Research Protocol for Nurse Practitioner Scope of Practice Laws

Prepared by the Policy Surveillance Program Staff

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Nurse Practitioner Scope of Practice Laws


II. Scope: Compile state statutes and regulations regulating nurse practitioners ("NP") scope of practice. This longitudinal dataset includes coding questions on NPs’ full practice authority, transition to full practice requirements, NPs’ prescriptive authority, and whether NPs must collaborate and/or receive supervision from another health care provider in order to practice.

III. Primary Data Collection

a) Project Dates: Legal research was conducted between January 15, 2015 and April 1, 2016.

b) Dates Covered in the Dataset: May 1, 2015 – April 1, 2016. This began as a cross-sectional dataset. The first date of every state record is the most recent amendment to that particular state’s law at the time of original publication in May 2015. The subsequent records’ effective dates reflect any time that a law in the state record was thereafter amended.

c) Data Collection Methods: The Policy Surveillance Program Team ("Team") building this dataset consisted of two legal researchers ("Researcher #1" and "Researcher #2" or "Researchers") and one Supervisor. The Team researched and collected scope of practice laws for nurses, focusing solely on Nurse Practitioners ("NPs").

d) Databases Used: Searches were conducted using WestlawNext and state-specific legislature websites. Full text versions of the laws were collected and pulled from state legislature websites.

e) Search Terms: The following searches were used in the current (Multistate Legislative Service - (LEGIS-ALL)) bill libraries of Westlaw:
   - adv: “advanced practice nurs!”
   - adv: “nurse practitioner!”
   - adv: "nurse practitioner!" /p scope
f) Initial Returns and Additional Inclusion or Exclusion Criteria: Included laws pertaining to the general scope of NP practice in the state (whether full practice or limited), prescriptive authority of NPs, and specific medical activities that NPs could perform without collaboration and/or supervision. Excluded areas of law include:

- Scope of practice for other types of Advanced Practice Registered Nurses ("APRNs"), including clinical nurse specialists, nurse midwives and nurse anesthetists, other than NPs, unless the state’s law does not differentiate between APRNs and NPs, and/or does not have laws specific to NPs. In such states, laws about APRNs generally were collected and coded.
- Licensing, education and training requirements to obtain an NP license or certification. During the April 2016 update, select licensing laws for four of the eight states that require NPs to participate in a transition to full practice period were scoped in: These states include MD, MN, NE and VT. For the other four states (CO, CT, ME, NV), transition to full practice requirements were already provided in previously gathered scope of practice laws.
- Scope of practice for Licensed Practical Nurses ("LPN").
- Any laws related to controlled substances. The team initially decided to scope these laws out because the provisions for controlled substance regulation varied significantly from standard laws on an NP’s ability to prescribe general prescription legend drugs. During the April 2016 update, laws regulating the prescription of controlled substances were scoped in order to determine whether any limitations were placed on an NP’s ability to prescribe all forms of medication independently of another provider.
- Laws related to dispensing medication: The team scoped these laws out because the provisions of laws related to medication dispensing varied significantly from laws regulating the ability of NPs to conduct other activities. Medication dispensing laws are also very complex and codified in variety of different chapters across state codes and regulations.
- Laws related to the pronouncement of death and ordering of medical equipment were scoped out because of inconsistencies and vagueness in the law. The inclusion of these activities within NPs scope of practice was often
implied in the law already, making their inclusion in this dataset as specific medical activities potentially misleading.

IV. Original Coding (May 2015)

Note: During the April 2016 update, the original coding scheme was reformulated, and all previous questions were removed. The original dataset has been achieved and the data no longer appears on LawAtlas.org. We have included general information below about the development of the original dataset. For a copy of the original protocol, data or other supporting documents, please contact LawAtlas@temple.edu.

a) Development of Coding Scheme: The Team worked in collaboration with Siobhan M. Gilchrist, JD, MPH, a Health Policy Analyst for the Centers for Disease Control and Prevention, to determine the focus of the research and the key questions to be coded. The Researchers then conceptualized coding questions and circulated them for review by the Supervisor. When the questions were finalized, the researchers entered the questions into the LawAtlas Workbench.

b) Quality Control

- The supervisor performed quality control by downloading all coding data into Microsoft Excel and examined the data for any missing answers, incorrect citations, and caution notes.
- 59% of records were redundantly coded by the Team throughout the development of the data set (30 of 51). The Supervisor assigned 100% redundant coding of the first 10 jurisdictions. The rate of divergence was 43%. The supervisor assigned the next 10 jurisdictions for redundant coding and the rate of divergence fell to 16% on April 20, 2015. The Supervisor assigned the next 10 jurisdictions for redundant coding and the rate of divergence again fell to 8% on April 27, 2015.
- The divergences and caution notes were discussed and resolved by the supervisor and researchers in a coding review meeting. Divergences were then recoded to the agreed upon response.
- A naïve coder was brought on to code 20% of the total number of records (11 of 51). The rate of divergence was at 15%. The supervisor conducted a coding review on April 27, 2015. Re-coding was completed and the final rate of divergence was 0%.
Prior to publication, the Supervisor downloaded all coding data into Microsoft Excel to do a final review of coding answers, statutory and regulatory citations, and caution notes. All unnecessary caution notes were deleted and all necessary caution notes were edited for publication.

V. Update (March 1, 2016 – April 1, 2016)

a) Updated Data Collection Methods

The Policy Surveillance Program Update Team (“Team”) consisted of two legal researchers (“Researcher #1” and “Researcher #2”) and one Supervisor. The Team began to research scope of practice laws already included in the dataset for any amendments. However, prior to beginning any data collection for updates, the Team reformulated the scope of the dataset with help from the American Association of Nurse Practitioners (“AANP”). AANP is the largest and only professional association for nurse practitioners of all specialties in the U.S. and subject matter experts in this field. AANP recommended re-formulating all original coding questions in order to better capture the variations in state practice environments across the 51 jurisdictions covered in the dataset. As a result all original coding questions were removed, and 13 new coding questions were included which created an entirely new coding scheme that is discussed below. Based on the new questions, select licensing laws for four of the eight states that require NPs to participate in a transition to full practice period were scoped in: These states include MD, MN, NE and VT. For the other four states (CO, CT, ME, NV), transition to full practice requirements were already provided in previously gathered scope of practice laws. During the update, laws regulating the prescription of controlled substances were also scoped in order to determine whether any limitations were placed on an NP’s ability to prescribe all forms of medication independently of another provider.

b) Databases Used

Searches were again conducted using WestlawNext and state-specific legislature websites. Full text versions of the laws were collected and pulled from state legislature websites.

c) Search Strategy

The Researchers supplemented prior research to include transition to practice requirements by reviewing the table of contents chapters on nurse practice acts to locate transition to practice requirements within the law. Again, MD, MN, NE and VT contained transition to practice requirements within their NP SOP licensure laws which the Team included for purposes of the updated dataset. Prior research was also supplemented to include select laws related to the prescription of controlled substances in order to determine whether any limitations were placed on an NP’s ability to prescribe all medication types independent of another provider. UT’s laws on the prescription of controlled substances by NPs were scoped in for this reason.

d) Updated Findings

- Overall, a total of 22 jurisdictions had updates, and three jurisdictions contained amendments that impacted coding for the original records recoded under the new scheme. NE and MD contained changes removing the requirement that NPs must collaborate, or work under, the supervision of a provider in order to practice. CO law reduced the number of NP transition to practice hours from 1,800 to 1,000 and added a provision permitting NPs to collaborate with another NP during their transition period.

e) Updated Coding Methods

- All 51 original records (that were valid-through May 1, 2015) were recoded under the new coding scheme. Of the 51 original records, MD, MN, NE and VT were recoded after adding in the licensure laws scoped in as discussed above (See V(a) Updated Data Collection Methods). Thereafter, updated records were created for all 22 states with updates. During the recode, the Team met bi-weekly as a group and consulted with AANP to refine the coding scheme as needed to include to the most direct indicators of NP scope of practice. Below are specific rules used when coding the reformulated questions and answer choices in the dataset:

**Question:** “Are nurse practitioners provided full practice authority under the law?”

- This question was added in order to allow users to easily identify which jurisdictions provided NPs full and autonomous practice authority.
- States were coded as “Yes” where the law does not require an NP to collaborate or receive supervision from a provider in order to practice.
“Collaboration” includes any language explicitly requiring an NP to collaborate and/or enter a collaborative agreement with a provider. “Supervision” includes explicit use of the word “supervision,” “supervise,” or “delegation,” including a requirement that an NP enter a delegation and/or protocol agreement with a provider in order to conduct a particular activity.

Question: “Is a transition to practice period required before a nurse practitioner is granted full practice authority?”

- This question was only answered where “Yes” was coded for the previous question: (“Are nurse practitioners provided full practice authority under the law?”).
- This question was added to capture transition to practice requirements found in eight full practice states. This question was coded “Yes” where the law explicitly required NPs to collaborate or work under the direction of another provider for a specific period before being provided full practice authority. “Yes” was also only coded where the transition period was 1) temporary; 2) required for an NP to conduct one or more activities; and 3) required some formal relationship with a provider during the transition period (regardless of whether a formal written agreement was required or not).

Question: “Which provider may a nurse practitioner collaborate with during the transition to practice period?”

- This question was only answered where “Yes” was coded for the previous question: (“Is a transition to practice period required before a nurse practitioner is granted full practice authority?”).
- During all transition to practice periods, NPs must collaborate with a specific type of healthcare professional/provider. Certain providers were consolidated into the following response categories:
  - Physician: Includes “Doctor,” any licensed “Medical Doctor,” “MD,” “Osteopathic Physician” or “OP”.
  - Nurse Practitioner: “Nurse Practitioner” was also coded where the law indicated Advanced Practice Registered Nurses (APRNs), which include NPs.
  - Advanced Practice Registered Nurses (Non-NP APRN): Include all non-NP APRNs such as clinical nurse specialists, certified nurse midwives, or certified registered nurse anesthetists. This response was coded in addition to “Nurse Practitioners” when the law stated
all APRNs could collaborate with an NP during the transition to practice period.

**Question:** “What is the length of the transition to practice period?”

- This question was only answered where “Yes” was coded for the previous question: (“Is a transition to practice period required before a nurse practitioner is granted full practice authority?”).
- The length of the transition to practice periods varied across jurisdictions. Researchers coded multiple responses where 1) the law required a combination of time periods; or 2) the law provided more than one option. For example, NV requires a transition period of 2,400 hours or two years. In contrast, Connecticut requires a transition period of 2,000 hours and three years. Caution notes were provided for states which required multiple answers. Additionally, answer choices were conceptualized as followed:
  - 24 months: Includes “two years”; and
  - 36 months: Includes “three years.”

**Question:** “Does the law limit the practice authority of nurse practitioners?”

- The Team added this question in order to allow users to easily identify which jurisdictions limited the practice authority of nurse practitioners.
  - This question is the inverse of the first question “Are nurse practitioners provided full practice authority under the law?” Thus, states that provide full practice do not limit the practice authority of NPs and vice versa.
  - States were coded “Yes” whenever an NP was required to collaborate, enter into a written agreement, and/or receive any form of supervision or delegation from another provider in order to practice. In contrast, “No” was coded if a state provided full practice authority as defined in the dataset’s first question.
  - Optional consultation, referral, or collaboration with another provider was not coded as limiting an NP’s practice authority.

**Question:** “Must nurse practitioners collaborate with a provider as part of their practice?”
This question was only answered where “Yes” was coded for the previous question: ("Does the law limit the practice authority of nurse practitioners?").

After consulting with AANP, the research Team decided to create a separate question specifying whether an NP was required to collaborate with another provider. Research revealed that required collaboration was a distinct form of limitation placed on an NP’s practice authority.

- This question was coded “Yes” whenever the law required an NP to collaborate and/or enter into a collaborative practice agreement with another provider to conduct one or more activities. This question was coded “no” where the law required supervision in order for an NP to conduct all activities. For example, NC and FL require a collaborative practice agreement but require supervision for all activities.
- Optional consultation, referral or collaboration with another provider was not coded as requiring collaboration.

**Question:** “Must a nurse practitioner collaborate with a provider in order to prescribe medication?”

- This question was only answered where “Yes” was coded for the question: ("Must nurse practitioners collaborate with a provider as part of their practice?").
- Prescriptive authority is a specific practice area where NPs are commonly required to collaborate with another provider. For this reason, the Team decided to make this a separate question.
- “Yes” was only selected where the law explicitly required collaboration in order to prescribe legend or controlled drugs.

**Question:** “What activities can nurse practitioners perform without collaboration?”

- This question was only answered where “Yes” was coded for the question: ("Must nurse practitioners collaborate with a provider as part of their practice?"). This question captures any activities NPs may conduct autonomously where NPs are required to collaborate with another provider in order to conduct one or more other activities.
- Responses were only selected where the state explicitly indicated an NP could conduct an activity 1) autonomously; and/or 2) where the law included no language requiring an NP to perform the activity in collaboration with another provider. The responses were conceptualized and/or consolidated as follows:
Manage a patient’s treatment” includes explicit use of, including with any tenses (ing, ate, ent), for “manage,” “administer,” “provide,” “coordinate” and “deliver” treatment as well as any other language showing the direct ability to provide treatment.

“Initiate appropriate treatment” includes explicit use of, including with any tenses (ing, ate, ent), for “initiate,” “begin,” “develop,” “prescribe” and “commence” as well any language demonstrating an NP can begin a new form of treatment for a patient.

“Perform medical diagnosis” includes explicit use of “perform,” “conduct,” and “provide” medical diagnosis as well as “diagnose” used alone to describe an NPs ability to perform this activity. This does not include the ordering of medical or diagnostic tests or the review of patient medical information of which separate answer choices were developed to code these activities.

“Make referrals to specialists” indicates the ability to refer patients to other “medical professionals.” Also coded where the law explicitly stated NP’s may conduct “referrals” broadly. This response was not selected when the law only indicated NP’s could refer patients to general health or community resources.

“Law does not indicate specific activities nurse practitioners can perform without collaboration” was selected where the law was not clear as to whether NPs had the ability to perform any activities without collaboration. This answer choice was created by the Team to capture those states which did not explicitly prohibit NPs from performing a particular activity without collaboration and was silent on the matter.

“Nurse practitioners are not authorized to conduct any activities without collaboration” was selected wherever the law required NPs to collaborate with a provider in order to conduct any activity.

**Question:** “Must nurse practitioners be supervised by a provider as part of their practice?”

- This question was only answered where “Yes” was coded for the question: (“Does the law limit the practice authority of nurse practitioners?”).
- After consulting with AANP, the research Team decided to create a question specifying whether an NP was required to work under the supervision of another provider. Research revealed that supervision was a distinct form of limitation placed on an NP’s practice authority. In contrast to collaboration,
supervision requirements are frequently more restrictive, requiring NPs to report to a provider regularly, be closely monitored, and/or only conduct activities that were delegated to them under a written agreement.

- This question was coded “Yes” whenever the law explicitly required an NP to be “supervised” and/or receive “supervision” in order to conduct one or more activities.
- “Yes” was also coded where a provider was required to “delegate” an activity to an NP and/or the NP had to enter a delegation or protocol agreement before they could conduct one or more activities.
- Some states required both collaboration and supervision. In these states “Yes” was coded for both questions unless supervision was required for all activities. States that require supervision and collaboration include VA, MO, IL. These states require collaboration for all activities and only supervision in order for an NP to prescribe medication.
- Optional consultation, referral, or supervision from another provider was not coded as requiring supervision.

**Question:** “Must a nurse practitioner be supervised by a provider in order to prescribe medication?”

- This question was only answered where “Yes” was coded for the question: (“Must nurse practitioners be supervised by a provider as part of their practice?”).
- Prescriptive authority is a specific practice area where supervision and/or delegation is commonly required. For this reason, the Team decided to make this a separate question.
- “Yes” was only selected where the law explicitly required supervision or delegation in order for an NP to prescribe legend or controlled drugs.

**Question:** “What activities can nurse practitioners perform without supervision?”

- This question was only answered where “Yes” was coded for the question: (“Must nurse practitioners be supervised by a provider as part of their practice?”).
- This question captures any activities NPs may conduct autonomously where NPs are required to be supervised by another provider in order to conduct one or more other activities.
- Responses were only selected where the state explicitly indicated an NP could conduct 1) the activity autonomously or in collaboration with another provider;
and/or 2) where the law included no language requiring NPs to receive supervision or delegation from a provider in order to conduct the activity.

  o “Law does not indicate specific activities nurse practitioners can do without supervision” was selected where the law did not indicate whether NPs had the ability to perform any activities without supervision. This answer choice was created by the Team to capture those states which did not explicitly prohibit NPs from performing a particular activity without supervision but was silent.
  o Nurse practitioners are not authorized to conduct any activities without supervision” was selected wherever the law required NPs to receive supervision from a provider in order to conduct any activity.

IV. Quality Control

Quality control consisted of the Supervisor exporting the data into a Microsoft Excel document each day the Researchers completed coding to examine the data for any missing entries, citations, and caution notes and to calculate divergence rates. 27% of the records were redundantly coded throughout the life of the update. Redundant coding revealed a divergence rate of 10% on May 3, 2016. The Team discussed all divergences throughout the process and re-coded as necessary.

Prior to publication, the Supervisor downloaded all coding data into Microsoft Excel to do a final review of coding answers, citations, and caution notes. All unnecessary caution notes were deleted and all necessary caution notes were edited.