As the dust settles in the wake of the biggest public health crisis in a century, I’ve wondered why governors and legislatures in states without nurse practitioner (NP) full practice authority (FPA) didn’t permanently lift restrictions on NP scope of practice. At least 21 of the remaining 24 supervisory states—through executive order, legislative action, or both—temporarily removed some scope of practice barriers during their declared state of emergency or to a specified date beyond it.

Close to Home

I live and practice in North Carolina, a supervisory state with a 50-year-old law mandating physician supervision and joint regulation of NP practice by the boards of nursing and medicine. In March 2020, our legislature passed a 70-page coronavirus bill that included waivers for 2 of our most cumbersome and senseless NP regulations: documentation of annual review of a collaborative practice agreement and documentation of biannual meetings with a “supervising physician.” Initially set to expire at the end of 2021, these waivers were later extended through 2022 for a total duration of 32 months. Although new NP graduates were exempted, well over 95% of our roughly 12,000 NPs have had almost 3 years of practice without this useless “check the box” physician supervision. It seems logical that restrictive laws and regulations eliminated for the short-term—without a demonstrable downside—could be (and should be) eliminated permanently. The pandemic set the table for disruptive innovations like telehealth so why not FPA?

It was simplistic to think that my state (or others) would make these temporary reprieves permanent during even a once-in-a-lifetime emergency. In the almost 3 decades since New Mexico passed the nation’s first “independent practice” bill (launching the state-by-state pursuit of unrestricted NP practice that continues today), only certain kinds of crises (eg, unremitting provider shortages, widening health disparities, and escalating numbers of unerved/underserved) have provided enough of a compelling backdrop to give FPA momentum. So far, 3 states (ie, Delaware, Kansas, and New York) have achieved FPA during the pandemic, not because of it. Political context, a political form of preexisting conditions, was too powerful for even a pandemic to overcome.

A Complete Picture

Just as a patient’s preexisting conditions are important context used by NPs in developing an accurate differential diagnosis and an appropriate treatment plan, political arenas and politically charged issues have context that impacts decision making by lawmakers. Politics is seemingly equal parts Las Vegas odds making and Newton’s third law (ie, for every action there is an equal and opposite reaction). Elected officials consider the chances of being helped or harmed by causes they support, bills they file, and votes they cast. Every decision is ultimately about staying in office and maintaining or increasing power and influence. Once NPs understand and accept this reality, they will be better able to align their expectations and “asks” with the political terrain.

Play the Hand You’re Dealt: A North Carolina Example

Although our House bill has 75 sponsors (and only 61 votes are needed to pass it on the floor), 2 of the Health Committee chairs have continued to block a committee hearing (1 of them is a physician). After appealing to the Speaker to intercede and getting a firm “no,” our lobbying team pivoted to the Senate where 3 powerful members are primary bill sponsors. We held closed-door meetings with insurers and scored a big win—formal support by Blue Cross and Blue Shield of North Carolina. Their letter to all legislators urging the passage of FPA legislation stunned the medical community. A second invitation-only meeting, this one with the state’s 4 largest hospitals, was not as fruitful. Although not opposed to FPA per se, they maintained a neutral position rather than anger one provider group or the other. (This meeting was in fall 2021. In April 2020, the largest private nonprofit hospital announced its support of FPA for NPs.)

FPA received an unforeseen boost with the creation in late 2021 of an ad hoc legislative committee on health care access and Medicaid expansion (we are 1 of 12 states without expansion). One of the 6 lengthy committee meetings held between January and April 2022 was devoted to advanced practice registered nurse FPA. Six of the 8 handpicked speakers made impressive pro-FPA presentations; this was no coincidence because the committee chairs controlled the agenda and were FPA bill sponsors. The increasingly favorable atmosphere for Medicaid expansion was also a plus for FPA because of its demonstrated impact on access to care in underserved rural areas in states like Arizona. FPA is one of a handful of health policy changes that could move as single bills or be included in a health care omnibus bill taken up before the legislative session ends this year. The 2022 legislative session is about to convene as this column goes to press.

The CASE Method

There are valid criticisms of the medical lobby, but a lack of investment in political activism and advocacy isn’t one of them.
State medical societies have systematically cultivated political and legislative influence for decades. They have perfected the use of personal connections and campaign contributions to reinforce their world view that physicians are the putative thought leaders and decision makers in health care. However, clearly the proverbial early bird doesn’t always get the worm or there would not be 26 states with FPA. The states that have achieved it, especially during the last decade as the American Medical Association and state medical societies have heightened their vigilance and strengthened their offense, are proof that medicine’s near-monopolistic grip on political power can be loosened. Surely, FPA states have succeeded in part by lifting pages from medicine’s playbook, using what I refer to as the “CASE method”—Copy And Steal Everything. NPs don’t need to waste time reinventing the wheel. We must commit to doing what so obviously works. Although decades of research support the universal adoption of FPA, in politics, power and evolving political context can move the needle in ways that data alone cannot.

Hope Is Not a Strategy

Advocacy reminds me in many ways of caring for patients with chronic illnesses, something I did for decades in family practice. Just as we would never approach the clinical care of such patients with a “drop-in” mentality (ie, showing up only when it’s convenient for us or emergent for them), we must commit ourselves to the continuous and often unglamorous work needed to move issues like FPA through our state legislatures. We can’t use magical thinking in the political world any more than we would use it in our clinical one. No policy maker will advance our agenda because we’re the “most trusted” or most noble profession. Politics isn’t T-ball. Power is not a trophy handed out to individuals or groups based on their participation or good sportsmanship. If the pandemic has taught us anything, it’s that being called “health care heroes” is more platitude than platform.

Into the Zone

My view is that North Carolina and other supervisory states didn’t miss some mythological pandemic-created opportunity to cinch FPA. No magic bullet or magical moment exists. Nothing can replace the rigor needed to change an entrenched (although outdated) physician supervision paradigm. NPs who have scored an FPA win in their state no doubt accounted for political preexisting conditions, navigated legislative intricacies, and reframed frustrating setbacks on their journey. Their efforts over time altered enough of their state’s unique political context to create a tipping point for FPA. Those of us still practicing in supervisory states must do the same.

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In compliance with standard ethical guidelines, the author reports no relationships with business or industry that may pose a conflict of interest.