Full Practice Authority: APRN Readiness, Barriers to Practice and Access in South Carolina

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South Carolina is predominately a rural state that consistently demonstrates poor health rankings, due to the lack of Medicaid expansion, healthcare deserts, and a decreasing physician supply. Nurse practitioners, certified nurse midwives, and clinical nurse specialists are seeking full practice authority as one legislative strategy to improve access to care and outcomes. To prepare for the legislative initiative, the Coalition for Access to Healthcare Board conducted a survey of APRNs' readiness to seek full practice authority as well as identify any perceived barriers to practice and access to care.

The 2022 public health data paint a dismal picture for chronic disease management and outcomes (*Table 1*). Additional data highlights 27 of 46 counties having none or fewer than three primary or specialty physicians in the areas of family, women's health, pediatrics, and psychiatry per 10,000 people. Health rankings demonstrate SC has the 4th highest rate of preterm births among all 50 U.S. states and 8th highest rate of maternal deaths.[1-2,4] On a positive note, according to Area Health Education Consortium (AHEC), after APRN scope of practice modifications in 2018, primary care access improved slightly, increasing from 41st to 37th, with NPs and CNMs maintaining primary care services in non-metropolitan areas of South Carolina.[1,5]

Table 1. South Carolina County Data for Physicians[1-4]

• 22 counties < 3 family practice physicians
• 14 counties with 0 women's health physicians
• 10 counties with < 3 women's health physicians
• 10 counties with 0 pediatric physicians
• 7 counties with < 3 active pediatric physicians
• 17 counties with 0 general psychiatry physicians
• 27 counties < 3 general psychiatry physicians

To date, 27 states, Washington DC and the Veterans Administration have full practice authority for APRNs which authorizes NPs, CNMs and CNSs to practice "to the fullest extent of their education" as recommended by the Institute of Medicine. 6,7,10 Based on access and health data indicating health care desserts and poor health outcomes for South Carolinians, full practice authority is essential now.[1-5]

Purpose

The purpose of this descriptive study was to determine readiness to pursue full practice authority and identify perceived barriers or access to care for Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNSs).

Background

Studies consistently show that NPs have excellent outcomes for chronic disease management and for CNMs reducing C-section rates. [11,14-24] Literature also indicates that NPs and CNMs are safe and cost-effective providers.[11,18-19,31] Physician groups contend that supervision and/or collaboration ensures that APRNs provide safe care.[30] During the COVID-19 pandemic, the Governor issued a temporary Public Health Emergency Order by temporarily removing collaborative agreement requirements and other restrictions. Removing these restrictions facilitated APRNs to have additional authority to care for patients and establish primary care practices across SC. The SC Board of Nursing reported less than 0.3 % of APRNs were disciplined during the Pandemic and less than 0.1% overall, mirroring national data.[28] Patient safety is a frequently cited reason by physicians that APRNs should not fully practice to their training and licensure, however, there is a paucity of evidence that supports unsafe care. Furthermore, there is no evidence

Table 2. Participant Demographics (N=368)

Demographic	Number	Percent
Numbers of years in practice	1-2 = 60 3-6 = 75 7-10 = 69 11-15 = 45 16-20 = 37 21+ = 82	16.30% 20.38% 18.75% 12.23% 10.05% 22.26%
Rural or Urban or Both	Urban = 167 Rural = 165 Both = 151 Telehealth = 107	45.5% 44.96% 41.14% 29.16%
Work in primary or acute care	Primary Care = 323 Acute Care = 43	84% 16%
Services providedphysicians	Primary Care = 230 Psychiatric Care = 36 Pain Management = 13 Hospice = 35 Acute care = 75	63.3% 10.47% 3.58% 9.64% 20.66%
Certificationdiatric physicians	FNP = 267 PNP = 11 CNM = 5 Psych NP = 18 Women's Health = 3 Adult Gerontology Primary = 31 Acute Care = 19	72.55% 2.99% 1.36% 4.89% 0.82% 8.42% 5.16%

to support quality of care is compromised or unsafe without physician collaboration or supervision.[9,25-26,30] Rather regulatory restrictions lobbied by physician groups place undue access burdens and barriers to care for the patient and increase cost to healthcare system.[29]

Methods

A convenience sample of 1500 APRNs (NPs, CNSs, CNMs) was asked to complete a 15-item questionnaire via Survey Monkey over three months in 2023. The APRN email lists were obtained from four regional NP and CNS groups, one statewide CNM group, and the South Carolina Nurses Association (SCNA). Criteria for inclusion were currently licensed and actively practicing as a SC NP, CNM or CNS.

The non-psychometric instrument, developed by the Coalition for Access to Health Care, a nonprofit, APRN advocacy group, consisted of 14 questions containing discrete noncontinuous variables related to full practice authority, perceived barriers to practice, and access to care. One item requested additional feedback, allowing respondents to "free text".[8] Consent was implied via voluntary and anonymous participation. No identifiers could be traced to the participant. Data were retrieved by the President of the Coalition and maintained in a secure encrypted excel file for analyses. Data were tabulated for descriptive statistics only. No inferential data or thematic analyses were conducted. There were no conflicts of interest or funding to report. Institutional Review Board approval was not sought because this study was conducted for quality improvement.

Results

Description of the Sample Characteristics

The sample consisted of 368 APRN respondents, for a 25% percent participation rate. The survey indicated a majority of FNPs (n=267, 73%) with 21% participants (n=82) having 21 years or more in practice. A majority (n=165, 45%) provide services in rural areas while some (n=151, 41%) indicated providing services in both rural and urban areas. Most respondents (n=323, 84%) provide primary care across various settings while a portion (n=43, 16%) provide care in acute care settings. For this survey, primary care was defined as family, pediatrics, gerontology, women's health, mental health, long term care, college health, free clinics, rural health care centers, federally qualified healthcare centers, prison health, school-based clinics, private office, and hospice/palliative care. Acute care was defined as in-hospital based specialty care, emergency room care, and critical care (*Table 2*).

Descriptions of Perceived Barriers to Care or Access

Findings showed that most respondents (n=244, 67%) identified the current requirement for a collaborative physician as a perceived barrier to practice. Respondents voiced concern that the physician could dissolve the agreement resulting in the closure of their practice or suspension to practice or prescribe. Participants (n=145, 40%) indicated their collaborating physician charged a cost-prohibitive fee ranging from $500 to $3000 per month for this requirement. Participants (n=181, 50%) also indicated that the requirement to ensure quality of care by conducting audits or meetings, presented logistical challenges during busy practice times and during the pandemic when face to face meetings were restricted. Other impediments included required shared or incident to billing (n=103, 28%), a lack of role or title recognition within institutions (n=109, 30%) prohibiting the use of "Doctor" despite educational achievement and statute, and lack of APRN representation on employer governing bodies or organizations that render decisions on scope of practice, collaboration policies, and billing practices (n=176, 48%) (*Table 3*).

Comments by participants emphasized obstacles to practice such as the inability to obtain a CLIA waiver, required collaboration agreement, reimbursement inequities for the same Current Procedural Terminology (CPT) code service, and the inability to order controlled medications in birthing centers.

An overwhelming majority, (n=351,

Table 3. Barriers to APRN Care or Access

Barriers to APRN Care or Access	Numbers	Percent
Inability to order diabetic shoes	n = 118	32.33%
Requirement for a collaborating physician	n = 244	66.85%
Requirement for physician to ensure quality	n = 181	49.59%
Organizational requirement for shared or incident to billing	n = 103	28.222%
Lack of role recognition or titling	n = 109	29.86%
Lack of APRN representation on organizational boards or committees	n = 176	48.22%

96%) of respondents, replied "yes" to supporting full practice authority legislative changes. Moreover, (n=241, 68%) indicated they would financially support legislative efforts for full practice authority. Among those that would not financially support full practice efforts (n=114), cited cost-prohibitive operating expenses for their own APRN practice and a lack of salary support in their current position. While a qualitative review of respondents' comments was not conducted, certain themes did emerge. Responses indicated organizational disrespect, lack of role/title, restrictive physician collaborative agreements, physicians not certified, transition to practice, reimbursing physicians for collaborative agreements, antiquated scope of practice laws, and support for full practice authority.

Discussion

Our survey indicated that the majority of respondents were Family Nurse Practitioners practicing in a variety of primary care settings. Findings also identified perceived barriers to practice and access to care including the inability to order diabetic shoes, legal requirements for a collaborating physician, organizational barriers, and a lack of representation on organizational boards or committees that render decisions on scope of practice process and billing practices. A majority indicated their support for seeking full practice authority.

In South Carolina, APRNs are required to establish a written collaborative agreement with a physician or physicians who are available for consultation and advice.30, 32 Unfortunately, if the physician(s) dissolves the agreement, the APRN is unable to practice or prescribe until another physician agrees to enter into a collaborative agreement. This unintended consequence results in practice closings, APRN unemployment, care delays, and decreased access to patient care.

Conclusion

Allowing APRNs to practice to the full extent of their education and training strengthens the overall health of communities through increased access to care. This is especially true for primary, prenatal, and mental health care. Removing antiquated barriers to practice will allow advanced practice nurses to establish practices, manage patients in outpatient and underserved settings, and reduce emergency department visits for primary care, pediatrics, women's health, and mental health care. ■

References online:
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