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 nurse practitioner (“NP”) scope of practice statutes and regulations, which delineate the extent of their autonomy to practice without collaborating with another health care provider. This dataset began as a cross-sectional study in 2015 and was updated through August 1, 2017. The current longitudinal dataset includes relevant laws and regulations effective from May 1, 2015 to August 1, 2017. The Policy Surveillance Program (“PSP”) conducted research and created this dataset in collaboration with the National Nurse-Led Care Consortium (“NNCC”).

III. Primary Data Collection


b) Dates Covered in the Dataset: May 1, 2015 – August 1, 2017. This began as a cross-sectional dataset. Two updates were performed in April 2016 and August 2017 to create a longitudinal dataset.

c) Data Collection Methods: The research team (“Team”) building this dataset consisted of two legal researchers (“Researchers”) and one supervisor (“Supervisor”) from the Policy Surveillance Program along with a consulting Supervisor from the NNCC. The Team researched and collected scope of practice laws for nurses, focusing on nurse practitioners.

After relevant statutes and regulations were identified, the Researchers created a Master Sheet for each jurisdiction. A Master Sheet is an internal document that includes citations, effective dates, and statutory history for all relevant statutes and regulations included in the project’s scope.
The first 10 jurisdictions assigned were 100% redundantly researched by both Researchers to confirm that all relevant law was being collected; 20% of the remaining jurisdictions were redundantly researched.

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

e) Search Terms: “advanced practice nurse!;” “nurse practitioner!;” “nurse practitioner!" /p scope; nurse! /p scope
   - Keyword searches performed by the Researchers were supplemented by reviewing the table of contents of the sections of state law related to NP scope of practice. All chapters were examined in their entirety for relevant law. The Researchers also collected effective dates for the most recent version of relevant statutes and regulations.

f) Information about initial returns and additional inclusion or exclusion criteria:

Included areas of law include:
   - Laws pertaining to the general scope of NP practice authority in the jurisdiction (whether full practice or limited practice), prescriptive authority of NPs (legend drugs and controlled substances), specific medical activities that NPs could perform without collaboration and other common supervision requirements found in the law.

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 jurisdiction’s law does not differentiate between APRNs and NPs, and/or does not have laws specific to NPs. In such jurisdictions, laws about APRNs generally were collected and coded.
   - Licensing, education and training requirements to obtain an NP license or certification.
     - During the April 2016 and August 2017 updates, select licensing laws for jurisdictions that require NPs to participate in a transition to full practice period were scoped in: These jurisdictions include MD, MN, NE, SD and VT.
   - Scope of practice for Licensed Practical Nurses (“LPNs”).
Laws related to dispensing medication: The team scoped out these laws 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 a variety of chapters across different 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 is often implied in the law already; therefore, including those activities in the dataset as discrete medical activities could be potentially misleading.

Coding (May 2015)¹

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

- Quality Control – Background research: The first 10 jurisdictions assigned were 100% redundantly researched to confirm that all relevant law was collected by the Researchers; 20% of the remaining jurisdictions were redundantly researched.

- Quality Control – Coding: Logistically, 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. Redundant coding was also completed in batches of 10 jurisdictions at a time, with the Supervisor identifying divergences in each batch.

¹ During the April 2016 update, the original coding scheme described in this section was reformulated, and all previous questions were removed. The original dataset has been archived and the data no longer appears on LawAtlas.org. This section includes general information about the development of the original dataset. For a copy of the original protocol, data or other supporting documents, please contact LawAtlas@temple.edu.
The Supervisor assigned 100% redundant coding of the first 10 jurisdictions. Due to the complexity of the subject matter, the rate of divergence was 43%. The Supervisor then assigned the next 10 jurisdictions for redundant coding and the rate of divergence fell to 16%. The Supervisor then assigned the next 10 jurisdictions for redundant coding and the rate of divergence again fell to 8%. Fifty-nine percent of records were redundantly coded by the Team throughout the development of the dataset (30 of 51).

- **Quality Control – Naïve Coding:** After all coding was completed, a naïve coder coded 20% of the total number of records (11 of 51). The rate of divergence was 15%. The Supervisor then conducted a coding review to resolve all divergences and any re-coding was completed by the Researchers.

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.

IV. Update (April 2016)

a) **Scope:** Prior to beginning the April 2016 update, 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.² AANP recommended reformulating 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. This established an entirely new coding scheme, discussed below.**

Based on the new questions, select licensing laws were scoped in for jurisdictions (MD, MN, NE and VT) that require NPs to participate in a transition to full practice period. Laws regulating the prescription of controlled substances were also scoped in in order to determine whether any limitations were placed on an NP’s ability to prescribe all forms of medication independently of another provider.

After all new laws were identified based on the reformulated scope, all relevant laws and amendments effective after the original May 1, 2015 valid-through date of the dataset were collected. This update changed this dataset from a cross-sectional to a longitudinal dataset, capturing all relevant laws in effect from May 1, 2015 to April 1, 2016.

b) **Data Collection Methods:** The Supervisor and one Researcher checked legal citations on Westlaw and legislative tracking websites for any amendments or newly enacted law that passed after May 1, 2015. In addition, the search terms listed in section III(e) were used to search for any new laws that had been enacted since the last data collection phase. The Researcher created new records (a record refers to a set of coded responses for each jurisdiction, for each point in time included in the dataset) and updated legal text for jurisdictions with new laws or changes to existing laws that affected answer choices. The Researcher cloned records and updated the legal text for jurisdictions with changes that did not affect answer choices.

c) **Updated Findings:** Twenty-two jurisdictions had updates, and three jurisdictions contained amendments that impacted coding for the original records recoded under the new scheme.

d) **Coding Methods:** During the April 2016 update, all 51 original records were recoded under the new coding scheme. Thereafter, updated records were created for all 22 jurisdictions with updates. During the recode, the Team met bi-weekly and consulted with AANP to refine the coding scheme as needed to include the most direct indicators of NP scope of practice.

e) **Quality Control**

- **Quality Control – Background Research:** The Researcher supplemented prior search terms to include transition to practice requirements by reviewing the table of contents chapters of 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.
The Supervisor reviewed the Researcher’s results for jurisdictions with any newly added laws and for those with updates to ensure all amendments were accurately captured.

- **Quality control – Coding:** 27% of the records were redundantly coded throughout the update under the new scheme, which included all three jurisdictions with substantive updates (NE, MD, CO). 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 until a 0% divergence rate was reached.

Logistically, quality control also consisted of the Supervisor exporting the updated data into Microsoft Excel and checking for completed coding of answers, citations, and caution notes.

V. **Update (August 2017)**

a) **Scope:** Prior to beginning the August 2017 update, the Team partnered with the National Nurse-Led Care Consortium (“NNCC”) in order to further expand the existing dataset by integrating six questions from the Nurse Practitioner Prescribing Laws dataset that was created by NNCC in October 2015. NNCC tracks healthcare policy developments that impact their member health clinics, which are generally managed by nurse practitioners. The six questions added from NNCC’s Nurse Practitioner Prescribing Laws dataset to this dataset explore practice restrictions that apply to prescribing, as well as to other clinical activities. In order to code the newly integrated questions, select laws related to physician and NP collaboration requirements were scoped in for jurisdictions that limit the practice authority of NPs. These requirements include mandated in-person and telecommunication meetings, on-site collaborative practice, chart review, and the ratio of collaborating health care providers to collaborating NPs.

After all new laws were identified based on the expanded scope, all relevant laws and amendments effective after the original May 1, 2015 valid-through date of the dataset were collected. This update expanded the longitudinal duration of this dataset to capture all relevant laws in effect from May 1, 2015 to August 1, 2017.

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b) Data Collection Methods: A Supervisor at PSP, a Supervisor at NNCC, and two Researchers checked all legal citations on Westlaw and legislative tracking websites for any amendments or any newly enacted legislation from after April 1, 2016. In addition, the search terms listed in section III(e) were used to search for any new laws that had been enacted since the last data collection phase. The Researchers created new records with updated legal text for jurisdictions with new laws or changes to existing laws that impacted answer choices. The Researchers cloned records and updated the legal text for states with changes that did not impact answer choices.

c) Updated Findings: Twenty-four jurisdictions had updates, and four jurisdictions (GA, MS, ND, SD) contained amendments that impacted coding for original records that were recoded under the expanded scheme.

d) Coding Methods: During the August 2017 update, the six new questions adapted from NNCC’s Nurse Practitioner Prescribing Laws dataset were coded for all existing records in jurisdictions that limit NP practice authority. Thereafter, updated records were created for all 24 jurisdictions with updates. Throughout the coding of new questions, the PSP and NNCC Team met bi-weekly to refine the coding scheme as needed, and to ensure a precise and unified integration of PSP and NNCC datasets.

The following details specific rules that were utilized to code the questions and responses in the dataset:

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

- This question was created in order to allow users to easily identify which jurisdictions provide full and autonomous practice authority to NPs.
- Jurisdictions 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. Collaboration and supervision also include any requirements that NPs enter into a “practice agreement,” “protocol,” or other similar relationship with another healthcare practitioner in order to conduct activities.
There is one exception for IA, which was coded as full practice even though the law required a collaborative practice agreement between a practicing physician and NP. This coding decision was based on direct feedback from our subject matter experts at AANP. AANP recommended coding IA as full practice based on the law’s description of the collaborative relationship between an NP and physician which identifies both providers as independent and joint decision makers with no supervision requirements specified. Iowa Admin. Code r. 655-7.1(152). Under IA’s law, “collaboration” is defined as a “process whereby an ARNP and physician jointly manage the care of a client.” Iowa Admin. Code r. 655-7.1(152). A “collaborative practice agreement” also “means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner.” Iowa Admin. Code r. 655-7.1(152).

**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 imposed in ten jurisdictions that authorize full practice. This question was coded “Yes” where the law explicitly requires NPs to collaborate or work under the direction of another provider for a specific period before being provided full practice authority.
  - “Yes” was coded where the law requires NPs to practice pursuant to a formal relationship with a provider during a temporary transition period (regardless of whether a formal written agreement is required).
  - Where a transition to practice period was only required in order to carry out certain clinical activities, a caution note was provided. For example, CO only requires a transition period in order to prescribe medication.

**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. Providers were consolidated into the following response categories:
  o “Physician”: Includes “Doctor,” any licensed “Medical Doctor,” “MD,” “Osteopathic Physician,” or “OP.”
  o “Nurse Practitioner”: Includes explicit references to “nurse practitioners.” “Nurse Practitioner” was also coded where the law indicated collaboration with Advanced Practice Registered Nurses (APRNs), since NPs are a type of APRN.
  o “Advanced Practice Registered Nurses (Non-NP APRN)”: Includes 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?”

• 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, Nevada 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 jurisdictions that required multiple answers.

• Additionally, answer choices were conceptualized as followed:
  o “24 months”: Includes “two years”; and
  o “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 jurisdictions that limit the practice authority of nurse practitioners. It is the inverse of “Are nurse practitioners provided full practice authority under the
Thus, jurisdictions that provide full practice authority do not limit the practice authority of NPs and vice versa.4

- Jurisdictions were coded “Yes” where an NP was required to collaborate, enter into a written agreement, protocol, or collaborative practice agreement, and/or receive any form of supervision or delegation from another provider in order to perform an activity. In contrast, “No” was coded where a jurisdiction provided full practice authority as defined in the dataset’s first question.

- Again, as described under the question “Are nurse practitioners provided full practice authority under the law?”, there is one exception for IA that was coded as not limiting an NP’s practice authority where a collaborative practice agreement exists based on direct feedback from subject matter experts, AANP. AANP recommended coding IA as full practice based on the law’s description of the collaborative relationship between an NP and Physician which identifies both providers as independent and joint decision makers with no supervision requirements specified. Iowa Admin. Code r. 655-7.1(152).

- Optional consultation, referral, or collaboration with another provider was not coded as limiting an NP’s practice authority.

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

- This question was only answered where “Yes” was coded for the question: “Does the law limit the practice authority of nurse practitioners?”
- Prescriptive authority is a specific practice area where NPs are commonly required to collaborate with and/or be supervised by another provider. For this reason, the Team decided to make this a separate question.
- This question was answered “Yes” if an NP could not exercise prescriptive authority for legend drugs or controlled substances without the “collaboration” or “supervision” of another healthcare practitioner. This question was also answered “Yes” if there were any requirements that NPs enter into a “practice agreement,” “protocol,” or other similar relationship with another healthcare practitioner in order to conduct all clinical activities.

4 During the duration of this dataset NE, MD, SD and DE passed laws that provide full practice authority to NPs. Thus, responses to this question were changed to “No” on the date that full practice authority amendment(s) became effective in these states.
• Where collaboration was only required in order to prescribe a specific type of medication(s), a caution note was provided. For example, Utah only requires collaboration to prescribe Schedule II and III controlled substances. West Virginia also only requires collaboration to prescribe Schedule II controlled substances.

Question: “What activities can nurse practitioners perform independently of another provider?”

• This question was only answered where “Yes” was coded for the question: “Does the law limit the practice authority of nurse practitioners?”
• This question captures any activities that NPs may conduct autonomously where NPs are required to collaborate with another provider in order to conduct one or more other activities.
• Individual responses were selected where the jurisdiction explicitly indicated an NP could conduct an activity autonomously; and/or where the law did not include language requiring an NP to perform the activity in collaboration with another provider and/or supervision with another provider. The responses were conceptualized as follows:
  o “Perform examinations”: Includes explicit use of “examination” (“physical examination”)
  o “Perform diagnosis”: Includes explicit use of “perform,” “conduct,” and “provide” diagnosis, as well as “diagnose” or “diagnosis” used alone to describe an NP’s ability to perform this activity. Diagnosis does not include the ordering of medical or diagnostic tests or the review of patient medical information; separate answer choices were developed to code these activities. Diagnosis also does not include the explicit authorization of an NP to conduct a “nursing diagnosis” or where the law indicates the type of diagnosis performed by an NP was different and/or distinct from a physician. Examples of where “Perform diagnosis” was coded include:
    ▪ The NP is “responsible and accountable for…a broad range of health services, which include…diagnosis and prescription of medications, treatments, and devices for acute and chronic conditions and diseases.” Okla. Admin. Code § 485:10-15-6(b)(2)(C).
- “Perform an advanced assessment”: Includes explicit use of the phrase, as well as “comprehensive assessments.” It was not coded where “assessment” was used without reference to “advanced.”
- “Order tests”: Includes explicit use of the phrase, as well as for “ordering” or “initiating” of “laboratory,” “imaging,” or “diagnostic” tests or “studies.”
- “Interpret patient medical information”: Includes “interpreting” of “laboratory and imaging studies,” and “analyzing and synthesizing data.” (La. Rev. Stat. § 37:913(3)(a)(i)). Also includes explicit use of the term “evaluation.” Examples include:
  - “observation, assessment, diagnosis, intervention, evaluation, rehabilitation, care and counsel, and health teachings of persons who are ill”; 22 Tex. Admin. Code § 221.13(c).
- “Administer medication”: Includes explicit use of the terms “administer” or “administration” of drugs or medications. This response was not dependent on whether or not the NP could independently prescribe the drug or medication the NP was administering. For example, AR authorizes NP to administer “medications and treatments as prescribed by practitioners authorized to prescribe and treat in accordance with state law,” Ark. Code § 17-87-102(9)(E). Where collaboration was only required in order to administer a specific type of medication(s) a caution note was provided. For example, Utah only requires collaboration to administer Schedule II and III controlled substances. Utah Code Ann. § 58-31b-102(13)(c)(ii).
- “Counsel or educate patients”: Includes explicit use of “counseling,” as well as “consultations,” “guidance,” “teaching.” Examples include:
- “Initiate treatment”: Includes explicit use of, including with any tenses (ing, ate, ent), for “initiate,” “begin,” “develop,” “order,” “prescribe” “institute” and “commence” as well as any language demonstrating an NP can begin “treatment” for a patient, absent the preceding language. Examples include:
- “practice activities include, but are not limited to: advanced assessment, diagnosis, treatment, referrals, consultations and other modalities”; 244 Mass. Code Regs. 4.02.
  - "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 indicating the direct ability to provide treatment. Also coded for “interventions” or “maintenance” of treatment. Examples include:
    - “manage preventive care services, and diagnose and manage deviations from wellness and long term wellness”; N.J. Stat. § 45:11-49(a)(1).
    - “coordinates health care plans to enhance the quality of health care and diminish both fragmentation and duplication of service”; 067.00.3 Code Ark. R. § 1(B)(f).
    - “advanced assessment, diagnosis, treatment, referrals, consultations, and other modalities for individuals, groups or communities across the life span for health promotion or health maintenance”; 244 Mass. Code Regs. 4.02.
    - “promotion and maintenance of health or prevention of illness”; See 22 Tex. Admin. Code § 221.13(c).
    - “correction”; (“treatment, correction… for common health problems.” See Utah Code Ann. § 58-31b-102(14)(b)
    - “coordinates health care plans to enhance the quality of health care and diminish both fragmentation and duplication of service”; 067.00.3 Code Ark. R. §1(B)(1)(f).
  - “Make referrals to specialists”: Includes explicit use of “referrals,” to other “medical professionals” or “licensed health care professionals.” Also coded where the law explicitly states that NPs may conduct “referrals,” broadly. This response was not selected when the law only
indicates NPs could refer patients to general health or community resources. Examples include:

- “referrals, consultations, and other modalities”; 244 Mass. Code Regs. 4.02.
- Coded when activities of an NP are done “in collaboration with the health team.” See 22 Tex. Admin. Code § 221.13(c).
- “Make assignments to others that take into consideration client safety”; 22 Tex. Admin. Code § 217.11(1)(S).

- “Law does not indicate specific activities nurse practitioners can perform independently”: 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 or supervision: i.e., the law was silent on the matter. Includes instances where the law did not provide for full practice authority, but also did not explicitly list activities that NP could do without collaboration.

- “Nurse practitioners are not authorized to conduct activities independently”: Selected wherever the law required NPs to collaborate with or receive supervision from another health care provider in order to conduct any activity. If states explicitly use the word “independently” to describe certain actions an APRN may perform, this answer choice is still coded if there is a general collaboration or supervision requirement in order for the NP to practice. Examples include:
  - Prior to DE becoming a full practice state on September 1, 2015, APRNs were authorized to apply to a Joint Practice Committee for the right to “engage in independent practice.” However, NPs were still required to maintain a collaborative practice agreement with a licensed physician, dentist, podiatrist, or licensed Delaware health care delivery system in order to practice; see Del. Code tit. 24, Â§ 1902(b)(1). For this reason, “Nurse practitioners are not authorized to conduct any activities independently” was coded; see Del. Code tit. 24, § 1902(b)(2).
In MI, due to the lack of detail in the law, subject matter experts were consulted and this response was coded for NPs using the general physician delegation requirements that apply to registered nurses.

Note: The six questions below were adapted from NNCC’s Nurse Practitioner Prescribing Laws dataset and added to this dataset during the August 2017 update, in collaboration with NNCC. The scope of these questions was also expanded from their previous application, which focused on prescriptive authority, to apply to all clinical activities. Where a specific supervision requirement only applied to one or more clinical activities, and/or was changed based upon the amount of time an NP and a collaborating provider have been in practice together, a caution note was provided. Caution notes were also provided where a supervision requirement varied according to the practice settings and/or patient population treated.

Question: “How frequently must a nurse practitioner meet with a collaborating provider in person?”

- An in-person meeting requirement was coded wherever explicitly indicated in the law, or where “direct communication” between an NP and collaborating provided was required and delineated “direct communication” from other forms of communication, such as telecommunication or electronic communication.
- In-person meeting requirements were also coded where the law required “meetings” without specifying how the meetings must be conducted. For example, NC law states that a nurse practitioner and the primary supervising physician shall have monthly meetings for the first six months to discuss practice relevant clinical issues and quality improvement measures. 21 N.C. Admin. Code 36.0810(4)(c).
- “Once per month” was coded where explicitly indicated or where the law states at least once every thirty days.
- “Frequency of in person meetings is not specific in the law” was coded when a collaborating provider and NP must meet in-person as described, but there is no frequency specified. It is also coded where no frequency is specified and an NP has the option to choose between different methods of communication, including in-person meetings. For example, IL states “Methods of communication shall be available for consultation with the collaborating physician... in person or by telecommunications in accordance with established written guidelines as set forth in the written agreement.” 225 Ill. Comp. Stat. Ann. 65/65-35(b).
“Law does not include in person meeting requirement” was coded where no direct communication or meeting requirement was present.

**Question:** “How frequently must a nurse practitioner meet with a collaborating provider by telecommunication?”

“Frequency of telecommunications meetings is not specified in the law” was coded in the following circumstances:
- When a collaborating health care provider and an NP must be available by telecommunication, but no frequency is specified.
- When a collaborating health care provider and an NP have an option to choose between several methods of communication, including telecommunication with no frequency specified. Examples include:
  - “Methods of communication shall be available for consultation with the collaborating physician…in person or by telecommunications in accordance with established written guidelines as set forth in the written agreement.” 225 Ill. Comp. Stat. Ann. 65/65-35(b).
  - “when the collaborating physician is not in direct personal contact with the nurse practitioner…the physician must be available by telecommunication.” S.D. Admin. R. 20:62:03:04.
  - “the collaborating physician must be easily in contact with the APRN by radio, telephone, electronic or other telecommunication device.” 060.00.1-30 Code Ark. R.
  - “collaborative relationships shall mean that a nurse practitioner communicates, in person, by telephone, or through written means, including electronically, with a physician who is qualified to collaborate in the specialty involved.” N.Y. Comp. Codes R. § Regs. tit. 8, § 64.5(g)(1)(i).
- When “electronic communication” is listed as another communication option, a caution note was provided.
- “Law does not include telecommunication meeting requirement” was coded when a communication requirement was stated, but there was no explicitly specified type of communication delineated. It was also coded when the only communication requirement is “electronic communication,” for which a caution note is provided.

**Question:** “How frequently must a nurse practitioner practice with collaborating provider on-site?”
• On site practice requirements were coded where “on-site” practice was explicitly stated and/or where the law required an NP and collaborating provider to work together in each other’s presence.


Question: “What percentage of charts must a nurse practitioner submit to a collaborating provider for review?”

• “Percentage of charts for review is not specified in the law” was coded where no explicit percentage is provided and/or where the physician has the discretion to determine the number or percent of charts that must be reviewed.

• Where the law only requires that charts be reviewed on a time-based frequency, a caution note was provided. For example, NY states, “The practice agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months.” N.Y. Education Law § 6902(3)(a)(iii).

Question: “How many nurse practitioners are permitted to collaborate with a provider?”

• Ratios of NP to collaborating provider practice requirements were coded where the law explicitly limited the number of NPs a collaborating provider could supervise and/or engage in a practice agreement. When multiple answer choices are selected, a caution note is provided to explain the ratio requirements. For example: Virginia has both “four” and “six” answer choices coded because a physician can only enter into prescriptive authority agreements with at most four NPs, but can be the “physician on patient care team” for at most six NPs. Va. Code § 54.1-2957.01(E)(2); 18 Va. Admin. Code § 90-40-100(A).

e) Quality Control

• Quality Control – Background Research: The Team reviewed all laws previously collected by NNCC to code their Nurse Practitioner Prescribing Laws Dataset and collected any laws diverging from those collected by PSP during their April 2016 reformulation of NP SOP dataset in order to
code the six new questions integrated into the dataset during the August 2017 update. During the background research phase the Team also removed any law no longer in scope due to the April 2016 dataset reformulation.

To ensure all relevant law was collected, the Researchers also used prior search terms included in section III(e) to search for any new laws that had been enacted since the last data collection phases for PSP and NNCC. Researchers further reviewed the table of contents of nurse practice acts to verify that all supervision requirements captured by the six new questions were collected. 20% of jurisdictions were also redundantly researched (10 of 51). The Supervisors reviewed the Researchers redundant research and research for any jurisdictions with any newly added laws and/or updates to ensure all amendments were accurately capture.

- **Quality Control – Coding:** Logistically, quality control also consisted of one Supervisor exporting the updated data into Microsoft Excel and for checking for completed coding of answers, citations, and caution notes. 29% of jurisdictions were also redundantly coded throughout the update under the expanded scheme (15 of 51). Two rounds of redundant coding were completed. The first round included ten jurisdictions and revealed a divergence rate of 5.8%. The second round of redundant coding included five jurisdictions and revealed a divergence rate of 11.9%. The Team discussed all divergences throughout the process and re-coded as necessary until a 0% divergence rate was reached.

- **Quality Control – Final Data Check:** The Team also reviewed coding for all 36 jurisdictions not redundantly coded to ensure all resolutions reached during the two coding reviews were implemented uniformly across all jurisdictions’ records in the dataset.

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.