

Help or hindrance: Exploring nurse practitioners' perceptions of transition to practice legislation

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ABSTRACT

Background: Fourteen states have adopted transition to practice (TP) legislation, which requires newly certified nurse practitioners (NPs) to practice under a senior clinician. States have adopted such legislation despite vast evidence indicating NPs provide safe care.

Purpose: The purpose of this study is to explore NPs' perceptions of the effects of this legislation and to describe communication between NPs and senior clinicians working in TP states.

Methods: Using a cross-sectional, descriptive design, we surveyed a convenience sample of NPs working in TP states. Descriptive statistical analysis and qualitative content analysis were conducted.

Results: Most respondents believed TP legislation posed unnecessary regulatory barriers but also believed it promoted professional development. No statistically significant relationships between professional characteristics, regulatory variations, and these perceptions were identified.

Implications for practice: Given the increasing number of states considering TP legislation, and the vast variability in TP models, additional research into the effects of this regulation is needed.

Keywords: Autonomy; health policy; health care access and delivery; legislation; nurse practitioners.

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Introduction

Nurse practitioners (NPs) play a critical role in health care provision. More than 270,000 NPs are currently licensed to practice in the United States, and almost 29,000 graduated between 2017 and 2018 (American Association of Nurse Practitioners [AANP], 2019). Although NP education and certification are standardized nationally, state law determines NP degree of autonomy. Since 2010, a new and increasingly popular regulatory model has emerged: transition to practice (TP). States with TP legislation require newly certifying NPs to practice under the supervision or mentorship of a senior clinician before becoming eligible for greater autonomy (Phillips, 2019).

Background and significance

Fourteen states have adopted TP legislation. Not all nurse practice acts provide clear guidelines on whether NP experience gained in other states satisfies TP requirements, although others provide specific guidelines for NPs new to the state. Maryland explicitly recognizes the experience NPs gained in other states (Maryland Board of Nursing, 2015). Connecticut requires a transition period for all NPs new to the state (Connecticut State Department of Public Health, n.d.). Transition to practice requirements range from 1,000 hours (Colorado) to 5 years (Virginia) (Phillips, 2019). Illinois requires NPs to complete 250 continuing education credits in addition to 4,000 supervised practice hours (Illinois Nurse Practice Act, 2019a). In most states, TP requirements apply to all practice areas. However, states including Colorado and Nevada limit TP requirements to prescribing privileges (Colorado Nurse Practice Act, 2018; South Dakota Board of Nursing, 2019).

Some states allow new graduate NPs to be mentored by an experienced NP; other states require physician supervision. Mentoring requirements vary: for example, in Nebraska, a NP must have practiced for 10,000 hours to qualify as a mentor although any physician may mentor (Nebraska Department of Health and Human Services, 2019). South Dakota requires physician and NP mentors to

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have at least 2 years of experience (South Dakota Board of Nursing, 2019). Vermont places no experience requirements on physician mentors but requires NP mentors to have four years of experience (Vermont Board of Nursing, 2015). In Maine, a NP mentor must have 10 years of clinical health care experience and 5 years of NP experience (Maine Board of Maine State Board of Nursing, n.d.). In Minnesota, NPs may only serve as mentors if they work in an environment where physicians and NPs collaborate (Minnesota Board of Nursing, n.d.).

Although most states' nurse practice acts do not dictate details of the mentor–mentee relationship, a few states' acts do. In Colorado, a mentor does not have to work at the same physical site as the mentee but must be available to communicate synchronously (Colorado Nurse Practice Act, 2018). In Illinois, communication may be asynchronous (Illinois Nurse Practice Act, 2019b). In Delaware, NPs must discuss at least 10% of the patient cases they encounter over their 2-year, 4,000-hour transition period with their supervising physician (Delaware Division of Professional Regulation, n.d.; Delaware Nurse Practice Act, 2019). Completing TP requirements leads to full practice authority in most but not all states (**Table 1**).

Despite a lack of supporting evidence, TP legislative models have grown in popularity. The Pennsylvania Senate recently deliberated a bill that would require NPs to

complete three years of physician-supervised practice (Pennsylvania Coalition of Nurse Practitioners, 2019). The Florida House recently passed a bill that would have allowed NPs greater autonomy after completing 2,000 hours of physician supervision or graduate coursework in pharmacology; the Florida Senate did not consider the bill (Florida Association of Nurse Anesthetists, 2019).

Purpose

Researchers have demonstrated that NPs provide safe and effective care from the point of graduation; restricting NPs' practice provides no value to patient care but increases costs of and decreases access to care (DesRoches, Clarke, Perloff, O'Reilly-Jacob, & Buerhaus, 2017; Kuo, Loresto, Rounds, & Goodwin, 2013; Kurtzman et al., 2017; Oliver, Pennington, Revelle, & Rantz et al., 2014). Nationally, physician groups support restricting NP autonomy and assert physician oversight promotes safe patient care (American Medical Association, 2016). However, at the state level, some physician groups have conceded TP legislation as a political compromise to granting NPs full practice autonomy at certification, claiming TP legislation parallels physician residency requirements and protects the public (Brassard, 2014). No evidence supports these assertions. Claims that TP legislation provides medical residency level education and

Table 1. Variation in TP requirements

State/Low (L)/High (H) Restriction	Requirements	Supervisor/Mentor Discipline	Practice Autonomy After Transition
Colorado (L)	1,000 hours, only prescribing	Physician/NP	Full
Connecticut (H)	3 years, 2000 hours	Physician	Full
Delaware (H)	2 years, 4,000 hours	Physician, Podiatrist, or licensed health care delivery system	Reduced
Illinois (H)	4,000 hours, 250 CE	Physician	Reduced
Maine (H)	24 months	Physician/NP	Full
Maryland (L)	18 months	Physician/NP	Full
Minnesota (L)	2080 hours	Physician/NP collaborative setting	Full
Nebraska (L)	2000 hours	Physician/NP	Full
Nevada (H)	2 years, 2000 hours Schedule II only	Physician	Full
New York (L)	3,600 hours	Physician	Reduced
South Dakota (L)	1,040 hours	Physician/NP	Full
Vermont (H)	2 years, 2,400 hours	Physician/NP	Full
Virginia (H)	5 years	Physician	Restricted
West Virginia (H)	3 years	Physician	Reduced

Note: NP = nurse practitioner; TP = transition to practice.

support to new graduate NPs could be confusing to the public and new graduate NPs, an overwhelming majority of whom express interest in postgraduate support such as NP residencies and fellowships (Hart & Bowen, 2016).

The specific impacts of TP legislation are unknown because no studies have considered this regulatory model. This study begins inquiry into TP legislation by asking how do NPs working in states with TP legislation perceive the effects of this legislation.

Methods

This study used a descriptive, correlational design. Content analysis of open-ended questions was used to identify themes among responses. The East Carolina University and Medical Center Institutional Review Board approved the research as an exempt study before data collection. Data were collected from a convenience sample of NPs attending a national conference in June 2018. Inclusion criteria were as follows: NP of any certification who currently practiced, had practiced, or was seeking employment in Colorado, Connecticut, Delaware, Maine, Maryland, Minnesota, Nebraska, Nevada, South Dakota, Vermont, Virginia, and West Virginia. Interested individuals received a letter describing the study and outlining participants' rights and the survey instrument. Consent was implied if the individual completed the survey after reviewing the letter. The nature of the recruitment method precluded power analysis. The survey was a researcher-designed questionnaire developed from a review of literature on NP regulation. Nurse practitioner volunteers and nurse researchers reviewed the draft questionnaire; it was revised based on their feedback.

Data analysis

Descriptive statistical analysis was used to describe sample characteristics. The relationships between years of RN experience, years of NP experience, level of education, and senior clinician discipline on perceptions of TP's impact on competency development, NP barriers, patient safety, and consumer access were explored. Because the variables of interest are categorical, chi-square tests for independence were used to explore associations between the variables. Given significant variability in state regulation of NPs and low numbers of participants from some states, TP states were assigned to a low or a high restriction category for data analysis. Low restriction states are those that require mentorship or supervision for fewer than 2 years and 4,160 hours (1 year = 2,080 practice hours). When states required month/year and hour requirements, the longer of the two was used for classification. Of the states sampled in this study, Colorado, Maryland, Minnesota, Nebraska, and South Dakota met low-restriction criteria. Connecticut, Delaware, Maine, Nevada, Vermont, Virginia, and West Virginia met high-restriction criteria (**Table 1**).

Part III of the survey was to be completed only by participants who were working or had worked with the supervision or mentorship of a senior clinician as part of

TP requirements. Participants who did not answer part III were called the pre-TP group. Participants who answered part III, indicating they had worked or were working under TP legislation, were called the TP group.

Results

The sample consisted of 114 NPs practicing in 11 of the 12 inclusion states. **Table 2** summarizes the participants' characteristics.

Competency, safety, barriers, and access

Participants were asked to rate the following items on a Likert-type scale: 1. State mandated TP periods contribute to competency development among new graduate NPs. 2. State mandated TP periods promote safe NP practice. 3. State mandated TP periods pose unnecessary regulatory barriers to new graduate NPs. 4. State mandated TP periods limit consumer access to care. Analysis found that 58.8% of participants strongly agreed or agreed that TP legislation contributes to new graduate NP competency development. Just over 50% (51.8%) strongly agreed or agreed that TP legislation promotes safe NP practice. Nearly 60% (59.6%) strongly agreed or agreed that TP legislation limits patient access to care and 52.5% strongly agreed or agreed that transition requirements pose unnecessary regulatory barriers.

Chi-square tests for independence were used to examine the relationship between responses to these four questions and the participants' characteristics and regulatory environment. Given the limited sample size and interest in those who agreed with the statements, strongly agree/agree responses were categorized as agree and strongly disagree/disagree/neutral responses were categorized as disagree. Chi-square analysis indicated no statistically significant associations between years of RN experience, years of NP experience, NP education level (Master of Science in Nursing or Doctor of Nursing Practice), state restriction level (high or low), mentor's discipline (physician or NP), or TP group (pre-TP or TP), and responses to questions about TP legislation's effects on competency, safety, NP barriers, and patient access (**Table 3**).

Chi-square tests of independence were performed to examine the relationships between responses to the first four items addressing perceptions of TP legislation. For this analysis, strongly agree and agree responses were categorized as agree and strongly disagree and disagree responses were categorized as disagree. Neutral responses were excluded. Analysis found significant associations between those who agreed TP legislation promotes competency development and those who agreed it promotes patient safety and those who disagreed the legislation poses unnecessary regulatory barriers (**Table 4**). We can conclude that there is strong evidence that those who think TP legislation promotes competency and safety do not believe it poses unnecessary regulatory barriers.

Table 2. Participant characteristics

Characteristic	n	%
Sex		
Female	100	87.7
Male	14	12.3
Age		
<30	4	3.6
30–40	19	17.4
41–50	23	21.1
51–60	45	41.3
>60	18	16.5
Missing	5	
RN experience		
<5 years	21	18.4
5–10 years	30	26.3
>10 years	63	55.3
NP experience		
<5 years	37	33.0
5–10 years	13	11.6
>10 years	62	55.4
Missing	2	
Highest NP education		
MSN	74	66.1
DNP	31	27.7
Other	7	6.2
Missing	2	
Population focus		
FNP	63	57.3
ANP/AGNP	15	13.6
ACNP	7	6.4
Multiple	21	19.1
Other	4	3.6
Missing		4
Residency Participation		
No	110	96.5
Yes	4	3.5
Practice state		
Colorado	36	31.6
Connecticut	7	6.1
Delaware	2	1.8

Table 2. Participant characteristics, continued

Characteristic	n	%
Maine	0	0
Maryland	17	14.9
Minnesota	10	8.8
Nebraska	7	6.1
Nevada	9	7.9
South Dakota	6	5.3
Vermont	3	2.6
Virginia	11	9.6
West Virginia	3	2.6
Multiple	3	2.6
Group		
Pre-TP	53	46.5
TP	61	53.5

Note: ACNP = Acute Care Nurse Practitioner; ANP/AGNP = Adult Nurse Practitioner/Adult Geriatric Nurse Practitioner; FNP = Family Nurse Practitioner; NP = nurse practitioner; TP = transition to practice.

Senior clinician–nurse practitioner relationships and nurse practitioner development

Most participants reported that their senior clinician was a physician (59%). Most (61%) reported working at the same physical site as their senior clinician very frequently or frequently during the first month they practiced while most also worked at the same physical site as their senior clinician frequently or very frequently during the first 6 months they practiced (62.7%). Most also reported that they communicated very frequently or frequently with their senior clinician during the first month (70.7%) and first 6 months (61%) of their practice. A chi-square test for independence (with Yates' continuity correction) indicated no significant association between mentor/supervisor discipline (physician or NP) and communication frequency (never/rarely/occasionally or always/usually) during the first month, $\chi^2(1, n = 52) = 2.40, p = .12, \phi = -0.26$. No significant association between mentor/supervisor discipline and communication frequency was found during the first 6 months, $\chi^2(1, n = 53) = 1.90, p = .17, \phi = -0.23$. Participants reported that they were generally not provided with protected time to discuss patients and clinical questions with the senior clinician. Most (57.7%) never, rarely, or sometimes had protected time with their senior clinician, whereas 22% usually had it and 20.3% were always provided protected time.

Participants were asked whether the supervision they received or were receiving during the TP period was meaningful to their overall development as NPs. Sixty percent agreed or strongly agreed that it was meaningful, 11.7% were

neutral, and 28.4% disagreed or strongly disagreed. A chi-square test for independence (with Yates' continuity correction) indicated no significant association between mentor/supervisor discipline (physician or NP) and meaningfulness (strongly agree/agree or neutral/disagree/strongly disagree), $\chi^2(1, n = 30) = 0.635, p = .426, \phi = .281$ —or between state requirements (low or high) and meaningfulness (strongly agree/agree or neutral/disagree/strongly disagree), $\chi^2(1, n = 58) = 0.447, p = .504, \phi = 0.127$.

Employment effects

Thirty-one point six percent strongly agreed or agreed that requiring a TP period made finding a job more difficult, 28.3% were neutral, and 40% strongly disagreed or disagreed. Twenty-two percent were considering relocating to a state that did not require TP periods and 13.2% sought or were seeking employment in a state because it had TP requirements. Chi-square tests for independence (with Yates' continuity correction) indicated no significant association between state requirements (low or high) and difficulty in finding a job (agree/strongly agree or disagree/strongly disagree), $\chi^2(1, n = 42) = 0.002, p = .961, \phi = 0.061$. There was also no significant association between state requirements (low or high) and the NP considering relocating (agree/strongly agree or disagree/strongly disagree) to a state without TP requirements, $\chi^2(1, n = 46) = 0.016, p = .899, \phi = -0.072$.

Content analysis

Conventional content analysis was used for open-ended question response analysis (Hsieh & Shannon, 2005). The survey included two similar open-ended questions; responses were grouped for analysis. Seventy-eight respondents replied to the open-ended questions, 72 of whom (57.9% total respondents) included information relevant to the questions. Analysis identified three key themes: mentored transitions, legislative barriers, and frustration with arbitrary legislation.

Mentored transitions

The importance of mentorship in the transition of new graduate NPs was the dominant theme identified through content analysis ($n = 39, 54.2\%$). Three sub-themes were identified: competency development, nonlegislative solutions, and NP mentorship.

Competency development. Twenty-two (30.6%) participants expressed concerns about new graduate NP competence. Nineteen respondents (26.4%) linked TP legislation to competency development. One remarked, "I feel like it's [TP legislation] a good safety net for both pts [patients] and the new NPs." Another wrote, "I believe there is too much to know coming right out of school to be a safe practitioner, and I'm a seasoned nurse. The transition period can provide a time to learn more."

Nonlegislative solutions. Of the participants who wrote about the importance of mentorship, 14 (19.4%) expressed concern about legislating support. One wrote, "The mandate alone does not add to the experience or quality of care provided by the NP." Another participant remarked, "some transition program is needed—it is the mandated part that is concerning." Another stated, "I don't think legislation is relevant to this transition," which reflected another participant's statement, "Practice requirements should be determined by professional organizations/educators not mandated by law/regulation." Almost 10 percent ($n = 7$) of respondents expressed interest in residency programs. One wrote, "I support residency programs for transition support." Another stressed the distinction between TP legislation and residency support, "there's nothing helpful in TP hours. Now, if you were talking about a residency that would be great." One participant who works in a TP state began her career in a state with full practice autonomy and wrote, "I was practicing in Arizona my first 2 years, which did not mandate transition periods but had good mentors. I found this to be the most helpful."

Nurse practitioner mentors. Five (7%) stated that it was important that NPs, not physicians, mentor new graduates. One respondent wrote, "NPs should mentor their own." A participant from Connecticut wrote, "I would like to see transition under NP instead of just MD/DO—but otherwise fully approve of 1–3 year transition period." An NP who had served as a mentor wrote, "I've been able to answer a few questions via telephone, which I feel has been beneficial to them [new graduate NPs]."

Legislative barriers

Participants ($n = 34, 47.2\%$) described barriers imposed by TP legislation. A participant from Colorado wrote, "Many NPs have difficulty finding positions as new grads because of the limits on their license. They end up going out of state to find their first job." Another participant reported practicing in a neighboring state that does not require TP hours. Others saw the legislation as a barrier to effective collaboration: "TP agreements mandate no additional true oversight on education of new NPs. They also insult the good sense and judgment of people already trained to work collaboratively."

Frustration over arbitrary legislation

Participants ($n = 31, 43.1\%$) expressed frustration that state lines determined their degree of autonomy. One wrote, "Why am I not safe in Virginia but perfectly fine in Maryland or DC?" This same respondent also wrote, "Why 5 years? Seems arbitrary. What if I change practice areas—from cardiology to pulmonology—do I have to have a 'new' transition period?" A respondent from Maryland wrote, "If full practice authority is acceptable in other states, then why is it not good for all?" Another respondent, who reported 20 years of NP experience before moving to a state that required transition periods even for experienced NPs, commented, "I had to

Table 3. Cross tabulation^{a,b} competency, safety, barriers, and access^c with RN experience, NP experience, NP education, TP legislation, TP group, and mentor discipline

	Promotes Competency				Promotes Safety				Poses Barrier				Inhibits Access			
	#Disagree%	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV
RN experience																
<5 years	7	14	.906	CV	8	13	1.728	CV	10	11	.950	CV	10	11	.642	CV
	33.3%	66.7%		.089	38.1%	61.9%		.123	47.6%	52.4%		.091	47.6%	52.4%		.075
5–10 years	14	16			17	13			12	18			11	19		
	46.7%	53.3%			56.7%	43.3%			40.0%	60.0%			36.7%	63.3%		
>10 years	26	37			30	33			32	31			25	38		
	41.3%	58.7%			47.6%	52.4%			50.8%	49.2%			39.7%	60.3%		
NP experience																
<5 years	15	22	.060	CV	18	19	.464	CV	14	23	2.02	CV	13	24	.835	CV
	40.5%	59.5%		.023	48.6%	51.4%		.064	37.8%	62.2%		.134	35.1%	64.9%		.086
5–10 years	5	8			5	8			7	6			6	7		
	38.5%	61.5%			38.5%	61.5%			53.8%	46.2%			46.2%	53.8%		
>10 years	26	36			30	32			32	30			27	35		
	41.9%	58.1%			48.4%	51.6%			51.6%	48.4%			43.5%	56.5%		
NP education																
MSN	32	42	.270	ϕ	35	39		ϕ	31	43	3.617	ϕ	26	48	2.74	ϕ
	43.2%	56.8%		.072	47.3%	52.7%	.000	.020	41.9%	58.1%		-.206	35.1%	64.9%		-.183
DNP	11	20			14	17			20	11			17	14		
	35.5%	64.5%			45.2%	54.8%			64.5%	35.5%			54.8%	45.2%		
TP legislation																
Low	32	44	.000	ϕ	38	38	.046	ϕ	33	43	1.30	ϕ	30	46	.000	ϕ
	42.1%	57.9%		.020	50.0%	50.0%		.040	43.4%	56.6%		-.128	39.5%	60.5%		-.005

(continued)

Table 3. Cross tabulation^{a,b} competency, safety, barriers, and access^c with RN experience, NP experience, NP education, TP legislation, TP group, and mentor discipline, *continued*

	Promotes Competency				Promotes Safety				Poses Barrier				Inhibits Access			
	#Disagree%	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV	#Disagree %	#Agree %	χ^2	ϕ /CV
High	14	21			16	19			20	15			14	21		
	40.0%	60.0%			45.7%	54.3%			57.1%	42.9%			40.0%	60.0%		
TP group																
Pre-TP	25	28	1.02	ϕ	30	23	2.18	ϕ	24	29	.052	ϕ	22	31	.002	ϕ
	47.2%	52.8%		.113	56.6%	43.4%		.156	45.3%	54.7%		-.039	41.5%	58.5%		.022
TP	22	39			25	36			30	31			24	37		
	36.1%	63.9%			41.0%	59.0%			49.2%	50.8%			39.3%	60.7%		
Mentor																
Physician	14	22	.535	ϕ	16	20	.644	ϕ	19	17	.011	ϕ	15	21	.000	ϕ
	38.9%	61.1%		.132	44.4%	55.6%		.140	52.8%	47.2%		.048	41.7%	58.3%		.025
NP	6	17			7	16			11	12			9	14		
	26.1%	73.9%			30.4%	69.6%			47.8%	52.2%			39.1%	60.9%		

Note: NP = nurse practitioner; TP = transition to practice.

^a χ^2 with Yates' continuity correction reported 2 x 2 tables

^b ϕ reported for 2 x 2 tables and Cramer's V (CV) is reported tables > 2 x 2

^cStrongly agree/agree responses categorized as agree; strongly disagree/disagree/neutral responses categorized as disagree.

Table 4. Cross tabulation of competency, safety, barriers, and access responses^a

Question	Promotes Safety				Poses Barrier				Inhibits Access			
	Disagree	Agree	χ^2 Yates'	ϕ	Disagree	Agree	χ^2 Yates'	ϕ	Disagree	Agree	χ^2 Yates'	ϕ
Promotes competency												
Disagree	30	1	69.7 ^b	.904	2	33	27.53 ^b	-.59	3	32	11.69 ^b	-.390
Agree	3	56			33	18			24	29		
Promotes safety												
Disagree	xx	xx	xx	xx	2	34	28.75 ^b	-.621	4	34	12.59 ^b	-.410
Agree	xx	xx			30	15			23	24		
Poses barrier												
Disagree	2	30	28.75 ^b	-.621	xx	xx	xx	xx	22	8	38.80 ^b	.690
Agree	34	15			xx	xx			4	54		
Inhibits access												
Disagree	4	23	12.59 ^b	-.410	22	4	38.80 ^b	.690	xx	xx	xx	xx
Agree	34	24			8	54			xx	xx		

^aStrongly agree/agree categorized as agree; strongly disagree/disagree categorized as disagree. Neutral excluded.

^bSignificant <.001

apply for attestation under my Attending who was willing to sign for me but puzzled as to why an experienced NP needed supervision. We both were embarrassed.” Even respondents who valued mandated transition support expressed concern about arbitrary variations in requirements. For example, one respondent commented, “I think 1 to 2 years is reasonable—any more than that would be a barrier.”

Discussion and limitations

Quantitative response analysis found mixed perceptions of the effects of TP legislation. Most participants who felt TP legislation contributed to competency development and patient safety did not feel the legislation posed unnecessary regulatory barriers or limited patient access. Some participants agreed that the legislation promoted patient safety and NP competency and believed the legislation poses barriers to patient access. One explained, “I do think they’re [transition requirements] unnecessary but that doesn’t mean that they don’t increase competence/safety! But when they really limit NPs getting into underserved areas. . . [they do] more harm than good.” Despite over 50% of participants agreeing that TP periods promote competency development and contribute to patient safety, of those who had actually worked under TP regulation, almost 40% did not feel the legislation contributed to competency development.

Content analysis revealed an appreciation for mentored transition and support for nonlegislated opportunities for new graduate NPs, such as residencies and fellowships. This finding echoes studies that report new graduates express interest in postgraduate support programs (Hart & Bowen, 2016). Several participants in this study also reported that they doubted their own competence as new graduates or the competence of new graduate NPs with whom they worked, which also reflects the finding of Hart and Bowen (2016) that new graduate NPs doubt their competence.

The variability of TP legislation and the small numbers of participants from many TP states limit these findings. The research is also limited by the emerging nature of this legislation: for instance, at the time the survey was conducted, TP legislation had just been passed in Virginia; thus, respondents from Virginia did not have experiential insight into the legislation’s effects. Future researchers might recruit at the state level to examine the effects of state level variation more closely.

Conclusion

This study is the first to ask NPs who practice in states with TP legislation about their perceptions of the effects of this legislation. It is also the first to describe the relationship between NPs working in this regulatory model and their mentoring or

supervising clinician. Given the increasing number of states considering this legislative model, and the vast variability in TP models that have been adopted, additional research is needed. If TP legislation is found to have positive effects on new graduate NP competency development and patient safety, researchers must explore which variations provide the greatest positive impacts while causing as few restrictions to patient access to care as possible. Future research questions include what is the ideal length for a transition period? What elements of practice should be regulated? Who should mentor and what should be the communication expectations? Legislation, like our practice, should be evidence-based. If these regulatory environments can provide support to new graduate NPs, it is critical that we determine which aspects best balance supporting new graduate NPs without compromising the patient access to care.

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