an independent license and full scope of practice for NPHCPs is the Coalition for Patient Rights. Made up of 35 health care organizations responding to AMA-SOPP they promote the use of a broad

spectrum of NPHCPs to ensure accessibility, quality, affordability and sustainability of health care for all consumers – both insured and uninsured (CPR, 2011). They call for "a balanced study of healthcare providers to include an evaluation of whether physician scope is overbroad." In addition, the Citizen Advocacy Center (CAC) has a new project involving a panel of consumers and consumer organizations charged with understanding the history and current bottlenecks hindering scope of practice legislation as well as the rule of medical boards. Increasing public awareness of the issues surrounding NPHCP need for independent licensure and full scope of practice in an unbiased forum is one avenue to effective change.

The American Association of Retired Persons (AARP) adopted a new policy on scope of practice in the spring of 2010 in response to the identification of nurses as critical players in bringing health care access to the health care needs of Americans. AARP realized that legal barriers are preventing nurses from practicing to the full extent of their education certification and licensing so their policy states: "Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification." (AARP, 2010).

So too the Josiah Macy, Jr. Foundation's Report on "Who will provide primary care and how will they be trained," (Cronenwett & Dzau, 2010) – stated in the recommendations that "coupled with efforts to increase the number of physician, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult

for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical home or other models of primary care delivery" (pg. 18).

So how should we proceed in addressing scope of practice? Schmitt and Shimberg (1996) are the most often quoted about this issue: they discuss that the process of evaluating a scope of practice is intended to:

- ensure that the public is protected from unscrupulous, incompetent and unethical practitioners;
- offer some assurance to the public that the regulated individual is competent to provide a certain service in a safe and effective manner;
- provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses.

If professionals and legislators could follow these three guidelines, perhaps the heated debates that look like turf battles could be lessened and we could provide additional access to care for more Americans.

Time to Make our Voices Heard

Despite the paucity of press coverage, we have a seat at the "big" table: there is nursing representation at federal policy discussions. Additionally AARP together with the Robert Wood Johnson Foundation (RWJF) have begun the Campaign for Action, engaging stakeholders from diverse sectors who are working together to transform the future of

nursing at state and local levels (Action Coalitions, 2011). Regional Action Coalitions (RACs) are being formed throughout the United States; fifteen so far have been launched in California, Michigan, Mississippi, New Jersey, New York, Washington, Idaho, Utah, Colorado, New Mexico, Illinois, Indiana, Louisiana, Virginia and Florida. To assure sustainability, RACs are being given technical assistance through AARP, thanks to a grant from the Robert Wood Johnson Foundation (Action Coalitions, 2011). Services such as access to grant writers, sustainability planning/facilitation, links to potential funders and collaboration with existing RWJF nursing grant programs are available to APRNs (Action Coalitions, 2011).

Individually we can have influence at the federal, state and local levels. You don't have to be in Washington, D.C. to do this; in fact when it comes to regulations that will impact practice, it's really all about the state level. So here is what we APRNs – and indeed all NPHCPs specifically can to do:

- If you live in a state with an existing RAC, get involved by contacting them
- Collaborate with consumer advocates to help us show legislators what would be best for health care delivery in their state to meet the needs of their constituents;
- Educate legislators to understand the historical controversies as well as our full scope of practice;
- Educate the general public, colleagues and patients about our full scope of practice and the research demonstrating our effectiveness, if not superiority

- Challenge language used in the media so that "healthcare provider" replaces wherever "physician" or "doctor" is stated;
- Publicly rebut inappropriate, incorrect statements by professional medical organizations.

Our profession needs to make its voice heard during this crucial regulatory period so that our scope of practice allows practitioners to practice to its fullest potential throughout all 50 states. Section 2706 of PPACA prohibits a health plan or insurer from discriminating against healthcare providers with respect to participation and coverage if they are "acting within their scope of state license or certification" (Fields & Ridenour, 2011). We are ideally suited to be both independent caregivers and delivery team leaders in this preventive care focused new environment. There will be an estimated 40,000 primary care provider shortage by 2014, when PPACA goes into full effect. There have been calls for removal of practice barriers since the 1990s. "(T)he scope of practice conferred upon each (provider) should be as full as possible, consistent with safe and effective practice, for only then will healthcare consumers reap the benefits of increase access to high-quality care at reduced cost" (Safriet, 2002).

References

Action Coalitions (January 17, 2011). Retrieved from http://thefutureofnursing.org/content/regional-action-coalitions.

American Association of Retired Persons (AARP). (2010). *Scope of practice for advanced practice registered nurses.* Retrieved from http://www.midwife.org/documents/AARPPolicySupplementScopeofPractice.pdf

American Medical Association (AMA). (2009). *AMA Scope of practice data series.* Retrieved from http://www.aanp.org/AANPCMS2/publicpages/08-0424%20SOP%20Nurse%20Revised%2010-09.pdf

American Nurses Association (ANA). (2011, June 8). *Scope and standards of practice.* Retrieved from http://www.nursingworld.org/scopeandstandardsofpractice

Antos, J., Bertko, J., Chernew, M., Cutler, D., Goldman, D., McClellan…Shortell, S. (2009). *Bending the curve: Effective steps to address long-term health care spending growth.* Brookings Institute. Retrieved from http://www.brookings.edu/reports/2009/0901 btc.aspx#

Bauer, J.C. (2010). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners*, *22*(4), 228-231. doi:10.1111/l. 1745-7599.2010.00498x

Christian, S., Dower, C., & O'Neill, E. (2007). *Overview of nurse practitioner scopes of practice in the United States – Discussion.* San Francisco, CA: UCSF Center for the Health Professions.

Coalition for Patients Rights (CPR). (2011, June 2). *Healthcare Coalition focuses attention on patient access issues.* Retrieved from http://www.patientsrightscoalition.org/Media-Resources/News-Releases/PatientAccessIssues-NR.aspx

Cronenwett, L. & Dzau, V.J. (2010). Chairmans's summary of the conference. In B. Culliton (Ed.) *Who will provide primary care and how will they be trained?* Durham, NC: Josiah Macy, Jr. Foundation.

Cunningham, R. (2010). *Tapping the potential of the health care work force: scope-of-practice and payment policies for advanced practice nurses and physician assistants.* Retrieved from http://clinician1.com/images/post_images/NatHlthforumPA:NP.pdf.

Devi, S. (2011). US nurse practitioners push for more responsibilities. *The Lancet,* 377:625-626.

Dower, C., Christian, S., O'Neil, E. (2007). *Promising scope of practice models for the health professions.* Center for the Health Professions, University of California, San Fransisco. Retrieved from http://futurehealth.ucsf.edu/Content/29/2007-12_Promising_Scope_of_Practice_Models_for_the_Health_Professions.pdf

Eibner, C.E., Hussey, P.S., Ridgely, M.S., & McGlynn, E.A. (2009, August). *Controlling health care spending in Massachusetts: An analysis of options.* Rand Health. Retrieved from http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_spending_exec_sum_rand_08-07-09.pdf

Engebretson, J. (2010). *AMA scope of practice partnership tightens its grip: Resolutions, 902,904 invoke accusations of McCarthyism.* Retrieved from http://www.dynamicchiropractic.com/mpacms/dc/article.php?id=52017

English, K. (2010). *AMA reviews audiology's scope of practice: the academy responds.* Retrieved from http://www.audiology.org/advocacy/grnews/Pages/gr200910a.aspx.

Fields, S. D., & Ridenour, N. (2010, April 18). *Raising the profile of NPs and NP education.* NONFP Meeting, Washington, DC.

Grady, E. (2010). *The renaissance of primary care: Primary care is too important*. Retrieved from http://www.npworldnews.com/columns/details/the-renaissance-of-primary-care-primary-care-is-too-important/.

Grady, E. (2011). *Weighing the pig won't fatten it.* Retrieved from http://www.webnponline.com/columns/details/weighing-the-pig-wont-fatten-it/.

Health Resources and Services Administration (HRSA). (2011, May 17). *Shortage designation: HPSAs, MUA/Ps*. Retrieved from http://bjpr.hrsa.gov/shortage/index.htm

Institute of Medicine (IOM). (2008). *Retooling for an aging America: Building the health care workforce.* Retrieved from http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx

Institute of Medicine (IOM). (2010a). *The Future of nursing: Leading change, advancing health.* Retrieved from http://iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Institute of Medicine (IOM). (2010b). *A summary of the December 2009 forum on the future of nursing: Care in the community.* Washington, DC: The National Academies Press.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2008). Substitution of doctors by nurses in primary care (Review). *The Cochrane Database of Systematic Reviews*, Issue 3. The Cochrane Collaboration: J. Wiley and Sons, Ltd.

LeBuhn, R. & Swankin, D.A. (2010). *Reforming scopes of practice. A White Paper.* Washington, DC: Citizen Advocacy Center.

LeBuhn, R., Swankin, D.A., & Gulish, A. (2010). *Reforming scopes of practice: Empowering non-physician providers to meet the health care needs of consumers and communities: A tool kit.* Retrieved from http://www.cacenter.org/files/ReformingScopesofPractice-ToolKit.pdf

National Council of State Boards of Nursing (NCSBN). (2008, July). *Consensus model for APRN regulation: Licensure, accreditation, certification & education.* Retrieved from: https://www.ncsbn.org/APRN_leg_language_approved_8_08.pdf

National Council of State Boards of Nursing (NCSBN). (2008, August). *APRN model act/Rules and regulations*. Retreived from https://www.ncsbn.org/APRN_leg_language_approved_8_08.pdf

National Council of State Boards of Nursing (NCSBN). (2009). *Changes in healthcare professions's scope of practice: Legislative considerations.* Chicago, IL.

Nurse Practitioner Roundtable. (2009, December 8). *Response to AMA scope of practice*

data series. Retrieved from http://www.aanp.org/AANPCMS2/publicpages/AMANPModuleLtr120809.pdf

Ppaca & Hcera; Public Laws 111-148&111-152. (2010, March 23). Retrieved from http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

Pew Health Professions Commission (1995). *Reforming health care workforce regulation: Policy considerations for the 21st century. Report of the Taskforce on Health Care Workforce Regulation.* Retrieved from http://www.soundrock.com/sop/pdf/Reforming%20Health%20Care%20Workforce%20Regulation.pdf

Phillips, S. J. (2011). *23rd Annual legislative update: As healthcare reforms, NPs continue to evelove.* The Nurse Practitioner, *36*(1), 30-52.

Safriet, B.J. (2002). Closing the between *can* and *may* in health-care providers' scopes of practice: A primer for policymakers. *Yale Journal on Regulation*, *19*(2), 301-334.

Schmitt, K. & Shimberg, B. (1996). *Demystifying occupational and professional regulation: Answers to questions you may have been afraid to ask.* Lexington, KY: Council on Licensure, Enforcement and Regulation

Stringer, H. (2010). *Unlocking opportunities. Healthcare reforms may open doors for nurse practitioners and patients.* Retrieved from http://news.nurse.com/article/20100610/AP01/100610001

Svorny, S. (2008). *Medical licensing: An obstacle to affordable, quality care.* CATO Institute, Policy Analysis No. 621, Executive Summary. Retrieved from http://www.cato.org/pubs/pas/pa-621.pdf

Ward, K. (2011, March 24). *FTC letter bolsters nurse practitioners case.* Retrieved from www.sunshinestatenews.com/print/24934311