Barriers to Practice and Impact on Care: An Analysis of the Psychiatric Mental Health Nurse Practitioner Role

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Abstract

This paper is a retrospective review of the literature analyzing the role of the psychiatric mental health nurse practitioner role in the community. Presented here is an appraisal of national and state mental health initiatives. Professional nursing regulations are reviewed, focusing on New York State advanced practice nursing. Barriers to practice are assessed with discussion on how barriers, such as statutory collaboration, impede access to treatment in the community for mentally ill psychiatric patients. The current New York State legislative agenda is featured. Clinical vignettes from a nurse practitioner's private community practice are presented to introduce and conclude how clinical practice barriers impede autonomous practice.

Clinical vignette (2007)

An advanced practice psychiatric mental health nurse practitioner (APRN-PMHNP) provides mental health services within a small community-based private practice. The New York State Nurse Practice Act mandates that a psychiatric nurse practitioner (NP) maintain a statutory collaborative agreement with a collaborating psychiatrist in order to provide comprehensive mental health services. Although some third-party insurance companies authorize APRN-PMHNPs on panels, a collaborative agreement must be established with a psychiatrist from each insurance panel. This becomes a critical issue when the collaborative psychiatrist decided to close his practice and abruptly discontinued the collaborative agreement. In order to prevent discontinuity in care, the APRN-PMHNP needed to establish a collaborative agreement with another psychiatrist and develop a practice agreement (Form 4NP) based on protocols established by the State of New York. This time-consuming process resulted in a disruption in treatment for several patients. The APRN-PMHNP managing this case reported a major incident by a high-risk patient that occurred as a result of this disruption in continuity of care. This case vignette highlights the potential negative consequences related to statutory collaborative agreements as well as the ability of an APRN-PMHNP to provide effective, safe, and consistent care.

Introduction

Several national initiatives in the past decade have identified mental healthcare indicators that have addressed system issues and the efficiency of access to mental health treatment by consumers within the community. Healthy People 2010, Healthy People 2020, and the National Consensus Statement on Mental Health Recovery are only a few of the national initiatives that are recognizing the lack of access and need for

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more mental health providers The National Business Group on Health is a health non-profit membership organization that includes 60 Fortune 100 companies, and employs 55 million workers. This organization recognized a need and set a goal to improve delivery of behavioral health care in general medical and mental health sectors (U.S. Department of Health and Human Services, 2007). In addition to the above, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2003) recognized the need to provide more mental health research and to place more providers trained in evidence-based practice into the community. SAMHSA is the largest supporter of mental health grant opportunities for mental health innovation and demonstration programs (SAMHSA, 2003).

APRN-PMHNPs are registered nurses with advanced master's and/or doctoral degrees in psychiatric mental health nursing. Though psychiatric NPs are recognized as a clinical resource, multiple authors suggest that they are underutilized as mental health providers (Feldman, Bachman, Cuffel, Friesen, & McCabe, 2003). Furthermore, according to the American Association of Colleges of Nursing, under-utilization of NPs, of all specialties, has been estimated to drive healthcare spending to near $9 billion annually (Rosseter, 2000). Barriers such as physician dominance, restrictions on reimbursement, state regulations, and scope of practice issues are further noted in the literature as interfering with the autonomy needed to fully utilize NPs of all specialties (Wortans, Happell, & Johnstone, 2006; Elsom, Happell, & Manias, 2005; Feldman et al., 2003; Staten et al., 2005; Baradell & Bordeaux, 2001; Drew & Delaney, 2009). The author of this article explores the current role of the community based psychiatric NP in New York State. The author also addresses barriers to practice that interfere and disrupt the continuity of care and place mentally ill patients at high risk within the community.

National statistics_

At the state and national level, there is increasing pressure to re-evaluate the limitations of statutory collaborative agreements on the role of advanced practice nurse, including the psychiatric NP, with the goal to provide more access to treatment providers by those in need (Agency for Healthcare Research and Quality, 2008). The 2008 National Healthcare Quality Report provided statistical data that highlights significant mental healthcare needs within the United States (see Table 1). Other studies have provided further insights into the demographics and impact of mental illness patients and providers. Walker (2010) reported that over 30 million Americans are indigent and currently uninsured. Of these 30 million, 7.6 million Americans will require some form of mental health care. The National Council for Community Based Healthcare further noted the substantial need for mental health services has resulted in a 15 to 17% increase in caseloads in community mental health centers (Walker, 2010). Additionally, the National Association of State Mental Health Program Directors, Medical Directors Council (2006) reported that individuals with serious and persistent mental illness have higher morbidity and mortality rates secondary to co-morbid chronic illnesses. Patients with mental illness have a lifespan on average 25 years shorter than those of healthy patients (Mazade & Glover, 2007).

Psychiatric mental health NPs are better equipped to assess, diagnose, and treat mental illness than primary care providers. As an advanced practice nurse, the psychiatric NP is educated in many types of nursing and other healthcare theories. Psychiatric NPs are also educated in the chronic care model, which provides a clinical framework for addressing the multidimensional nature of complex chronic illness (Boville et al., 2007). The psychiatric NP manages the patient's psychosocial and lifestyle issues, in addition to complex physical problems that often co-exist with mental illness. As an advanced practice nurse, the psychiatric mental health NP provides more time with patients, provides more education, and seeks consultation around more complex patients (Wortans et al., 2006; Elsom et al., 2005; Staten et al., 2005; Feldman et al., 2003). Therefore, the psychiatric NP is the natural provider to bridge the gap of access to mental health treatment within the community.

Reports provided by behavioral health managed care companies have noted that major segments of the U.S. population

Table 1.
National statistics regarding mental illness

Adults that suffer from mental illness	1:4
Adults with at least one episode of mental illness or substance abuse in 2006	32%
Americans with serious and persistent mental illness	6%
Americans over age 18 with major depressive disorder	15.8 million
Hospital-or office-based provider visits for mental disorder treatment annually	130 million
Primary care physicians who fail to properly diagnose depression	30-50%
Completed suicides in 2005	32,637
Largest age group increase in suicide	Ages 45-64
Percentage of completed suicides who had seen a primary care provider within 24 hours	40%

Note: Adapted from Feldman, Bachman, Cuffel, Friesen, & McCabe, 2003; Agency for Healthcare Research and Quality, 2008, 2009; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007; Hogan, 2003.

lack access to clinicians who can properly evaluate the need for, prescribe, and monitor psychotropic medications (Christian, Dower, & O'Neil, 2007). Feldman and colleagues (2003) further found that patient access numbers increase with those who require both psychotherapy and psychopharmacology from the same provider. With only 14.2 psychiatrists per 100,000 people in the United States, and declining numbers of psychiatric mental health NPs, there will continue to be a lack of access to treatment and fewer incentives to enter into community practice if barriers to treatment are not addressed (Feldman et al., 2003).

Growing numbers of children and adults are being forced to receive mental health treatment from pediatricians and primary care physicians even though the data substantiates that these clinicians are not skilled to provide accurate care. Thirty to fifty percent of PCPs fail to properly diagnose depressed patients (Feldman et al., 2003). The APRN-PMHNP is the logical provider that can offer access to treatment in the community for the patient or family that is wary of the stigma associated with mental health care and chooses to not attend treatment at the community mental health clinic.

Healthcare reform overview

In each state, a nurse practice act defines the scope of practice for advanced practice nurses. Within the scope of practice are the practice privilege parameters of the advanced practice nurse. Scope of practice and practice privileges determine where the practice will occur, and include the name of the designated location or facility. Scope of practice also includes the exceptions to the certified scope of practice, as agreed upon with the undersigned parties of the agreement (NYSED, 2011b).

As the Federal government looks at healthcare reform on a national level, individual states are also considering change. The Board of Nursing and APRNs in each state, New York included, have favored laws to expand the NP scope of practice to allow autonomous practice and permit expanding scope of practice. According to the Pearson Report (2009), there are now 15 states that have converted to independent practice for NPs. In 2008, 22 states expanded their legislative or regulatory state NP scope of practice. This is an increase of three states compared to 2007. Further expansion of state nurse practice acts would position psychiatric NPs to more effectively address the critical need for more community-based mental health providers. Groups, such as the Board of Medicine and psychiatrists, argue that psychiatric NPs are not qualified to practice independently, lacking sufficient education and training (Christian et al., 2007; Ginsburg, Taylor, & Barr, 2009). The thought is that those who oppose expansion of the NP scope of practice are doing it out of concern for public protection. However, there are also those who believe that the opposing groups are doing this out of competitive self-interests (Christian et al., 2007).

NP education, certification requirements and legal scope of practice are state-specific and vary considerably (Christian et al., 2007). In New York State, NPs have been authorized by statute to practice since 1988 (Elwell, 2007). Lugo, O'Grady, Hodnicki, and Hanson (2007) analyzed the Pearson National Nurse Practitioner study that measured and ranked each state based on the regulatory practices for NPs. Each year the Pearson study analyzes patient access to NP practices. Three dimensions are explored: 1) environments affecting consumers' access to NP providers, 2) environments affecting reimbursement and NPs' patients' access to related healthcare services, and 3) environments affecting NPs' patients' access to prescription medications. New York State was ranked 14 out of the 51 states; Arizona was ranked first and came in as the least restrictive, and Alabama, at 51, was listed as the most restrictive (Lugo et al., 2007).

Wing, O'Grady, and Langelier (as cited in Lugo et al., 2007) developed a Nurse Practitioner Professional Practice Index based on the categories of legal authority, reimbursement, and prescriptive authority. In New York State, legal capacity, defined as scope of practice, was expanded, but NPs were still underutilized due to regulatory limitations (based on the index): New York State scored 21 out of a potential score of 30. The study ranked NP patient access to services as 37 out of 40 and patient access to prescriptions as 27 out of 40. The overall ranking for the state was 85 out of 100. New York received a letter grade of B, for having a partial restrictive environment. This means that patients are able to access treatment, but there are barriers that interfere and delay access to the above services (Lugo et al., 2007).

As of January 2011, there were 1,060 advanced practice psychiatric nurses registered by NYSED (NYSED, 2010). Current statistics on the demographics of psychiatric mental health NPs and psychiatric clinical nurse specialists in both the adult and child/adolescent specialty area are displayed in Table 2. The data signifies that there is a trend of an aging workforce and a diminishing number of providers. There has been a 15% reduction of advanced practice psychiatric nurses between 1988 and 2003 (Staten et al., 2005). The 2005 legislative update conducted by the American Psychiatric Nurses Association reported that by the year 2013 the psychiatric nurse workforce is

Table 2.
Characteristics of the psychiatric nurse practitioner

Characteristics	Statistics
N = 2,195 respondents	
Average age (females)	55 years old (95% of workforce)
Average age (males)	44 years old (4% of workforce)
APRN-PMH (1988)	18% of nationally certified NPs
APRN-PMH (2003)	3% of nationally certified NPs
Estimated workforce size change by 2013	Reduced by 50% of current workforce

Note: Adapted from Staten et al., 2005.

expected to be reduced by as much as 50% due to nurses reaching retirement age (Staten et al., 2005).

The Nurse Practitioner Association New York State (NPANYS) collected current data on the scope of practice and barriers to practice using the psychiatric mental health survey (2009b). Fifty-one percent of the respondents had been in practice between 1 and 10 years. Another 28% had between 11 and 15 years of service, and another 17% had 16 to over 20 years of experience. Thirty-seven percent of the respondents operated an individual private practice, and 45% were employed at an institutional or university based community practice setting. The survey asked if respondents who were not currently in community based private practice would consider employment at that type of practice in the future. Only 31% of respondents said yes, and 69% responded that they would not consider their own practice. Eighty-one percent of respondents stated practice barriers impeded the ability to provide optimum patient care. In the survey, 62% of comments addressed issues with either the collaborating psychiatrist or the requirement of a psychiatrist signature on insurance forms and disability paperwork. The NPANYS survey listed reimbursement and empanelment (together scored 28%) as the number one priority issue for survey respondents. The second most frequently identified priority (22%) was the OMH mandate that the APRN-PMHNP is required to have a psychiatrist to sign the treatment plan, and the third most frequent priority (22%) was salary ranking (NPANYS, 2009b).

Barriers to practice

Although the regulations differ from state to state, in New York the statutory collaborative agreement requires that collaborating physicians complete retrospective quarterly record reviews to ensure that NP practice reflects accepted standards of medical practice and that NP practice is within the scope of practice (Zittel, 2006).

The Center for Health Workforce Studies (2004) at the University of Albany conducted a survey of all licensed NP specialties in New York State. Survey results showed variability in how often charts were reviewed. However, the majority of respondents, 78%, reported meeting weekly to daily with their collaborating physician, reflecting that the majority of NPs in New York still undergo review and meet with physician colleagues on a regular basis. The specialties were not categorized so there is no data to support how psychiatric NPs received chart reviews by psychiatrists (Center for Health Workforce Studies, 2004). Financial arrangements with collaborating physicians are another barrier to community based independent practice. Most psychiatric NPs that have a private practice within the community pay for the physician's time to honor the statutory collaboration agreement, including the initial negotiating of the practice protocols, yearly updates of the practice agreement/protocols, and quarterly record reviews. An example, in New York State, is Part 29 of Regents Rules that describes professional misconduct. Section 29.1 (b) (3) of the Rules states that unprofessional conduct shall include: "directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services" (NYSED, 2010). The NYSED Office of Professions interpreted this rule to mean that the NP can pay for collaboration but only within the fair market value of services to be provided. Dr. Susan Apold, immediate past chairwoman of the NPANYS, reported that there are cases around the state where the Regents Rule has not been observed (personal communication, November 17, 2009).

> The statutory collaborative agreement serves no public purpose, nor is it a substitute for professional judgment.

Support for barrier removal

Statutory collaboration creates artificial barriers to care (NPANYS, 2009a). Dr. Joy Elwell, chairperson of the Government Affairs Committee, and others in the NPANYS organization believe that the collaboration agreement is a mechanism to control the practice of NPs (Elwell, 2007). An NP's practice is not determined by the collaboration agreement. It is the scope of practice that determines how the NP practices. Yet the education law determines that NPs must have a statutory collaboration agreement with a physician/psychiatrist. Within the collaboration agreement, parameters of practice are negotiated between the psychiatrist and the NP. For example, the author's preference was to offer her specialty of dialectical behavior therapy to 11- to 18-year-old adolescents. This work did not include prescriptive authority of this age group, as she is adult-trained. The collaborating psychiatrist would not allow the NP to work with adolescents younger than 14 years old, and they had to be of adult height and weight. The clause in the education law states that if there is a disagreement between the NP and the physician, the physician's preference is the decision maker in spite of the NP's educational level or years of experience (NPANYS, 2009a). Twenty years ago, statutory collaboration was developed as a political compromise. The statutory collaborative agreement serves no public purpose, nor is it a substitute for professional judgment. Healthcare professionals are responsible for knowing their respective scope of practice and safely practicing within that parameter. Professional judgment is a requirement of NP practice and an expectation of the public (NPANYS, 2009a).

Managed care organizations have dominated healthcare delivery over the past two decades. These companies have become multi-state corporations that establish their own set of rules. These rules exclude NPs as providers on the insurance company panels and impose additional practice restrictions, such as mandating a statutory collaboration agreement with an empanelled physician. In addition to insurance company restriction, organized medicine has launched an aggressive campaign to further restrict scope of practice of APRNs through federal

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and state legislation that would give physicians more power and control over nursing practice (American Nurses Association, 2009).

There are few studies in the literature addressing the statutory collaboration, reimbursement, and access to treatment as barriers to treatment (Elsom et al., 2005; Feldman et al., 2003; Staten et al., 2005; Pearson, 2009; Weiland, 2008; Lugo et al., 2007). An extensive literature review by United Behavioral Healthcare, as cited in Feldman and colleagues (2003), was conducted from 1997 to 2001. This review accounted for identified barriers to providing treatment, such as prescriptive authority, including lack of interest in the addition of prescriptive authority, work-setting limitations, personal comfort with prescribing, ability to develop a collaboration agreement with a physician, fees, legislative and statutory obstacles, and obtaining a Drug Enforcement Agency number (Feldman et al., 2003).

In 2001, United Behavioral Healthcare conducted a national survey to better understand barriers to prescriptive privileges and availability of APRN-PMHNPs (as cited in Feldman et al., 2003). United Behavioral Healthcare surveyed the availability of a group of nurses and psychiatrists and the ability to receive patient referrals. Fifty-eight percent of the nurses had prescriptive authority but did not work in private practices. Of the 58% of nurses, only 16% had a strong desire to have a private practice regardless of the prescriptive authority. The most significant barriers to establishing a private practice included: billing and administrative burdens, the cost of malpractice insurance, the demands of current jobs, and difficulty obtaining referrals (Feldman et al., 2003).

The quality of the collaborative relationship between the nurse and physician was cited as another potential barrier to practice patterns. NPs cited concerns around the prescriptive practice agreement with physicians. Three cited barriers were: physician concerns about liability (24%), physicians' choices of different drugs rather than supporting those selected by the NP (20%), and physician reluctance to prescribe medications selected by the NPs (20%) (Kaplan & Brown, 2004).

New York State legislation

In New York State, Assemblyman Gottfried and Senator Young have sponsored legislation known as the NP Modernization Act (2011) to amend the education law to allow NPs the right to practice without the statutory collaboration agreement. This bill would also provide direct and equitable insurance reimbursement to the NP for the same services performed by the physician. If approved, the NP Modernization Act will also establish an NP advisory panel, recommended by the State Board of Regents. The fiscal implications of this bill are to reduce the administrative costs for NYSED. This bill will also cut costs for institutions, since the institutions are currently charged with paying the cost of the supervision for the statutory collaborative agreement (T. Nicotera, personal communication, May 5, 2011). However, it is unclear who will fund the administrative costs of the advisory board that is to be recommended by the State Board of Regents.

The NP Modernization Act is necessary, as statutory collaboration serves no clinical purpose. It does not establish the quality of the care provided by the NP. It does not serve a purpose for access to care; if anything, statutory collaboration limits access to care. In addition, statutory collaboration does not speak to the level of education of NP or the national certification of the psychiatric nurse specialty. Statutory collaboration does not speak to the NP's years of clinical expertise in the field of psychiatry.

The American Medical Association would disagree with the above comments by the author, firmly asserting that a physician needs to supervise the NP to provide safe, high-quality care. However, NP associations across the country, and in particular in New York State, have fired back at the American Medical Association. The American Nurses Association, the American Academy of Nurse Practitioners, the American College of Nurse Practitioners, and the National Council of State Boards of Nursing have all published position statements indicating that modification of state NP legislation is essential in allowing NPs full access to provide the care that they are trained to deliver. The American College of Physicians (ACP) presented its position on NPs as primary care providers (Ginsberg, Taylor & Barr, 2009). The ACP speaks in terms of collaboration and each discipline having special skill sets that complement one another. The ACP position calls for NPs and physicians to work together in partnerships to provide high-quality care. The ACP position asks to not limit access to care, but to use all providers and their special skill sets to keep access to care open on an ongoing basis. The ACP's position is that with the impending primary care shortages expected in the future, there is a need to look at all potential providers and how each discipline can assist in the care of patients (ACP, 2009). In 2011, the American Psychiatric Association announced that there are diminishing numbers of psychiatric residents. According to Vine (2009), there are currently 38,000 psychiatrists in the United States. An additional 5,450 practitioners are needed to bring the ratio to one psychiatrist for every 10,000 people. Armstrong and Forte (2010) completed exit interviews with psychiatric residents. In New York State, there were 230 psychiatric residents and 53 child and adolescent residents that left residency in that year. Of those reported, 48% planned to work in urban areas, and only 4% planned to practice in rural areas (Armstrong & Forte, 2010). Psychiatric NPs are the logical alternative to continue to allow open access to high quality mental health care.

Removal of barriers to treatment through passage of the NP Modernization Act will streamline access to treatment. Currently, there is a lack of access to appropriate services for patients with major mental illness (Feldman et al., 2003). Once NP provider barriers are removed, patients will be able to access treatment more freely. The NP Modernization Act will position psychiatric NPs as a source for mental health care within the community, whether it is through a private office practice or within a public health clinic setting. In addition, the bill will potentially allow psychiatric NPs to open nurse-run mental healthcare clinics and offer cost-effective care that could save the state millions of dollars.

Additional proposed legislation addresses insurance payment for acknowledgement of NP services. Assemblyman Gottfried and Senator Duane have initiated the Reimbursement Assurance Bill (2009), which will assure that health plans do not deny reimbursement for services rendered by NPs acting within their lawful scope of practice. The Access Protection Bill,(2010), also by Gottfried and Duane, will prohibit health plans from excluding NPs from their provider networks and to insure that reimbursement rates are reasonable. The hope is that this bill will promote practice opportunities for NPs.

Opposition

Major opposition to the NP Modernization Act comes from the insurance companies who set up barriers for empanelment based on the statutory collaborative agreements (Elwell, 2007). Most insurance companies only allow the NP empanelment if they are in a collaborative agreement with a paneled physician. If the paneled physician terminates with the insurance company, due to reduced reimbursement rates or changes to the insurance company policies, the NP must also terminate. The NP is then left to find another physician on the panel to engage in the collaborative relationship. This can be a complicated and cumbersome process for the NP. Another example is when the physician is investigated by the insurance company or has practice privileges suspended by the Office of Professional Practice. The APRN is then dually unable to practice or bill the insurance company due to the requirement that the collaborating physician must remain on the panel. These barriers have a serious impact; they can disrupt the continuity of care and put patients at risk, especially those patients that are considered part of vulnerable populations, such as the mentally ill (NPANYS, 2010).

Clinical vignette (2010)

An APRN-PMH in private practice is notified that her collaborating psychiatrist is involved in a complicated and potentially career-paralyzing incident. The psychiatric NP consulted her own legal counsel due to the established statutory collaboration mandates with this psychiatrist. A recommendation was made to break ties with the psychiatrist and find a replacement. Unfortunately, a replacement was not accessible and led to an immediate need to close the NP's private practice due to loss of the statutory collaborative agreement. This led to a rapid transition and termination for 70 patients. The incident resulted in a major disruption of care and a difficult transition for all patients involved.

Discussion

There are a number of barriers that impede the APRN-PMH from being able to provide care to the full extent of her scope of practice. These barriers provide a disincentive for psychiatric NPs to set up practice in the community, including rural communities. As the primary care provider shortage continues, so does the shortage of psychiatrists and psychiatric NPs. With the slow decline of psychiatric NPs, the concern is that barriers create a lack of motivation for the psychiatric nurse to enter the advanced practice field of nursing and pursue independent practice.

Licensed healthcare providers, such as advanced practice NPs, have been discriminated against despite state scope of practice laws that allow for this practice (Elwell, 2007; Safreit, 2002). NPs have been restricted from leading demonstration projects, pilot programs, and incentive programs, and remain restricted on insurance reimbursement policies. The advanced practice nurse, in any specialty practice, needs to be recognized as a qualified provider to lead a nurse-managed healthcare center for disease management for the vulnerable, underserved patient population (American Nurses Association, 2009).

Psychiatric NPs, and all NPs, must learn to advocate for healthcare policy changes. NP's must get more involved in state and national associations that lobby to remove these statutory limitations of practice and encourage equity of reimbursement. In New York State, there are over 14,000 NPs (NPANYS, 2010), and only a little over 2,000 are represented through the NPANYS.

In conclusion, APRN-PMHNPs are appropriate caregivers to help protect, promote, and restore the health of the mentally ill population. The APRN-PMH is the provider that is knowledgeable about evidence-based practice. Resolving statutory and regulatory barriers to practice seems to be the natural solution to the current mental healthcare crisis, which then would authorize APRN-PMHNPs to follow through on their role in the community setting.

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