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Growth in retail-based clinics after nurse practitioner scope of practice reform

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ABSTRACT

Background: Retail clinics are largely staffed by nurse practitioners (NPs) and are a popular destination for nonemergent care.
Purpose: We examined if there was a relationship between NP practice regulations and retail clinic growth after the passage of a scope of practice (SOP) reform bill in Pennsylvania.
Method: General linear regression models were used to compare retail clinic openings in Pennsylvania, New Jersey, and Maryland between 2006 and 2013.
Discussion: From 2006 to 2008, Pennsylvania experienced a significant growth rate in net retail clinic openings per capita ($p = .046$), whereas New Jersey and Maryland experienced no significant increase ($p = .109$ and .053, respectively). From 2009 to 2013, Pennsylvania opened 0.20 clinics ($p = .129$), New Jersey opened 0.23 clinics ($p = .086$), and Maryland opened 0.34 clinics per capita per year ($p = .017$).
Conclusions: Our study of three states with varying levels of SOP restraint reveals an association between relaxation of practice regulations and retail clinic growth.

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Introduction

Accessing high-quality health care is a public health priority, yet many Americans have difficulty accessing convenient care for nonacute illness (Dill, Pankow, Erikson, & Shipman, 2013; Laurant et al., 2005). Retail-based clinics (RBCs) are one answer to growing demand nationwide for more expedient medical care. Largely staffed by nurse practitioners (NPs), RBCs deliver a range of services, including immunizations, routine physicals, health coaching and diagnosis, and treatment of nonemergent conditions, such as bronchitis, sore throats, and urinary tract infections (Gilman & Koslov, 2014; Scott, 2007; Spetz, Parente, Town, & Bazarko, 2013; Traczynski & Udalova, 2013). More recently, large chains such as CVS (MinuteClinic) and Walgreens have begun to provide disease management services for chronic illnesses such as diabetes and hypertension (Japsen, 2013; Scott, 2007).

As of October 2014, there were 1,790 RBCs operating in the United States, which represented a 20% increase over 2013 (Merchant Medicine, 2014). The growth of RBCs has been attributed to convenient hours, lower

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out-of-pocket costs, and shorter wait times (Battaglia, 2009; Hsu, 2008; Rozga, 2009; Traczynski & Udalova, 2013; Tu & Boukus, 2013). Retail clinic success has also been attributed to their reliance on NPs as a cost-efficient means to provide necessary care services. Despite their growing presence in the health care landscape, few studies have examined if restrictions to NPs' scope of practice (SOP) across states produce barriers to RBC growth and expansion (Battaglia, 2009; Gilman & Koslov, 2014; Rozga, 2009; Schleiter, 2009; Scott, 2007; Spetz et al., 2013).

Recent studies have noted that access to health care is constrained in states with more restrictive SOP laws. Kuo, Loresto, Rounds, and Goodwin (2013), for instance, found that Medicare beneficiaries gained more access to care in states with the least restrictive SOP laws (Kuo et al., 2013). Similarly, Xue, Ye, Brewer, and Spetz (2016) found that greater SOP authority was linked to expanded care delivery, especially among rural and vulnerable populations (Xue et al., 2016). Restrictive regulatory environments, in addition to limiting access to health care, may also serve as a means to prevent competition and restrict NPs from entering into RBC practice (Battaglia, 2009; Gilman & Koslov, 2014). For instance, adherence to supervisory requirements may be difficult in states and regions suffering from a limited number of physicians (e.g., rural communities; Gilman & Koslov, 2014; Traczynski & Udalova, 2013). Such provisions may be even more challenging when they are linked to geographic restrictions, where the physician must be not only available (by phone) but also immediately physically accessible (Institute of Medicine [IOM], 2010; Yee, Boukus, Cross, & Samuel, 2013). Other states impose ratios that limit the number of NPs that a physician (MD) may supervise (Gilman & Koslov, 2014; Spetz et al., 2013; Traczynski & Udalova, 2013). Intensive supervisory requirements, such as those posed by maximum ratios or on-site supervision, may threaten RBCs' financial viability because more physicians are required to serve in these roles, resulting in increased cost (Spetz et al., 2013).

Early in the development of retail clinics, a number of states introduced legislation restricting both NPs' SOP and RBCs. In March 2007, Illinois introduced a bill that would require RBCs to have more physician supervision and that allowed MDs to supervise no more than two NPs (H.R. 1885, 2007). In 2007, Florida passed a bill that limited the number of clinic sites that a physician could supervise to four (Battaglia, 2009; H.R. 699, 2006; Scott, 2007).

In contrast, other states have proposed legislation to relax NP SOP restrictions, in hopes of encouraging RBC growth (Robert Wood Johnson Foundation [RWJF], 2015). One example of this occurred in Pennsylvania during the Edward G. Rendell administration with the enactment of "Prescription for Pennsylvania" (Rx4PA), in 2007. Rx4PA was a health reform effort proposed to address the state's rising health care costs, improve health care quality, and increase access to primary care (Rendell, 2007). Rendell linked his proposed legislation, in part, to the removal of practice barriers for advanced practice nurses, while also achieving a secondary aim of encouraging the growth of retail clinics (Scott, 2007).

Up to this point, few studies have examined the association between SOP regulatory environments and RBC growth (Tu & Boukus, 2013; Tu & Cohen, 2008). Although the opening of retail clinics is associated with market forces, such as socioeconomic demographics and potential for profitability (Bachrach, Frohlick, Garcimonde, & Nevitt, 2015; Pollack & Armstrong, 2009), here we examine if there is an association between SOP regulations and retail clinic growth. Specifically, we examine SOP reform and retail clinic expansion in Pennsylvania after passage of Rx4PA. We begin with a brief overview of Rx4PA, followed by our results from an analysis of RBC growth in Pennsylvania and two bordering comparator states, New Jersey and Maryland, before (2006) and after (2008) passage of Rx4PA.

Overview of Rx4PA

In 2007, Pennsylvania Governor Edward Rendell introduced Rx4PA as his signature health reform proposal. According to the administration, Rx4PA represented "a set of integrated, achievable, practical strategies focused on driving down costs, providing universal coverage, improving the quality of health care and driving down inefficiencies of the health care system" (Rendell, 2007, p. 6). Its motto, "The cost of inaction is far too great," spoke directly to the billions of dollars lost annually in Pennsylvania because of medical errors, avoidable chronic care hospitalizations, hospital-associated infections, and the cost of the uninsured (Rendell, 2007, p. 6).

One of Rx4PA's key initiatives aimed to ensure that all licensed health care providers practiced to the full extent of their education, including nurses, NPs, midwives, physician assistants, pharmacists, and dental hygienists (Rendell, 2007). At the time, one of every 10 Pennsylvania adults reported lacking a primary health care provider, representing a significant public health problem (Pennsylvania Department of Health, 2006). Pennsylvanians were also 11% more likely than all other Americans to use the emergency room (ER; Chollet, 2006).

One of the bills in the RX4Pa legislation was related to NP' SOP (HB 1253). HB 1253 eliminated the 4:1 physician-to-NP ratios, changed the prescribing of Schedule II medications from 7 to 30 days, and extended their ability to prescribe schedule III and IV drugs from 30 to 90 days (H.R. 1253, 2007). HB 1253 also changed regulations to allow NPs to order physical, respiratory, and occupational therapy; initiate dietician referrals; prescribe durable medical equipment; and issue oral orders in long-term care. After passage of HB 1253, NPs were also allowed to perform disability assessments, sign initial methadone treatment evaluations, and issue homebound school certifications. The SOP bill was passed into law on July 20, 2007 (University of Pennsylvania Almanac, 2007).