

Removing restrictions on nurse practitioners' scope of practice in New York State: Physicians' and nurse practitioners' perspectives

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ABSTRACT

Background and purpose: In 2015, New York State adopted the Nurse Practitioners Modernization Act to remove required written practice agreements between physicians and nurse practitioners (NPs) with at least 3,600 hours of practice experience. We assessed the perspectives of physicians and NPs on the barriers and facilitators of policy implementation.

Methods: Qualitative descriptive design and individual face-to-face interviews were used to collect data from physicians and NPs. One researcher conducted interviews, which were audio-taped and transcribed. Twenty-six participants were interviewed. Two researchers analyzed the data.

Results: The new law has not yet changed NP practice. Almost all experienced NPs had written practice agreements. Outdated organizational bylaws, administrators' and physicians' lack of awareness of NP competencies, and physician resistance and lack of knowledge of the law were barriers. Collegial relationships between NPs and physicians and positive perceptions of the law facilitated policy implementation.

Conclusions: Policy makers and administrators should make efforts to remove barriers and promote facilitators to assure the law achieves its maximum impact.

Implications for practices: Efforts should be undertaken to implement the law in each organization by engaging leadership, increasing awareness about the positive impact of the law and NP independence, and promoting relationships between NPs and physicians.

Keywords: Nurse practitioners; scope of practice; primary care; policy.

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Background

Physicians, nurse practitioners (NPs), and physician assistants currently provide the bulk of primary care in the United States (U.S.) to meet the demands of an aging population and expansion of insurance coverage (Agency for Healthcare Research and Quality, 2014; Colwill, Cultice, & Kruse, 2008; DeVol & Bedroussian, 2007; Patient Protection and Affordable Care Act of, 2010). One projection suggests an additional 52,000 physicians will

be needed by 2025 to meet the primary care demand (Petterson et al., 2012); however, the supply of these providers is expected to decrease (Association of Medical Colleges Center for Workforce Studies, 2015). Conversely, NP workforce is expected to grow. In 2013, NPs comprised about 19% of the U.S. primary care provider workforce, and the number of NPs will increase by 93% by 2025 (Health Resources and Services Administration, 2016), potentially expanding the primary care capacity (Auerbach, et al., 2013; Green, Savin, & Lu, 2013).

However, the ability of NPs to care for patients has been limited by state-level scope of practice (SOP) regulations that determine the services NPs provide. Nurse practitioner state-level scope of practice laws vary across states. In 2017, 22 states and the District of Columbia authorize NPs to deliver care according to their competencies (Robert Wood Johnson Foundation, 2017). The remaining states impose restrictions, including the requirement of NPs to have supervisory or collaborative relationships with physicians. Some states require NPs to

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have such relationships both for delivering care and prescribing medication and services, other states impose restrictions only on one aspect. The Federal Trade Commission, the National Governors Association, and the National Academy of Medicine have criticized these laws and recommend removal of these restrictions to improve access to care (Federal Trade Commission, 2014; Institute of Medicine, 2010; National Governors Association, 2012). Indeed, states granting NPs greater SOP authority experience expanded health care utilization (Kuo, Loresto, Rounds, & Goodwin, 2013; Xue, Ye, Brewer, & Spetz, 2016).

In 2015, New York State (NYS) implemented the Nurse Practitioners Modernization Act (New York State Department of Education, 2015). The law removed the required written practice agreement between NPs and physicians for experienced NPs with more than 3,600 hours of practice. New NPs with less than 3,600 hours of practice still are required to have this agreement. The outdated policy requiring NPs to have a written practice agreement with physicians limited NPs' ability to independently care for their patients and practice in underserved areas with shortage of primary care physicians. This policy change aimed to promote NP independent practice and address the misdistribution of primary care services across NYS by allowing experienced NPs to practice independently in underserved areas (Center for Health Workforce Studies, 2013). In this study, we assessed the perspectives of physicians and NPs on the barriers and facilitators of implementing the NP Modernization Act 18 months after the policy adoption.

Methods

We used a qualitative descriptive design as described by Sandelowski (2010) to collect data from physicians and NPs because we know little about the law's implementation. Participants were recruited through purposive snowball sampling (Sandelowski, 2007). We contacted several practices in NYS, through our professional network in primary care, and informed practice managers or providers about the study and asked for assistance with recruitment. Both managers and providers distributed flyers about the study which included information about study's risks and benefits, and the contact information of the researchers. Participants were eligible for inclusion if they practiced as a primary care NP or physician and spoke and understood English. Interested participants contacted the researchers to schedule a convenient time and place (e.g., primary care office) for the face-to-face interview. Using the snowball sampling method, we also asked participants to refer colleagues as potential participants.

One researcher (AN), an experienced NP in NYS with expertise in qualitative designs, conducted all interviews using a semistructured interview guide that allowed for probing for additional information. The researcher kept a reflexivity journal prior to and during the interviews to

reduce bias. We developed the questions from existing evidence. Interviews started with questions regarding the practice, participants' roles, and then about the NP Modernization Act. Table 1 presents key questions.

Each interviewee signed a consent form. Interviews and data analysis were conducted concurrently (DiCicco-Bloom & Crabtree, 2006). As interviews progressed, participants provided information, which was further explored in subsequent interviews. All interviews were conducted in the participant's practice office with no others present during the interview. Interviews were audio-taped and lasted between 25 and 45 minutes. The interviewer took notes. Demographic and practice characteristic information was also collected. Data collection took place in the summer-fall of 2016.

Twenty-three interviews were completed initially (12 NPs and 11 physicians) and analyzed to identify codes and themes (Miles & Huberman, 1984). To further explore the codes and themes and develop an exhaustive description, we conducted three additional interviews with two NPs and one physician. In alignment with qualitative research principles (Sandelowski, 2007), data collection ended when interviews were not producing new information. This was reached after the 26th interview.

Interview audio-recordings were transcribed verbatim by a transcriptionist. We imported the data into the qualitative software package, Atlas, and using iterative content analysis (Bradley, Curry, & Devers, 2007), we analyzed the data. Two researchers independently read and reread transcripts for overall understanding and inductively coded the data (Hsieh & Shannon, 2005). We reviewed data line-by-line and when a concept became apparent, we assigned a code. We used constant comparison to refine codes and had regular in-person meetings to review discrepancies and achieve consensus. After identifying all concepts, we linked them to develop themes relating to barriers and facilitators of the law's implementation. We also conducted a comparative analysis in two groups (physicians and NPs) by retrieving data coded with both conceptual and participant codes. This comparison showed whether certain concepts were

Table 1. Examples of interview questions

Key Questions

- Can you describe the Nurse Practitioners Modernization Act? What does it state?
- Can you talk about how your organization has adopted the Nurse Practitioners Modernization Act?
- How has the Nurse Practitioners Modernization Act impacted your practice?
- What organizational barriers exist to adopt the Nurse Practitioners Modernization Act?

Table 2. Nurse practitioner (NP) and physician characteristics

Characteristics	NPs (N = 14)	Physicians (N = 12)
Age, mean (SD), years	41.36 (3.4)	45.78 (2.7)
Female, No. (%)	13 (93)	7 (58)
Highest degree, No. (%)		
Master's	5 (36)	—
Post-Master's	3 (21)	—
MD	—	11 (92)
Doctorate (PhD; DNP; PhD/MD)	6 (43)	1 (8)
Years of experience, mean (SD)	7.21 (1.8)	13 (2.4)
Main practice site, No. (%)		
Private practice	2 (14)	3 (25)
Academic medical center-affiliated practice	5 (36)	6 (50)
Hospital-affiliated practice	7 (50)	2 (17)
Community health center	—	1 (8)
Geographical location, No. (%)		
Urban	9 (64)	8 (67)
Suburban	5 (36)	3 (25)
Rural	—	1 (8)

reported differently between two groups. Findings were shared with participants to obtain feedback. Demographic data were analyzed using SPSS v24.

Results

Table 2 includes information about the 14 NP and 12 physician participants. The mean age was 41 years for NPs and 45 years for physicians. The mean years of experience for NPs was about 7 years and for physicians was 13 years. Twelve of 14 NPs (85.7%) were experienced NPs with at least 3,600 hours of clinical practice. The majority of NPs and physicians worked in practices affiliated with

hospitals or medical centers. We identified four barriers and two facilitators toward the law's implementation (Table 3), which emerged both in NP and physician interviews; thus, findings are combined.

Barriers

The following barriers emerged: stagnant organizational policy; lack of awareness of NP competencies; lack of knowledge about the NP Modernization Act; and physician autonomy and resistance to change.

Stagnant organizational policy. Almost all NPs reported that the law change did not affect their practice because

Table 3. Barriers and facilitators for implementing the nurse practitioners modernization act

Barriers

- Stagnant Organizational Policy
- Lack of Awareness of NP Competencies
- Lack of Knowledge about the NP Modernization Act
- Physician Autonomy and Resistance to Change

Facilitators

- NP and Physician Collegiality
- Positive Perceptions of the benefits of NP Independence and the Law

the organizational bylaws were not reformed to accommodate the change, particularly in practices affiliated with hospitals or medical centers. Eighty-six percent of NPs (12 out of 14), regardless of experience, had a written practice agreement with physicians. One NP employed in a hospital-affiliated practice for seven years described, "The bylaws...state that you have to have a collaborating physician...I still have a collaborating physician." She continued, "They (administrators) have not kind of come with the times yet...my collaborating physician in particular totally agrees with the Modernization Act and does not feel that she needs to oversee me in any way, shape, or form." Most NPs reported that their organizations do not plan to change their bylaws because of lack of advocates in the leadership to encourage change.

Practices sold to hospitals found that new owners were less supportive of expanding NP SOP. Hospitals not only did not promote NP independent practice, but they even restricted the practice of those NPs who had a broader SOP in a standalone practice prior to the hospital acquiring their practice. One NP with 15 years of experience provided an example:

Before (hospital) took over, I was comfortable, and the physician that owned the practice was very comfortable with me doing initial physical examinations, doing medical clearances, doing worker's compensation. All that has gone away since (hospital) bought the practice.

Physicians also confirmed that their organizations did not conform to the law. They saw this as a reflection of their organizations, which they perceived as out of touch with new policies. One physician practicing with NPs for 20 years stated, "I really think that the organization that I'm working for is just not up with the times. I don't think they're astute enough to... know what's out there."

Lack of awareness of NP competencies. Most participants, both NPs and physicians, perceived that some physicians and administrators are not familiar with NP competencies or the care NPs can deliver. One NP said, "I also don't think that all providers, like physicians, know what nurse practitioners can do and the extent we can do it, too." Physicians' comments confirmed NPs' concerns. One physician said, "I'm not really sure what their (NPs') training entails."

Physicians had conflicting views about NPs' abilities when speaking about NPs more generally compared with NPs they worked with directly. Most physicians viewed the quality of care of NPs in their practices positively, "The nurse practitioner that works here I feel is exceptional. So, if she went out on her own independently, I would have no hesitation about it." However, viewed as a group, the same physician's perception of NPs was not as positive, "I don't feel that way across the board for most NPs." Awareness of NP competencies and support for NP independent practice was higher among physicians who

worked with NPs; however, that awareness and support was individualized to the NPs they worked with. Physicians often perceived that these NPs are uniquely skilled and their competencies are not generalizable to the overall NP workforce.

Lack of knowledge about the NP Modernization Act.

Awareness of the policy change varied across the two groups. Although most NPs were familiar with the law, only a few physicians had heard about it. One physician stated, "I heard it is' something like they (NPs) can practice individually? Without any presence of any doctors?" Another physician said, "I don't know about NPs going independent. I have not seen that in any of my practices."

Even though most NPs knew the law had passed, they were not well informed about its details. One NP summarized as, "It is (NP Modernization Act is) basically promoting NP autonomy". Also, both physicians and NPs reported that their organizations are unfamiliar with the law or they do not keep informed about the state policy changes.

Physician autonomy and resistance to change. Two physicians reported resistance toward surrendering some of their rights despite recognizing that the law's implementation would reduce delays for patients by allowing NPs to bypass physician signing off on forms. One physician provided an example, "Ideally, I would hope that we (NPs and physicians) would be completely equal. But I know that after being in, like, 20 years of practice where I am sort of the final say, I might have a hard time giving up that." The same physician said, "Then you would have to sort of negotiate between the two providers." Another physician said, "not that they (NPs) don't know and they don't have any experience, but I feel still that I think there has to be some kind of communication with the doctor..."

Facilitators

Two factors emerged as facilitators: NP and physician collegiality and positive perceptions of the benefits of NP independence and the law.

Nurse practitioner and physician collegiality. Both NPs and physicians identified favorable collegial relations as facilitating the law's implementation. In practices where NPs and physicians had positive relationships, NPs were more likely to practice independently. Furthermore, in these practices, NPs were key members of the team. One NP said, "A lot of our physician colleagues...see me as a warrior with them..." Similarly, some physicians spoke about NPs being equal team members and independently delivering care to patients. One physician said, "the NP certainly is seeing patients on her own... she has her own panel." Other physicians emphasized the importance of having collegial relationships with NPs because it would benefit patients.

Positive perceptions of the benefits of NP independence and the law. Physicians were supportive of the law when they perceived that NP independence benefitted their practice by expanding its capacity. Nurse Practitioners could help practices meet the increased care demand and attract more patients. One physician with over 20 years of experience owning his practice said:

Expansion (NP SOP) is like if I have two "me's...because the NP is going to be doing the same thing that I do, it is' just that we are able to get as many patients as possible...I just want to make the office bigger."

Physicians who found the NP collaboration requirement burdensome were also more likely to support the law's implementation. One physician said, "I've asked that many times, 'Why am I signing for a nurse practitioner who has a Ph.D. and has been working with me since 1998?' I have absolutely no clue." Similarly, NPs perceived that environments where physicians and administrators had positive attitudes toward NP independence were more likely to adopt the law.

Discussion

Our study represents one of the first comprehensive assessments of the NYS NP SOP policy change implementation. Despite the attention on the NP workforce and the regulatory trend of loosening NP SOP restrictions nationwide (Robert Wood Johnson Foundation, 2017), no study has assessed how these laws are implemented. The response to policy change is important to understand because translation from policy into practice is a necessary step in realizing the law's goals. Our study reveals some important barriers toward the law's implementation, which should be addressed by policy makers and administrators to assure NPs in NYS practice according to the law. Despite that NP SOP is different in NYS, our findings may inform policy makers in other states considering reform of NP SOP laws. New York State has had a slow response to SOP law change compared with other policies. Research on other state policy changes has shown immediate and measurable responses (Gresenz, Edgington, Laugesen, & Escarce, 2012; Gresenz, Laugesen, Yesus, & Escarce, 2011; Laugesen et al., 2014; Sabik & Laugesen, 2012). Both NPs and physicians believe that their organizations lack the ability to embrace policy innovations and no efforts are undertaken to implement the law. These findings are consistent with previous research showing how implementation is frequently overlooked after legislation is passed (Pressman & Wildavsky, 1984).

Most practices had not changed their bylaws in accordance with the law. These findings contribute to new knowledge that legislative change alone is not adequate to maximize the contributions of the NP workforce to our health care system. For the *NP Modernization Act* to achieve maximum impact, many stakeholders, including

physicians and administrators, should get involved in efforts to embrace the law at the organizational level. With more NPs employed in practices associated with hospitals or medical centers, it is particularly important to work with leadership because these organizations seem to be more resistant to expanding NP SOP. Currently, about 32% of NPs in NYS practice in such settings (Poghosyan, Boyd, & Knutson, 2014). Supporting NP practice according to the state laws promotes patient safety (O'Grady, 2008).

Although NPs gained legal SOP in NYS in 1988 (Elwell & Ferrara, 2014), there remains a lack of awareness among some physicians about NP competencies. Evidence is clear that NPs deliver high-quality care (Kurtzman & Barnow, 2017; Newhouse et al., 2011). Therefore, increasing awareness about NP competencies could promote the implementation of the *NP Modernization Act*. Also, although the law affects both NPs and physicians, many physicians are unfamiliar with it. Raising awareness about the law, particularly how it can positively affect the practice of NPs and physicians, patient care, and the overall health care system may motivate its implementation.

Nurse practitioner and physician collegiality and leadership's positive perceptions of NP independence and the law facilitate the law's implementation. Physicians speak favorably about the NPs they work with and support NP independent practice if they already have favorable relationships. Our findings suggest that physicians' greater familiarity with NPs increases support for NPs. These findings are consistent with research showing that physicians practicing with NPs have positive attitudes toward them (Street & Cossman, 2010). As the number of NPs grows, it may lead to improved relationships between NPs and physicians and subsequently to a better implementation of laws aimed at loosening restrictions on NP SOP.

Our findings reinforce existing research showing that support for NPs depends on organizational leadership (Poghosyan et al., 2013). In organizations where leadership does not share resources with NPs and/or do not communicate with NPs, teamwork between NPs and physicians suffers, thereby inhibiting state policy adoption (Poghosyan & Liu, 2016). Efforts should promote the relationship between NPs and leadership to aid the implementation of the policy at the practice level.

The study has limitations. The study was conducted in NYS and the findings might not be applicable to other states. A purposive sample of participants was interviewed. Other NPs and physicians, especially from different geographic areas, might have different perspectives. Participants might not be truthful during the interviews. Future large-scale studies are needed. Studies might track how the law affects the supply of NPs

in underserved areas over time. Also, it is important to collect data from leadership.

Conclusion

The *NP Modernization Act* is a major policy accomplishment in NYS. Policy makers and administrators should make efforts to remove the barriers and promote facilitators of the law's implementation to assure the law achieves its maximum impact.

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