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Impact of Nurse Practitioner Scope of Practice Regulation on Psychiatric Mental Health Nurse Practitioner Practice

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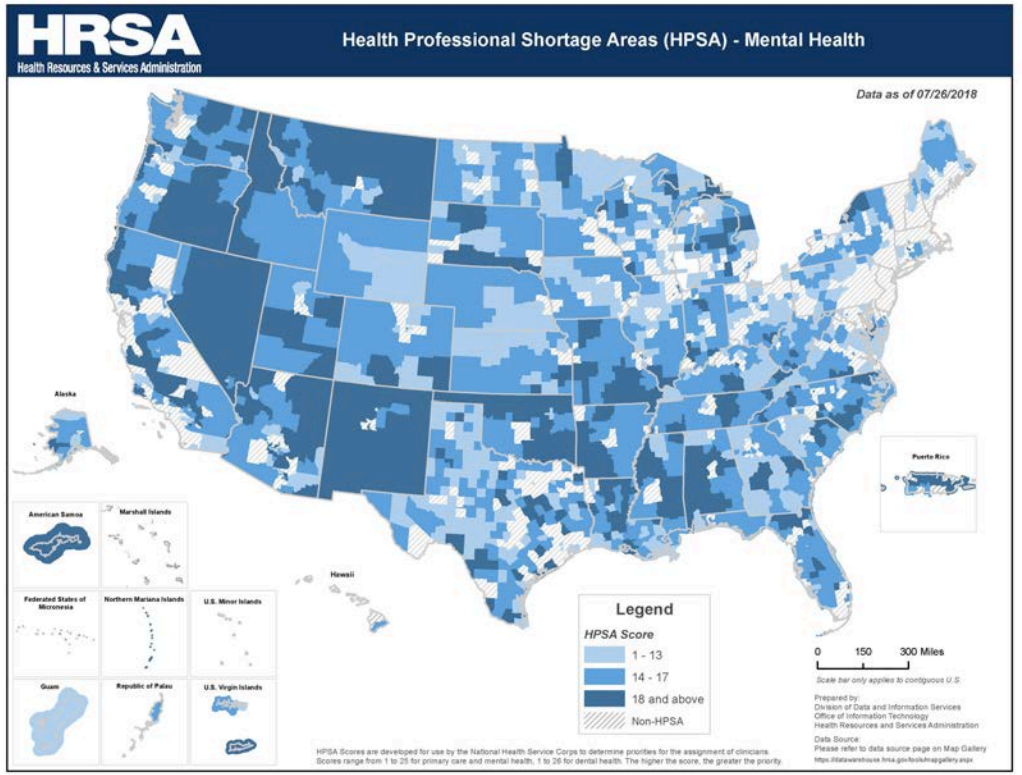
NCSBN Scientific Symposium

October 24, 2018

Background

- Shortage of BH providers, esp. prescribers
- PMHNPs have skill set to provide needed services
- State restrictions on scope of practice may limit optimal use of PMHNPs
- PMH-APRN practice associated with positive patient experiences & outcomes of care



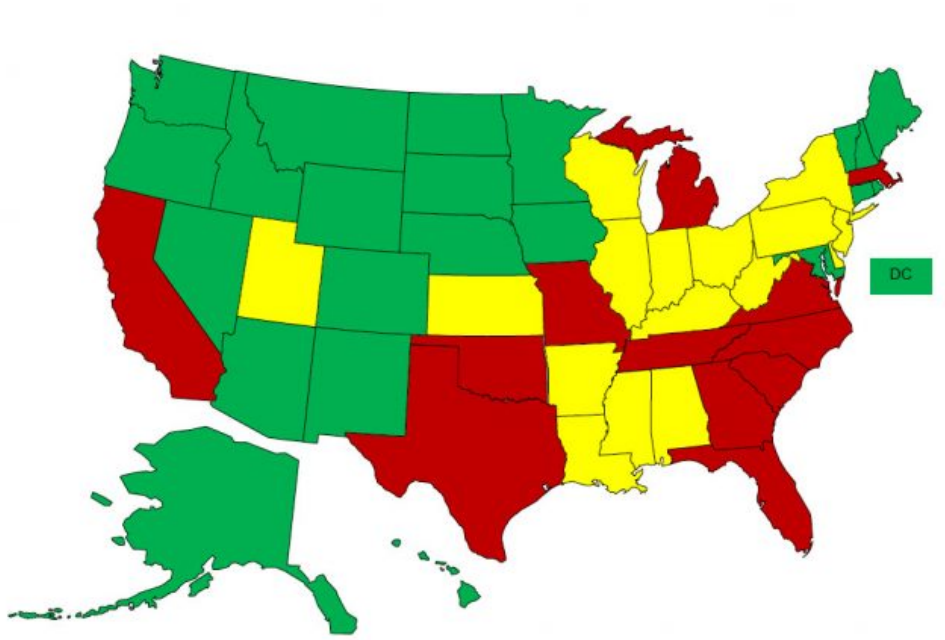
https://datawarehouse.hrsa.gov/ExportedMaps/HPSAs/HGDWMapGallery_BHPR_HPSAs_MH.pdf

Study Aims

1. Determine how state scope of practice affects PMHNP practice and education in states with different levels of NP autonomy
2. Identify effects of NP practice restrictions on access to behavioral health services in selected states.

Methods

- Selected 5 states with varying levels of NP autonomy
- Snowball sampling
- Data sources
  - Qualitative interviews
  - Document reviews
- Thematic analysis



https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment

Methods

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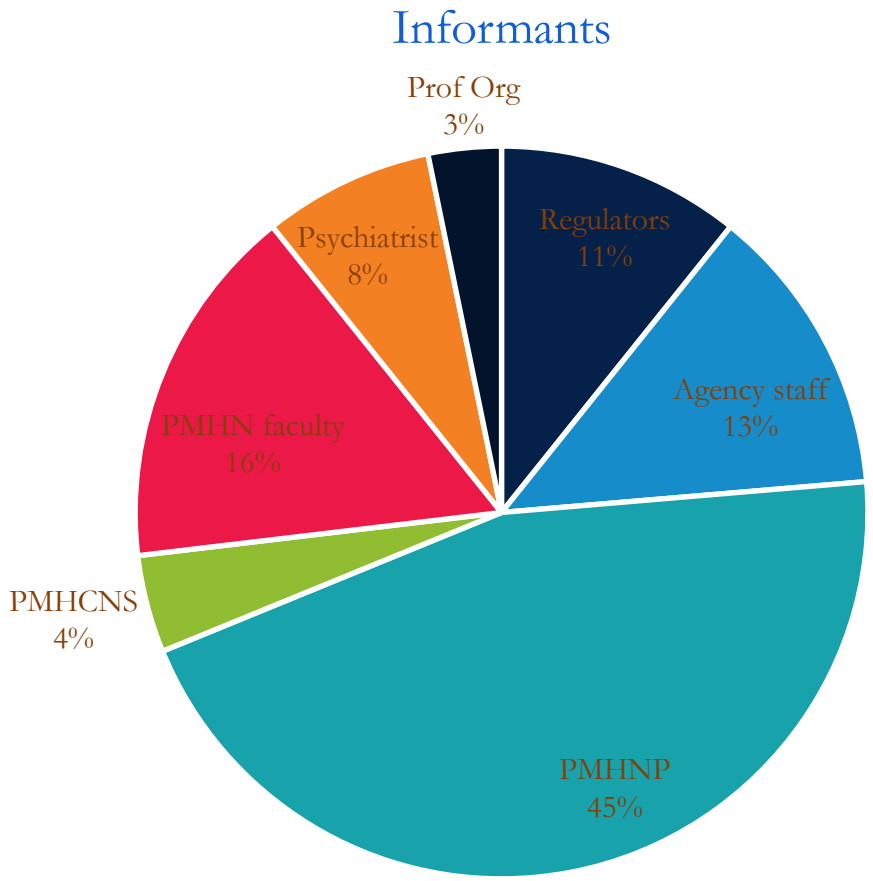


- 94 informants
  - 14-28/state
  - Group & individual interviews
- 40 organizations
  - 6-10/state

Oregon

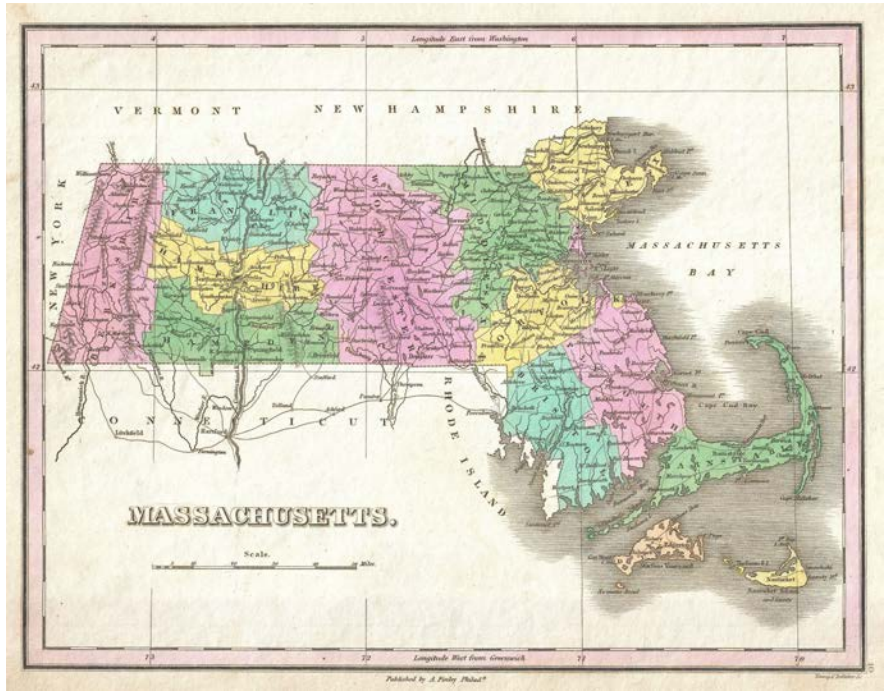
- Independent practice since ‘70s
- Prescriptive authority 1979
- Insurance parity for NPs in PC & BH
- Private/group practices common
- PMHNP student placements limited

Colorado

- Law changed to allow FPA for APRNs in 2015
- Requires1000 post-grad hrs. supervised prescribing before granted independent prescriptive authority
- Must keep “articulated plan” on file
  - Professional development
  - Consultation
  - QA
- PMHNPs can’t release legal holds

Massachusetts

- Independent practice except for prescriptive authority—collaborate w/ MD
- PMHCNS scope of practice essentially same as PMHNP
- APRNs required to have log of controlled substance prescriptions signed by collaborating MD in 96 hrs.

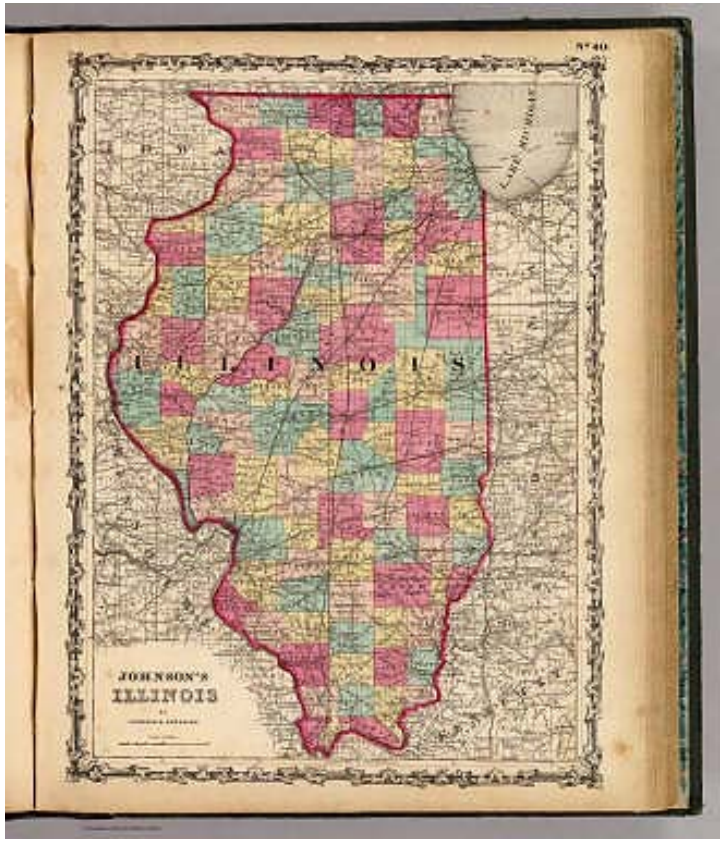


North Carolina

- NPs jointly regulated by BON & BOM
- APRNs required to have collaborative practice agreement w/ MD
- Avg. cost of MD collaborator $1500-3000/mo.
- No limit to how many NPs MD can supervise

Illinois

- January 2018: Legislation takes effect giving full practice authority to APRNs with 4000 hrs. supervised clinical experience
- APRN must practice in collaboration w/ MD until meets qualifications for FPA
- Can prescribe Schedule II-V independently, except for benzos & opioids
- Implementing regulations not yet published



Impact of Scope of Practice Regulation

Practice Model

- Psychiatric assessment & medication management most common role functions
- Full practice authority states
  - More freedom to develop nursing-based models of care
  - Mixed payor sources
  - More PMHNPs in leadership
- Restricted states
  - Expense of MD collaborator & difficulty with collaboration arrangements a significant impediment to private practice
  - Understanding of NP regulations very mixed

MD Supervision/Collaboration: Positives

- Collegial support
- Helpful for new grads

- *"I wouldn't feel comfortable practicing at this stage of my career without having someone who is more experienced who is required to answer my questions."*
- *"I would get MD consultation even if it wasn't required."*

MD Supervision/Collaboration: Negatives

Justifies unequal pay for same work

"The laws & regulations are a control issue to make sure that NPs don't get compensated as much as the doctors. Once you get rid of supervision, you'll have more clout with the insurance companies and get reimbursed at a higher rate."

Institutionalizes inequitable professional relationships

"The model of 'mandatory supervision' is challenging because it takes a lot of time and you can never 'prove yourself.' Once you have enough experience, you should no longer need supervision."

Economic Exploitation

"The Carolina Partners Nurses Supervision Program

Most Carolina Partners' psychiatrists supervise one or more nurse practitioners or PAs. Because North Carolina's supervision rules are modest, money earned from supervising good, experienced nurses or PAs is almost passive income for the doctor. Psychiatrists earn from $10,000.00 to $15,000.00 per nurse, so a doctor supervising four full-time nurses would earn up to $60,000.00 per year in extra income."

https://www.carolinapartners.com/doctors-without-bosses/ Retrieved 11/16/2017

Collaboration Negatives

Difficulty finding collaborating MD

"If you want to open a private practice, you may have a hard time finding a supervising psychiatrist. My real dream is to open a practice in X and work 2-3 days a week, but would be impossible to find a supervisor."

Collaborating MD less knowledgeable

- *"I'm being assigned to a brand-new psychiatrist, mostly so I can mentor her. This is not the first time it's happened."*
- PMHNP with specialty in perinatal MH disorders—none of her MD supervisors knew as much about it as she did

Collaboration Negatives

No supervision actually provided

"The relationship with the supervisor I had before my current one was bogus. I could barely track her down. Besides, I didn't have anything to talk to her about because I've been in practice for so long."

MD Supervision/Collaboration: Negatives

- Confusion about regulations
- Agency policies sometimes more restrictive than required by law
- Inefficient: wastes MD & PMHNP time

"Per [health system] bylaws, all NP notes have to be co-signed. The physicians hate it—they can't keep up with reading all the notes."

If the goal is consultation to provide quality practice….

- What we learned
  - Supervision ≠ Consultation
  - Supervision did not always occur with required frequency
  - Supervisor maybe not in similar clinical practice area
  - Often no choice in who was supervisor or supervisee
- Consultation worked best when
  - Matched in practice and location
  - Just in time consultation
  - Choice of collaborator
  - True peer collaboration, sharing knowledge and practice challenges

Conclusions

- APRN scope of practice legislation based on stakeholder interests, not evidence
- Lack of standardization leads to confusion
- Requirements for MD supervision
  - Add to cost of care without improving quality
  - Reduce access to care
  - Justify unequal reimbursement

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