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2018 NCSBN Scientific Symposium - Practice: Enhancing Psychiatric Mental Health Nurse Practitioner Practice: Impact of State Scope of Practice Regulations and the Practice Environment Video Transcript

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Event

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Presenter

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- [Dr. Bethany Phoenix] Well, thanks for coming to our session this morning. So we're going to be talking about psychiatric nurse practitioners and also other psychiatric/mental health clinical nurse specialists. Because, you know, some of the states that we visited, the scope of practice was not really too different for the two categories.

So you'll see that sometimes we'll use Psych NP, and sometimes we'll use Psych APRN. So the background for this is that there's a real crisis in behavioral healthcare, and a big component of this is lack of workforce. And you can see, looking at this map, the darker shades of blue indicate more severe levels of shortage of behavioral health providers.

So you can see that most of the country is pretty blue, and there are some counties that have no behavioral health prescriber at all, so a pretty serious workforce crisis. So psychiatric nurse practitioners and clinical nurse specialists have the skillset to provide the services that are needed by clients, you know, needing behavioral health services.

But state scope of practice restrictions may influence the degree to which its psychiatric advanced practice nurses can really use their skills to serve patients. So the, you know, other factor is that there is not a huge amount of research, but the research that there is indicates that Psych NPs, as similar to other NPs, have positive patient experiences of care and patient outcomes.

So our study aims were to determine how the state scope of practice affects Psych NP practice and education in states with different levels of nurse practitioner autonomy. And we're going to refer back to the same map that Jeannie had in her presentation, except ours has different colors.

And also, specifically, to look at the effect of NP practice restrictions on access to behavioral health services in these states. So this is the map that sort of categorizes levels of nurse practitioner autonomy that is kind of kept updated by the American Academy of Nurse Practitioners.

And so the green states are states where nurse practitioners have full scope, the yellow states, nurse practitioners have at least one component of their practice is restricted, and then the red states require physician supervision or consultation in order to practice.

So we picked two states that had restricted scope of practice, two states that had full scope of practice, and then one that had reduced scope of practice. Which were Oregon, Colorado were the two full-scope, Illinois was the reduced, and then North Carolina and Massachusetts were the restricted scope of practice.

So we used snowball sampling. We started with known contacts in those states, and that was kind of an influential factor in how we picked our states, so it's where we know people. Because if you're going to kind of parachute into a state for a week, you need to know people.

And you also need to be able to use people's names to get other people to answer your emails. And then, our original informants kind of recommended other people that might be willing to be interviewed. And then, we also reviewed online resources that discussed each state's scope of practice.

So we looked at the Nurse Practice Act and the other regulations that we were able to find. And then, we conducted qualitative interviews with a number of informants in each state. We interviewed people from the Boards of Nursing in each state, except for Illinois that was unable to meet with us, and then NP educators, people in practice, people in professional organizations.

You know, as we kind of got to know a little bit more about the state, we got a better sense of who would be able to give us the information that we were looking for. And then, we used thematic analysis to analyze this data. So this shows our informants. And as you can see, the largest group, slightly under half, was psychiatric nurse practitioners, and then the second largest group was Psych NP faculty, and a lot of those folks were in practice as well.

So for some of those, we talked both about their roles as educators and as practitioners. And we also interviewed some psychiatric CNSs, that was a smaller percentage, regulators, and then psychiatrists in the states where physician oversight was required.

So we had the total of 94 informants, and you can see the range for each state. And most of these were individual interviews, but we also did some group interviews with numbers of Psych NPs in the same agency or, you know, regulators, sometimes there were more than one of those.

And our total was 40 organizations represented by these informants. So I'm going to talk a little bit about each of the states, and then Susan will talk about some of our kind of overall findings. So Oregon was the first state we visited. Oregon is like a paradise for nurse practitioners.

They've had independent practice since the '70s and prescriptive authority since 1979. And so they also have something that's, you know, I think fairly unusual in that they have a law that requires parity and insurance reimbursement for nurse practitioners in primary care and mental health.

So that has actually been kind of an inducement for nurse practitioners to go into private practice because, although there's parity and insurance reimbursement, there is not parity in salaries within agencies.

There's still that discrepancy between physicians and APRNs. So that was kind of an interesting finding. And so one of the kind of perverse effects of, you know, this inducement for nurse practitioners to go into private practice is that it had the effect of limiting student placements for psychiatric nurse practitioners, because it's often more difficult to arrange placements in private practices because of concerns about malpractice and insurance, and so forth.

You know, and actually in Oregon, there is only one Psych NP program within the state, although there are some other programs in adjacent states that are fairly close to the border. So that's potentially an access issue. In Colorado, the law was changed in 2015 to allow full practice authority for nurse practitioners.

So we visited in 2017, which was fairly soon after this change, so people were still kind of getting adjusted to it. So this regulation requires that APRNs have 1,000 post-graduate hours of supervised prescribing before they get their independent prescriptive authority, which Colorado refers to as the "RXN."

And they also have to maintain this document that's called an "articulated plan" on file that mostly talks about plans for professional development, you know, continuing education, as well as who they would consult with if it was necessary to do so, and also addresses quality assurance.

So it's not prescriptive, but it sounds like it was sort of a bit of a fig leaf when nurse practitioners were granted full practice authority. So the one thing that we found that was a really significant restriction on Psych NP practice, which we heard a lot of people complain about, was that psychiatric nurse practitioners can't release legal holds.

So people who are hospitalized without their consent, Psych NPs can place those holds, but they can't release those. And that is actually not a nursing regulation, it's a behavioral health regulation because nurses, they're not named as professional categories who can release holds.

So that was the one really significant example we found of other agencies limiting Psych NP practice. So Massachusetts was our next state, and they're categorized as Restricted.

But I think, recently, in 2014, their Board of Nursing conducted a review of their regulations because they hadn't really been changed for about 20 years. And they removed some requirements that were not required by law, they were only required by regulation, so that prescriptive authority is the only aspect of APRN practice that requires collaboration with a physician.

And in Massachusetts, more so than any of the other states, Psych CNSs and Psych NPs pretty much had the same scope of practice and were used interchangeably. I mean, a lot of the folks that were recommended to us to interview, you know, we thought they were Psych NPs, and then we found out that they were actually Psych CNSs.

So there did not seem to be much differentiation between the two roles. Now, one of the sort of interesting and quirky things about Massachusetts regulation is that all prescribing APRNs have to keep a log of controlled substance prescriptions, and it has to be signed by their collaborating physician within 96 hours.

And we talked to the Board of Nursing representatives there, and we did see some private practice in Massachusetts. But they estimated that if there were full practice authority, there would be more nurse practitioners in private practice.

And then, North Carolina was the state that probably had the most restrictive practice regulation of all the places we visited, and it was the only place where NP practice was jointly regulated by the Board of Nursing and the Board of Medicine.

And so all APRNs were required to have a collaborative practice agreement with a physician. And this specifies what medications can be prescribed, what practices and procedures can be performed. And it needs to be reviewed annually and signed and reviewed by the physician and the nurse practitioner, and it needs to include progress and outcome measures that are documented.

And the kind of general vibe we got from Psych NPs there was that these were a lot of hoops that they had to jump through that did not really provide any value in terms of improving patient care. So a couple of things that we found was that the cost of physician collaboration or supervision was fairly high.

It seemed to be a little higher there than in some of the other states. Although we didn't systematically collect fiscal information, we did hear people talking about fees as high as \$1,500 to \$3,000 a month, which is obviously a significant cost of practice. Now, there's no limit to how many nurse practitioners a physician can supervise, so you can see that there's a significant financial incentive there, which we'll talk a little bit more about later.

And one other factor that we found there is that nobody except physicians can do involuntary commitments. So that's an important role or function for Psych NPs that requires physician supervision. And then, the last state we visited was Illinois, and they had just had a very recent change in their scope of practice legislation that just went into effect in January of this year.

So the actual implementing regulations were still in the process of being written when we visited the state. So it will allow full practice authority to APRNs with 4,000 hours of supervised clinical experience.

So APRNs that already have that amount of supervised experience can just, you know, kind of basically do an attestation, and then new graduates will be required to have that. Which is about two years full-time, so it's not an insignificant amount. And they must practice in collaboration with a physician until they meet the requirements for full practice authority.

So one of the things that was a little quirky about this is that they can prescribe Schedule II through V medications independently, except for benzodiazepines and opioids. And so they have to have physician supervision for that, which was actually a little bit more restrictive than what they had before.

So, you know, a big leap forward and a little step back. So anyway, now I'm going to go ahead and turn it over to Susan. - [Dr. Susan Chapman] Thanks. Next, I'm going to try to do some big-picture conclusions here, findings, and hopefully we'll have more to talk about during the Q&A.

So one of the big-picture pieces of this, I think, is that, as Beth pointed out, part of the reason for us looking at this is that we have – and everyone knows this – a severe shortage of behavioral health providers overall in the country. And looking at ways to address this, the Psych NP makes a lot of sense. One of the things that may not surprise any of you, but is I think a really interesting finding is that, for the most part, the Psych NPs we found were doing the same thing as the psychiatrists were doing, pretty much everything the same.

There was really no differentiation of practice, differentiation of cases assigned. It might be someone who had a particular expertise in that area, like Child Psych or different types of issues like, you know, depression or eating disorders, etc., but those were found equally among the NPs and the psychiatrists.

So this is really about kind of different practitioners doing the same work. We know there's a psychiatrist shortage in the country. There are various reasons for that. That is really not our topic and not to get into right now, but I think that makes this even more important. So we were trying to, "What is the real difference between these states when it comes down to practice? And what is the impact of scope of practice laws?"

And granted, this is a small sample, but I think these are pretty, hopefully, generalized with the findings. In the full practice authority states, what we found was this overall freedom to develop nursing-based models of care. We saw group practices that were nurse-managed led and, you know, hiring their own NPs, and also finding ways to make the job, you know, broader in terms of doing different kinds of things, able to contract out and work with populations that they might not have been able to work with in sort of a single practice arrangement.

Certainly, the parity in payment helped, particularly in Oregon, and we found more Psych NPs in leadership positions across the different types of practices. So for example, a Psych NP could be a medical director in a clinic. Those were actually some of the titles we found because there was no one else to step in.

In the restricted states, it's really basically about the collaboration and challenges in that collaboration, which I'm going to go into a little bit more. Overall, I would say that regardless of the state, the understanding of the practitioners and the supervisors and the clinic managers about their regulations and what they mean were very mixed in terms of, you know, "What's required, how do I set this up, etc.?"

So I'm going to talk a lot now about supervision/collaboration. Because states use different wording, and I think the words are important. Supervision does really have different connotations than collaboration. And later, I'm going to talk about consultation, which I think also has very different connotations.

But overall, very strong feelings. Whenever we got to this part of the interview, there were very strong feelings, so some of these quotes are going to reflect that. What are some of the positives? Well, for NPs new to practice, new to the prescribing, new to, you know, working independently, they appreciated some sort of consultation opportunity or supervision in terms of being new.

So particularly, for, you know, medication prescribing, if they were new to that. Now, this doesn't mean that it was always consultation from a physician, they just appreciated hearing from someone who was more experienced than them. And some said, you know, they wanted some sort of supervision consultation initially, even if it wasn't required.

A number of these next slides are going to be about some of the negative connotations about supervision and from very different perspectives. So one of these is really this idea that the supervision requirements really justify unequal pay for doing the same work, that perhaps getting rid of supervision would allow a more equal acknowledgement of the work and recognition of that work.

I'm not going to read all these quotes because I don't have that much time, but you can read them yourself. It also institutionalizes those inequitable professional relationships, and this is partly about this experience thing.

You know, as you get more experience, do you still need the same level of supervision. The supervision laws, for the most part, other than those initial practice requirements, do not change over time. So whether you're 5 years or 20, or whatever, you still are looking at the same requirement. It can be an opportunity for economic exploitation.

This is a handout we found from one of the states. In disclosure, it's not currently online. Someone figured out that it was not very PC. But as you can see, it kind of challenges that whole rationale for supervision and why it's needed to oversee work. And this is really saying, "Hey, the supervision can be a great economic opportunity for physicians as well, and you don't have to work that hard because they're doing the job."

So it was really inter-... And this had people in the state very hot, shall we say? Some other negatives, of course, are the difficulty in finding a supervising NP. And what does this mean? This can restrict where you practice. For example, we interviewed someone on Cape Cod, Massachusetts who said she would never... She was a CNS, who didn't prescribe because she said she'd never find a psychiatrist to supervise her in that regard, that the waiting time to see a psychiatrist on Cape Cod was six months.

So it really impacts, you know, at the bottom line here. These are not just political discussions, this is really impacting service and access to care. And then, how do you know that your supervisor is going to be more knowledgeable than you? You could be assigned a supervisor who's brand new. So it's really more a supervisee teaching the supervisor.

It's not the kind of relationship where you can always learn from if you are being assigned someone. And the NPs who were in practice settings, it was often a matter of coming in and this is the person that's assigned to be your supervisor. You're not choosing. You don't have a choice. In independent practice, it was more the, "How do I find someone?"

Actually, another negative – supervision was actually almost very rarely provided as it was stated in the laws, you know, where it was often an on-call, "Text me when you need me. Call me." There were some organizations that had regular meetings and those were really different kind of meetings, which I'll talk about in a minute.

But it was rarely practiced as what's expected via the regulations. Another thing is just confusion about the regulations. And as Jeannie mentioned previously, there was often a situation where the institution imposed further regulations than were required by law.

Those could be large organizations, behavioral health organizations, where they added extra elements of supervision that weren't even in the regulation, such as reviewing records. Some of the supervisors told us, "Well, we're required to review records. I think that's in the law," which it was not.

So what are we really after with supervision? And I have a serious typo here that I'm going to try to fix before we get this online. I'll tell you about it in a minute. But are we really after consultation? Are we really after collaboration? In which case, we're not getting that with supervision. That is not the same thing that we're seeing.

Supervision did not occur with required frequency. The supervisor may not even be in a similar clinical practice or, as I said, access by, you know, "Text me if you have a question," is a whole different way of practicing. Overall, even the psychiatrists we interviewed, that time for supervision was not often built into the schedule.

It was built into the pay, but not the schedule. And as I said earlier, often no choice of who that would be. And then, if a supervisor left or there was turnover, there was always the challenge of, "Oh my gosh, how will I find a new supervisor?" Particularly, thinking about moving to a new area, taking a new job, that issue of finding a supervisor was always sort of at the top of the list versus anything about, you know, "How will I like this job? What do I want to be? How do I improve access to care?"

So I call it "consultation." When did we find that consultation worked best? Well, when it was matched in practice and location, this was a group of colleagues working together in a location, you know, with a patient population that they were all working with.

And it was really back-and-forth consultation, collaboration. Sometimes it worked best when it was just in time. You know, "My collaborator is down the hall. I have a challenging patient. Let me go talk to this other person who I know has expertise in this area and, you know, get some just-in-time kind of advice, sharing." Choice, certainly, a big part.

Choice of who to collaborate with, this is not just expertise, but matching personality styles, matching access, as I said, matching location, so feeling comfortable with that person that you are going to

collaborate with. And then, true peer collaboration, which we found a lot of in the states. The states that were full practice, it wasn't that they didn't have supervision.

They certainly didn't call it "supervision," but they called it "collaboration," and they called it "consultation" with each other. There were groups of peers who got together over lunch and discussed cases. They made time in their schedules to discuss cases together and share with each other. So the notion that, you know, "I don't know something.

I'm uncomfortable with this. I'm going to seek advice from someone else," is still there no matter what kind of state regulations you have. And that was really where we found the best examples of this taking place. So in conclusion, you know, we found that some of these differences were really based on, you know, political interests, stakeholder interests.

And as we all know, the evidence, we have enough evidence. This is really the other issues here. Lack of standardization across the states, of course, leads to confusion. We didn't really study, but we'd love to study how the Psych NPs move state to state. We know a few from California, a restricted state, go to Oregon because it's a practice paradise, as Beth said.

But we really don't know how people choose where to work in terms of that scope of practice and the practice environment they want to be in, if they have that ability to move. But how do you move from one state to another? We got into telehealth a little bit, but that's another area where these issues come up.

And cost of care, of course, is another issue. I'll be done in a second. Cost of care increases when you take people away for supervision. Or, you know, for those in independent practice, it adds to their out-of-pocket costs, as Beth talked about some of those fees.

And it can be used to sort of justify the payment system, which may be a way to draw more people to behavioral healthcare. So the overarching issue here is severe shortage in behavioral health. We need more practitioners. Psych APRNs are an answer to that, and let's try to make that work by looking at regulations.

These are our references. And I'm happy to take a couple of questions. And we need to move [inaudible]. - [woman] [inaudible]- Pardon?

- No questions.

- No questions. I'll be around.