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# A Comparison of Perceived Nurse Practitioner Practice Barriers

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The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

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## Abstract

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Running head: PERCEIVED NURSE PRACTITIONER PRACTICE BARRIERS

# A Comparison of Perceived Nurse Practitioner Practice Barriers

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Abstract

Novice nurse practitioners (NP) face unique obstacles to practice. Few studies examine factors influencing early NP clinical performance. Therefore, this research project analyzed data obtained from 243 members of an NP professional organization, who were asked to identify barriers encountered within the first 3 years of practice. Responses were received from beginning and more experienced NPs. The top 3 barriers named were lack of public knowledge, lack of positions for NPs, and a lower salary than anticipated. The promotion of NP assets through expanded media coverage and individual educational efforts, the national standardization of the role, and the elimination of restrictive practice legislation can help reduce current barriers. Through the efforts of individuals, NP professional groups, and legislators, existing practice constraints can be mitigated, potential barriers anticipated, and solutions generated to ensure the continued success of this essential advanced practice role.

Key words: clinical constraints, advanced practice nurse, research

# A Comparison of Perceived Nurse Practitioner Practice Barriers

Career development is a major life transition. An increasing number of nurses are entering graduate school in pursuit of advanced degrees. The shift from skilled registered nurse to fledgling nurse practitioner (NP) can be overwhelming and stressful. Previously confident nurses can experience self- doubt and anxiety when entering a new level of practice. Personal, social, legal, and organizational influences have an effect on beginning NP practice. Few studies exist that discuss factors affecting NP clinical behavior. Moreover, studies identifying barriers blocking early NP performance are nonexistent. This study identified factors NPs perceive as hampering clinical practice within the first 3 years of employment as an NP.

Recent studies have examined aids and barriers to clinical practice for the advanced practice nurse (Hupcey, 1993; McFadden & Miller, 1994). Two such studies evaluated factors that have made an impact on practice from the perspective of the clinical nurse specialist (CNS) (McFadden & Miller, 1994) and the primary care NP (Hupcey, 1993). Two general themes emerged. First, support or lack of support by coworkers, supervisors, and physicians was the major factor influencing role performance. Second, mentor availability eased the transition to independent practice. As well as colleague support, McFadden and Miller (1994) identified the need for administrators who could define, clarify, and support the CNS role.

In response to the realization that little was known about the practice settings or the perceived barriers that California NPs confront, Anderson, Gilliss, and Yoder (1996) conducted a study focusing primarily on California NP employment characteristics. In addition, NPs were asked to identify any "social or legal barriers to practice" (p. 210) experienced. A similar study was conducted by The Veterans Health Administration (VHA), requesting data from advanced practice nurses (APN) regarding practice roles and barriers as well as asking for demographic, academic, and organizational information (Domine, Siegal, Zicafoose, Antai-Otong & Stone,

1998). Both groups of NPs identified limited prescriptive authority as a major barrier to practice. While, the California NPs (Anderson, Gilliss, & Yoder, 1996) found physician discrimination and resistance a major obstacle, the VHA practitioners (Domine, et al., 1998) identified both medical and nursing ignorance regarding the NP role as a hindrance to practice. The California NPs saw the public's lack of understanding of the NP role as limiting as well. In contrast to the VHA NP, reimbursement problems were a major issue for the California NP. The VHA practitioners viewed the lack of administrative support, the lack of admitting privileges, and the need for physicians to co-sign orders as key barriers to their clinical performance.

An earlier study conducted by the California Coalition of Nurse Practitioners found parallel opinions (Morrow, 1994). California NPs ranked prescriptive authority and reimbursement issues to be major constraints to practice. The NPs considered the scope of practice restrictive. The California practitioners expressed a desire to expand the NPs' public image by increasing media coverage.

Howard and Griener (1997) reported on the results of a national survey measuring constraints that Advanced Practice Psychiatric Nurses (APPN) had experienced within their practice. APPNs shared with other APNs dissatisfaction in the areas of reimbursement (Anderson, Gilliss, & Yoder, 1996), prescriptive authority, and lack of support by colleagues (Anderson, Gilliss & Yoder, 1996; Domine, et al., 1998). Public misunderstanding of the role of advanced practice nursing was also a recurrent theme. Restrictive managerial and bureaucratic practices were also identified as performance constraints (Howard & Griener, 1997). Uniquely, these participants described one's refusal to work off shifts or to accept payment from managed care insurers as personal practice constraints. Others expressed concerns about one's ability to perform within one's current position due to inadequate educational preparation or due to insufficient professional experience.

# Methodology

## Participants

This descriptive study identified factors nurse practitioners perceive as hampering clinical practice within the first 3 years of employment as an NP. Convenience sampling was used to recruit subjects (DePoy & Gitlin, 1998). Data were derived from mailed questionnaires received from NPs who are currently members of a state NP organization.

## Procedure

Following approval by the university's human subjects review board, participants were recruited. California has approximately 9,564 NPs licensed throughout the state (Pearson, 2000). The NP organization provided the names and addresses of over 2000 of the state's NPs. Names were randomly selected from the list and a total of 406 packets were mailed. Questionnaires were sent to practitioners of all employment lengths because the amount of time spent in the role was unknown. Each packet contained a cover letter explaining the purpose of the study, a description of implied consent, and a return addressed stamped envelope. A demographic survey as well as a questionnaire titled "Barriers to Nurse Practitioner Practice" was included in the mailing. After the packets were mailed, no further contact with the subjects was attempted.

## Instruments

### Demographic data

A brief demographic form was used to collect information about age, gender, ethnicity, educational history, years as an NP, current NP practice, and present work setting. NP employment history was divided into lengths of a) < 1 year, b) 1-2 years, c) 3-4 years, and d) 5 or more years.

Barriers to NP Practice Survey

This tool was adapted from an extensive national survey of certified NPs and CNS' conducted by the Washington Consulting Group. The Bureau of Health Professions, Division of Nursing sponsored this research (Washington Consulting Group, 1994). Written permission to use the survey was not required because as a federal document it is public information (D. D. Alt, personal communication, December 27, 1999).

The original Health Professions survey targeted certified NPs and certified and/or Master's prepared CNS' throughout the United States (US). Tools were developed to determine the number of practitioners, personal and professional characteristics, scope of practice, level of independent practice, practice settings, and the demographic and clinical profiles of the populations served. Selected NPs and CNS' from varied practice settings within the US acted as advisors in the development of the survey instrument (Washington Consulting Group, 1994). Psychometric properties regarding reliability and validity are unavailable.

For the purpose of this study, items from the tool titled "Barriers to Advanced Practice" were selected from the larger survey. The original instrument contained 28 barriers to practice including administrative, regulatory, employment, and educational restrictions. The questionnaire was revised by eliminating reference to CNS practice. The new tool listed 31 obstacles to practice and included themes on scope of practice, insurance reimbursement, hospital privileges, and professional collaboration (Morrow, 1994). Participants were instructed to check any barriers to practice experienced within the first 3 years of practice and were asked to comment on any unmentioned barriers experienced.

## Results

Packets were mailed to 407 subjects with 254 questionnaires returned. This is a response rate of approximately 60%. Data from 243 participants were analyzed. Eleven surveys could not

be used because the respondent's practice history was not identified, or the surveys were returned either unanswered, or undeliverable. Approximately 47% of the participants were NPs practicing less than 5 years and 53% of the respondents were practicing 5 or more years.

Information on the subjects' age, gender, educational history, and ethnicity is portrayed in Table 1. Nurse practitioners provide health care across the life span and practice settings. Table 2 describes NP practice characteristics.

The most common barriers NPs perceived as limiting early practice are listed in Table 3. The subjects did not rank barriers. There were several constraints the participants identified that were not included in the original list. A few NPs commented on the lack of mentoring or proctoring, and the absence of an evaluation process. These activities were seen as particularly helpful to new practitioners. Another participant identified the lack of control over daily scheduling. Such administrative tasks as the need to develop standardized procedures or protocols and the increased documentation requirements by government agencies were also identified as barriers. Administrative pressure to cross specialties despite inadequate training was another concern. Others expanded on the listed barriers with their commentary. Practitioners in search of a first position were particularly frustrated with the lack of employment opportunities for new graduates, the delay in obtaining a prescribing number, the absence of mentoring programs, and the limited educational preparation for those seeking positions in specialty areas.

## Strengths and Limitations of Study

This survey was limited to the membership of one state's NP organization. The NPs recruited may not be a representative sample of other NPs in California or the nation. Few minorities or males were represented. Therefore, the perceived barriers of those less represented in the sample may differ significantly from this predominately female, Caucasian group.

Responses were dependent on the accurate recall of the more experienced practitioners, many of whom pointed out that the first 3 years of their practice was more than 20 years ago.

The strength of the response rate and the richness of the comments allowed for better identification of restrictions faced by the NPs. The number of respondents was almost evenly divided into the more and less experienced NP categories. Despite the span of years dividing the 2 groups, many of the NPs recalled similar barriers.

## Discussion

The NP population responding to this survey on perceived barriers was, in general, female, white, middle aged, and master's prepared. National and statewide data on the ethnic distribution of NPs are unavailable. This study's sample was underrepresented in the African-American population as compared to the racial distribution of the California registered nurse (RN) population (4%). Nurse practitioner Hispanic representation was higher than in the RN sample (4%). The proportion of White, non-Hispanic and Asian/Pacific Islanders was almost identical to the RN population. Ethnic minorities in both groups were under represented as compared to state demographics (Center for the Health Professions, 1999).

The following discussion of barriers is rank- ordered from the most to the least frequently mentioned.

### Lack of Public Knowledge

Nurse practitioners of all practice duration viewed the lack of public knowledge as the most commonly experienced barrier to practice. Because fewer beginning NPs viewed this as an obstacle, it possible that public visibility has improved over the years. The absence of NP names on the provider panels of private insurers and health maintenance organizations (HMO) limits community awareness of the role and restricts the selection of NPs as primary care providers.

Role confusion by other health care providers, in particular advice or triage RNs and office staff obscures the image further.

Public knowledge of the NP role has improved through the efforts of individual practitioners and NP organizations. Direct reimbursement policies mandated by state and national agencies have also expanded consumer awareness of NP availability. And yet all the efforts to broaden exposure have resulted in only minor improvement in public knowledge.

Public confusion regarding NP contributions to patient care may intensify as the number of providers offering similar services increases. Physician, physician assistant (PA), APN, and NP responsibilities and duties often overlap. Traditionally, health maintenance, disease prevention, and patient care management have been provided by NPs across age groups and practice settings. A recent survey generated national recognition for NP capabilities when it was demonstrated that patient outcomes did not vary regardless of NP or physician care delivery (Mundinger, et al., 2000). Similar studies describing NPs in such a positive manner will promote public confidence and boost media attention.

Lack of Positions for NPs

Over the last decade, the number of NPs employed in the healthcare system has increased dramatically. Between 1992 and 1996, the number of nurse practitioners grew nationally by 47% (Moses, 1996). In 1996, approximately 63,000 NPs were practicing and it is estimated that by the year 2005 the number of employed NPs will increase to 106,000. Furthermore, graduation rates for other APNs and PAs have increased yearly. Within 5 years, it is predicted that the number of NPs will equal the number of family practice physicians. The national distribution of NPs and other providers is not uniform and tends to conform to patterns of physician concentration (Cooper, Laud, & Dietrich, 1998). As the population of primary care providers expands, competition for employment will intensify especially in areas of high clinician density.

This second most cited barrier generated many additional comments particularly by beginning practitioners. The experienced NPs found this item to be less of a barrier as compared to the newer NPs. Finding the first position was exasperating for many new graduates. One new NP wrote, " I have had 8 to 10 interviews in Northern California...I am considered too green...I am competing with FNPs with 3-10 years of working clinical experience". Some had experienced employer preference for PAs. Other beginning practitioners found that not having a prescribing license made it more difficult to secure a first position. Several NPs volunteered at free clinics to acquire more practice experience and to obtain enough hours to qualify for a prescribing number. Beginning NPs saw mentoring by more experienced health care providers and access to constructive feedback as a way to ease the transition to a new profession.

Lower Salary than Other Nursing Positions

More than half of the NPs practicing for less than 5 years identified lower salary as compared to other nursing positions as a barrier to practice. Others commented that they were aware of the wage difference but did not consider it to be a practice barrier. A new graduate saw lower reimbursement as an equalizer for inexperience. Others had worked in an institution as a RN prior to NP employment and were dismayed by the current compensation received for the expanded role. As the number of primary care providers increases, as competition for employment climbs, and as pressures to contain medical cost intensifies more and more NPs may experience salary stagnation (Grumbach & Coffman, 1998).

Prescriptive Authority

The inability to prescribe and to obtain a DEA number were not identified as major barriers for the less experienced NP. However, some of these NPs found the lack of prescriptive authority a "barrier to obtaining employment" and a cause of patient delays. Nurse practitioners with more than 5 years of experience found these items to be significant barriers to early

practice. In January 2000, immediately prior to the distribution of this questionnaire, 2 new bills became part of California law that clarified and enhanced the NPs ability to provide medication to patients (Legislative Update, 1999). These bills not only improve the ability of NPs to supply medication to patients but also increase the visibility of the NP role to the public, other health care professionals, and insurance providers.

## Practice Implications

Many of the practice barriers, which NPs with varying levels of experience cited, are interrelated. It is essential that barriers be addressed on a personal, professional, political, and legislative level. Knowledge of practitioner capability will increase as co-workers and support staff are educated about the scope of NP practice. Public awareness of this APN role will improve as verbal and written descriptions of NP abilities are provided at clinical sites (Brown & Olshansky, 1998).

Nurse practitioners promote professional development by maintaining clinical competency, by performing routine self-evaluation, and by mentoring new practitioners within clinical settings. Participation in local chapters of NP professional organizations not only fosters associations among colleagues with similar interests but also offers opportunities to discuss national and statewide legislation influencing NP practice. Furthermore, member announcements serve to notify job seekers of potential sources of employment.

National NP organizations have undertaken an aggressive campaign advocating the inclusion of NPs on primary care provider lists, the removal of exclusionary language from pharmaceutical advertising, and the elimination of existing barriers to practice through regional political and legislative activity (Quill, 2000). NP autonomy, reimbursement practices, and prescriptive authority vary from state to state. The standardization of these activities throughout the nation could decrease public and professional confusion surrounding NP ability and function.

In an increasingly competitive professional market, NPs need to be certain of the strengths and talents they bring to health care and to express these contributions openly. Data acknowledging NPs as appropriate sources of primary healthcare needs to be emphasized. More research is required documenting NPs as skillful providers of efficacious and cost effective health care to highly satisfied patients. These specifics can then be marketed to the public, employers, government agencies, and health plans. Such information also supports increased compensation for practitioner proficiency and productivity (Buppert, 2000).

Political activism is needed to resist policies contrary to NP growth. Collaborative practice among primary care providers should be promoted, while opposition to policies mandating physician-supervised practice and indirect reimbursement can be strongly supported. Nurse practitioners should endorse and contribute to the election of political candidates and legislators who are supportive of the expanded practice role.

The identification and comparison of past and current practice barriers gives all NPs an historical perspective of professional development, measures shared progress and setbacks, and outlines existing vulnerabilities. The future offers both opportunities and challenges for NP practice. Continued attention directed at the reduction of existing limitations and the generation of solutions will ensure the continued success of this essential advanced practice role.

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Table 1

Background Characteristics (N = 243)

| Characteristics | No. Subjects | % Subjects |
|---|---|---|
| Age | | |
| < 30 | 4 | 1.6 |
| 31-35 | 16 | 6.6 |
| 36-40 | 30 | 12.3 |
| 41-45 | 59 | 24.3 |
| 46-50 | 62 | 25.5 |
| 51-55 | 46 | 18.9 |
| > 55 | 25 | 10.3 |
| Not Given | 1 | .4 |
| Gender | | |
| Female | 233 | 95.9 |
| Male | 5 | 2.1 |
| Not Given | 5 | 2.1 |
| Ethnicity | | |
| African American | 4 | 1.6 |
| Asian/Pacific Islander | 20 | 8.2 |
| Hispanic | 15 | 6.2 |
| White Non Hispanic | 198 | 81.5 |
| Other | 4 | 1.6 |
| Not Given | 2 | .8 |
| Education | | |
| With MSN | 197 | 81.1 |
| Without MSN | 46 | 18.9 |
| Educational Specialty | | |
| Family/Combination | 144 | 60 |
| Adult/Combination | 33 | 14 |
| Women's Health | 30 | 12 |
| Gerontology/Combination | 22 | 9 |
| Pediatrics | 9 | 4 |
| Other | 5 | 2 |

Note. Percentages in the table and text may not add to 100% due to rounding.

Table 2

Practice Characteristics (N = 243)

| Characteristics | No. Subjects | % Subjects |
|---|---|---|
| Area of Practice [a] | | |
| Family | 87 | 36 |
| Adult | 44 | 18 |
| Women's Health | 28 | 12 |
| Gerontology | 21 | 9 |
| Emergency/Urgent Care | 11 | 5 |
| Pediatrics | 10 | 4 |
| Retired/Not Working | 8 | 3 |
| College/School Health | 7 | 3 |
| Occupational/Environmental Health | 4 | 2 |
| Other | 23 | 9 |
| Practice Sites | | |
| Private/Group Practice | 71 | 29 |
| Community/Homeless Clinic | 44 | 18 |
| Multiple Settings | 28 | 12 |
| HMO/Managed Care | 25 | 10 |
| Hospital/Affiliated Clinic | 24 | 10 |
| College/School | 11 | 5 |
| Long Term Care/Subacute | 8 | 3 |
| Retired/Not Working | 8 | 3 |
| Emergency/Urgent Care | 5 | 2 |
| Other | 19 | 8 |

Note. Percentages in the table and text may not add to 100% due to rounding.

[a] Values note a single area of practice or an area combined with the major area of practice listed.

Table 3

Comparison of Employment Length and Most Common Practice Barriers Experienced by NPs in First 3 Years of Practice

| Barrier | NP Employment | |
|---|---|---|
| | Less than 5 years | 5 years or greater |
| 1. Lack of public knowledge | 57 | 68 |
| 2. Lack of positions for NPs | 54 | 41 |
| 3. Salary lower than other nursing positions | 52 | 34 |
| 4. Lack of practice experience to function as expected | 41 | 32 |
| 5. Limitations of space and/or facilities | 40 | 35 |
| 6. Not identified as provider by private insurance or HMO panel | 39 | 48 |
| 7. Lack of understanding/differentiation of all advanced practice roles by other health professionals | 38 | 38 |
| 8. Resistance from physicians | 33 | 50 |
| 9. Lack of assistive/support staff | 33 | 36 |
| 10. Limitation on types of services reimbursed | 30 | 16 |

Note. The values represent percentages of NPs who identified the item as a barrier.