Montana nurse practitioners : prescriptive authority
by Keven Jean Comer

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
A critical component of health care provision by rural nurse practitioners (NP) is independent prescriptive practice. Montana is one of only 17 states With independent prescriptive authority for nurse practitioners. Each legislative year there exists the possibility that individual state laws governing prescriptive practice may change, making prescriptive authority more, or less, restrictive for nurse practitioners.

The purpose of this study was to: a) identify facilitators and barriers to the use of prescriptive practice encountered by Montana nurse practitioners, and b) to identify descriptive predictors of the utilization of prescriptive authority. Since the number of nurse practitioners was small (N = 173), the entire population was utilized. All licensed Montana nurse practitioners were sent a mail questionnaire which contained an adaptation of the Griffin (1992) Nurse Practitioner Prescriptive Authority Questionnaire (NPPAQ), a demographic form and questions regarding the extent and type of their practice.

The response rate was 73.4 percent. The contribution to cost effective care was the primary facilitator to the use of prescriptive authority. The strongest barrier identified was the state rules and regulations surrounding prescriptive authority. Those with prescriptive authority were more likely to see more clients, to work longer hours and to have been in practice fewer years than those who did not carry prescriptive authority. In addition, membership ip the Montana Advanced Practice Registered Nurse Association was significantly associated with carrying prescriptive authority. This study provides states that have either no legal provision or dependent prescriptive authority, a model of independent prescriptive practice with identified facilitators, barriers, and demographic predictors.

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APPROVAL

of a thesis submitted by

Keven Jean Comer

This thesis has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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VITA

Keven Jean Comer, born November 1, 1956, was the first of four children born to Byron Neil Schriever and Dorothy Jean Miller Schriever. She lived in a variety of states and countries during her formative years. In 1974 she completed her high school education and graduated from Canby Union High School in Canby, Oregon. In 1979, she graduated from the University of Portland with a Bachelor of Science in Nursing. Upon graduation she worked briefly on a large cardiac step-down unit. She then accepted a position in the Pediatric Intensive Care Unit (PICU) at Doernbecker Children's Hospital at Oregon Health Sciences University. She worked in the PICU and was a member of the pediatric transport team. She moved to Bozeman, Montana in 1983 and took a position in the ICU-CCU at Bozeman Deaconess Hospital. She has been certified as a critical care nurse since 1985. She enjoys teaching and is a current ACLS and PALS instructor. She is active in the Montana Nurses Association (MNA), having held a variety of offices at the local, district, and state levels. She was instrumental in the collective bargaining agreements at Bozeman Deaconess Hospital from 1988-1996. In 1989 she received the MNA "Eileen Robbins" award which recognizes exemplar workplace advocacy. In 1996 she was selected as MNAs "Nurse of the Year" which recognizes leadership. In February 1997, she was the co-recipient of a grant from Sigma Theta Tau International and Glaxo Welcome to study "Rural Nurse Practitioner Practice: Facilitators and Barriers". She is a member of the American Academy of Nurse Practitioners, the American Association of Critical Care Nurses, the Montana Nurses' Association, the Montana Advanced Practice Registered Nurse Association, and Sigma Theta Tau International. She is a member of the second cohort of Family Nurse Practitioner students at Montana State University College of Nursing and graduated in August 1997. She is married to Steven Comer and has two children, Stephanie and Matthew.

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ABSTRACT

A critical component of health care provision by rural nurse practitioners (NP) is independent prescriptive practice. Montana is one of only 17 states with independent prescriptive authority for nurse practitioners. Each legislative year there exists the possibility that individual state laws governing prescriptive practice may change, making prescriptive authority more, or less, restrictive for nurse practitioners.

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CHAPTER 1

INTRODUCTION

Access to health care is a persistent problem, which faces not only rural residents, such as those in Montana, but which can be found in urban and rural settings across the nation as well. Nurse practitioners offer a viable and cost-effective alternative to care which has been traditionally provided by physicians. During the past thirty years, nurse practitioners have taken the initiative in the care of clients across the age spectrum and in a variety of settings. Nurse practitioners are able to diagnose, treat, and manage a wide array of acute and chronic health conditions. Amidst the many roles performed by the nurse practitioner, an essential and integral element is the ability to independently prescribe pharmacotherapeutics.

When nurse practitioners are able to prescribe independently, not under the supervision of a physician, there is an increase in access, convenience, and quality regarding the delivery of health care as well as a reduction in health care costs (Hadley, 1989; United States Congress, 1986; Wilken, 1995). Nurse practitioner professional independence in decision making is directly related to the ability to independently prescribe drug therapies. Limitations to or prohibitions of the authority to prescribe decrease professional autonomy and result in unnecessary dependency on physicians.

Purpose

The purpose of this study was to: (a) identify facilitators as well as barriers to the use of prescriptive authority encountered by Montana nurse practitioners with prescriptive authority, and (b) identify demographic

factors associated with possessing prescriptive authority. This research contributes to the limited body of knowledge with regard to facilitators and barriers when utilizing prescriptive authority. In addition, a current Montana nurse practitioner database was initiated.

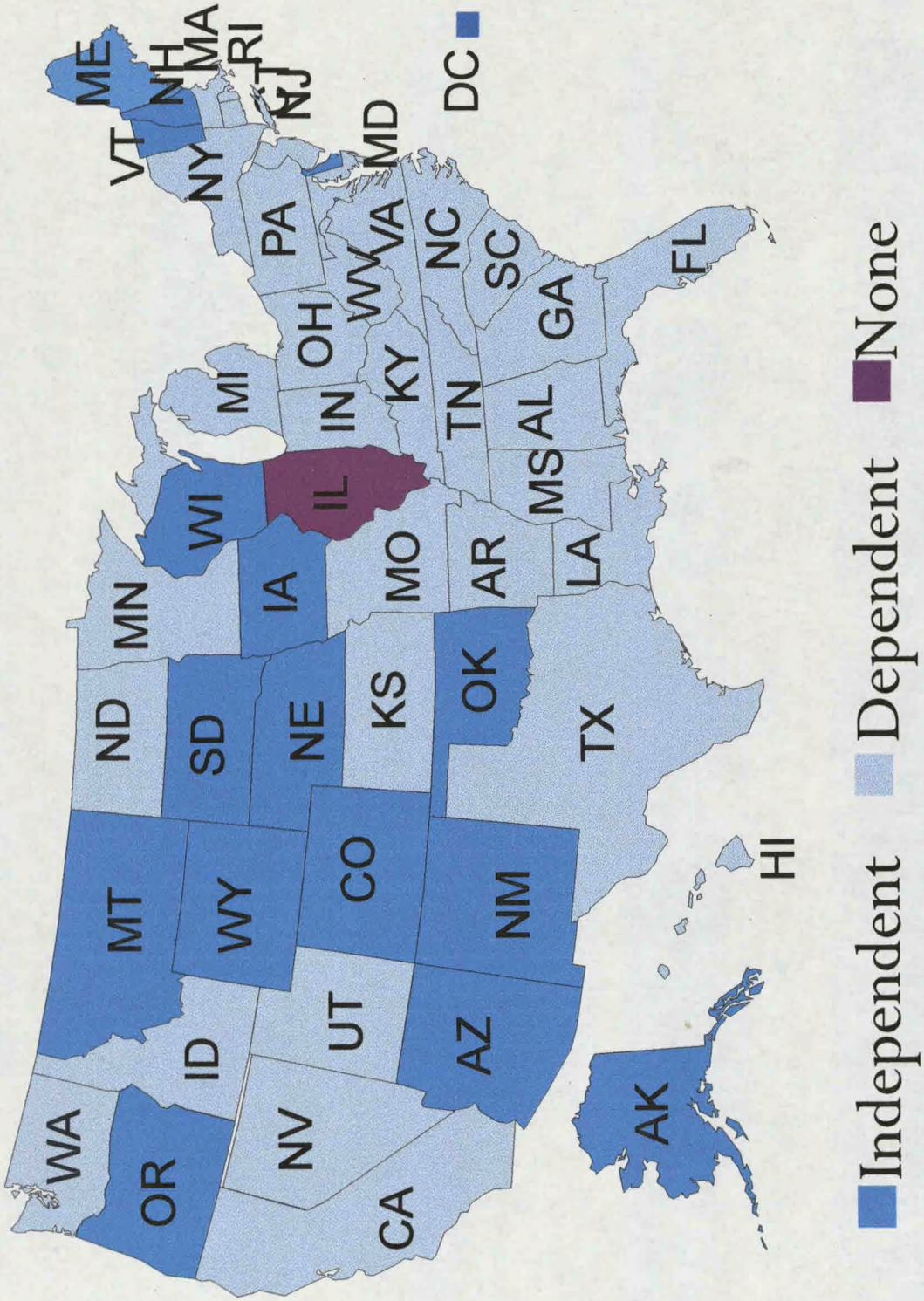
Significance

During the past 10 to 15 years the nurse practitioner role has expanded to include the ability to prescribe drugs. Prescribing is one adjunct utilized to deliver comprehensive health care to clients and complements the cycle of assessment, diagnosis, and treatment of the patient (Harkless, 1989).

The legal authority for nurse practitioners to prescribe drug therapies differs with individual state laws. This has resulted in a large disparity regarding the degree of prescriptive authority and professional autonomy which exists from state to state (McDermott, 1995). Montana is one of only seventeen states (the District of Columbia is counted as a state) in which nurse practitioners can prescribe independently of any required physician involvement in prescription writing. One state, Illinois, is without legal provision regarding nurse practitioner prescriptive authority and the remainder of the states have a variety of physician-supervised regulations constituting dependent prescriptive authority. (See Figure 1 for an accompanying map identifying the degree of prescriptive authority found in each state (Pearson, 1997)). As of July 1996, in Montana, of the 173 licensed nurse practitioners, 113 or 65 percent were recognized to use prescriptive authority within their specified practice environments.

Nurse practitioners in Montana have had independent prescriptive authority since 1991. However, there is a paucity of information regarding

Figure 1. Map identifying degree of prescriptive authority in each state.



the utilization of this prescriptive authority. In addition, identification of specific facilitators and/or barriers encountered by nurse practitioners in Montana is lacking. Nationally, there are limited studies investigating facilitators and barriers in states with progressive prescriptive licensure. The majority of the documentation relates to the barriers which exist in states with dependent, supervised prescriptive authority. In addition, there is limited quantitative data on facilitators which may assist in the utilization of prescriptive authority. Even though there is a scarcity of research regarding the utilization of prescriptive authority, there is an abundance of research which documents the high-quality of care, patient satisfaction, and cost effectiveness of nurse practitioners (United States Congress, 1986; Safriet, 1992).

Prescriptive authority for nurse practitioners in Montana is still in its infancy. There has been little documentation which addresses why certain nurse practitioners fail to utilize prescriptive authority. In addition, it is unknown which segments of Montana populations are being served and in what specific practice locations nurse practitioners utilize prescriptive authority. It is also unknown if independent prescriptive authority is a specific reason for practicing in Montana. Evaluations of possible impediments imposed by medical and/or pharmacy professions are nonexistent. Finally, there is a limited demographic profile of the nurse practitioner group in the state.

It is imperative to have documentation to evaluate the impact of nurse practitioner prescriptive authority on health care in Montana. During the past several legislative sessions, there have been actual and potential threats, by the Montana Medical Association, to the independent nature of Montana nurse practitioner prescriptive licensure. With adequate documentation,

nurse practitioners will be able to take a proactive approach and adequately respond with factual information to the significant practice issue of prescriptive authority.

One problem with many published articles on prescriptive authority is the evolutionary path prescriptive authority has taken. The field is moving so quickly that it is difficult to keep the literature current. With each legislative year there exists the possibility that individual state laws governing prescriptive practice may change, thus adding to or lessening the barriers encountered.

In a meta-analysis of nurse practitioners in primary care roles, Brown and Grimes (1993) found the majority of studies had been conducted during the 1970s with few studies conducted since. They maintained that the body of research regarding nurse practitioners has not benefited from improvements in research methodology and the increasing research experience of the nurse scientist. They stated the majority of studies have been conducted in urban areas while the expanded roles of the nurse practitioner were designed to fill health care needs in rural and underserved populations. They concluded that there is scant information on the rural populations which are being served by nurse practitioners.

It is within the best interest of the profession to continue to gather information substantiating the effectiveness of independent nurse practitioner prescriptive authority as it impacts the continuity of patient care. Harkless (1989) confirmed one important aspect of enhancing the nurse practitioner role is the sharing and disseminating of (nurse practitioner) knowledge to the profession and to the public.

This study was the first step in the acquisition of information regarding the barriers and/or facilitators encountered by Montana nurse practitioners

who prescribe drugs. The information gathered provides a better understanding of the problems encountered by those nurse practitioners which possess prescriptive authority.

Conceptual Framework

Autonomy, the ability to function independently, is a valued and sought after characteristic that is respected both individually and professionally. One of nursing's current and future goals is to increase autonomy in practice. Mahoney (1992a) agreed that in many levels of practice nurse practitioners are willing to accept the responsibilities inherent to autonomy. Independent prescriptive authority is a fundamental and essential dimension of autonomous practice and is motivated by the professional drive towards independence.

The evolution of nursing and the nurse practitioner role has been grounded in the philosophies, beliefs, and social conditions of the late nineteenth century through the present. Nursing today is the result of multiple influences such as the status of women, feminism, societal norms and conditions, economics, the cultural milieu, and social and technological changes (Dempster, 1994).

The practice of nursing has historically been molded as being dependent, instead of independent or autonomous. The hierarchical relationship with physicians began around the turn of the century. Traditionally, nurses carried out the orders of physicians and made few if any independent decisions about the care of patients. This relationship was based on societal norms of the times, with women in a subservient relationship to men. Over the years, this arrangement became a legal relationship with laws defining the roles and scopes of practice of physicians and nurses.