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Roger Brown, PhD
Director, Office of House of Delegates Affairs
American Medical Association
515 N. State Street
Chicago, IL 60654
Roger.Brown@ama.assn-org

Re: **Report 28 of the Board of Trustees (A-09): Collaborative Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio**

Dear Dr. Brown:

On behalf of the American Nurses Association (ANA), an official observer to the AMA House of Delegates, and the undersigned nursing organizations, we offer the following comments regarding AMA Board of Trustees Report 28, *Collaborative Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio.* The undersigned nursing organizations represent the estimated 260,000 advanced practice registered nurses (APRNs)[1] who, like our physician colleagues, are dedicated to providing valuable health care services in an increasingly challenging environment. APRNs, like other health care providers, value the importance of creating a health care system in which practitioners of all professions are able to make their maximal contribution, and where mutual respect forms the basis of transdiciplinary practice.

We agree with the report's point that the workforce shortage, particularly of primary care providers, needs urgent attention, and "it is imperative for physicians and APRNs to work together to ensure that patients receive optimal patient-centric care." We also agree that patients should be fully informed of the identity and role of *all* members of their health care team: physicians, nurses, advance practice nurses, therapists, etc. We also believe that patients should have the right to select, from the diverse array of qualified health care professionals, the providers of their choice to meet their individual health care needs.

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[1] Health Resources and Services Administration. National Sample Survey of Registered Nurses, Table 13. Distribution of advanced practice nurses by employment status and by national certification and state board recognition. Washington, DC. US Department of Health and Human Services. 2004. Retrieved 6/4/09 from http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/appendixa.htm.

Foundations and Legal Authority for Advanced Practice Registered Nurses

Like the practice of medicine, advanced practice nursing has evolved significantly over the years. Today, in order to enter advanced practice, nurse practitioners (NPs), nurse anesthetists (CRNA), nurse-midwives (CNMs) and clinical nurse specialists (CNSs) complete formal, accredited graduate educational programs, leading to a master's or doctoral degree in their specialty. These programs build on the student's prior baccalaureate education and clinical experience, and encompass both didactic as well as extensive supervised clinical practicum experiences. After graduation, APRNs pass national board examinations in order to attain certification prior to licensure. Strict standards for academic programs, licensure and certification ensure that APRNs are competent in their clinical specialty. Active engagement in ongoing practice and continuing professional education are requirements for recertification and/or licensure renewal.

Individual states hold the authority to regulate all health care professions based on state statutes. In the case of APRNs, this authority is typically vested in the respective Boards of Nursing, who determine an APRN's legally authorized scope of practice. Written agreements with other health care providers do not alter the state's authority in this area. APRNs practice within the recognized boundaries of their legally authorized scope of practice and adhere to other relevant nationally accepted professional standards of practice. Evidence of this is found in data from the Healthcare Integrity and Protection Data Bank (HIPDB) which shows that in the year 2008, the ratio of adverse actions (disciplinary and licensure actions of regulatory and other bodies, including criminal convictions) for NPs was 1 to 226, whereas it was 1 to 23 for MDs (medical doctors), and 1 to 13 for DOs (doctors of osteopathy).[2]

While national standards exist in the education and certification of APRNs, there is some inter-state variability in the regulation of APRNs. This, along with some state-based idiosyncratic requirements, sometimes bar APRNs from practicing to the full extent of their education and qualifications, and hinder their ability to make maximal contributions to health care. These impediments decrease patients' access to health care and threaten rather than enhance patient safety and quality of care. In 2008, over 40 nursing organizations endorsed the "Consensus Model for APRN Regulation,"[3] which provides for consistent national standards for licensure of APRNs to complement those for accreditation, certification and education that already exist. These standards form the legal foundation for APRN practice.

[2] Pearson, L. (2009). The Pearson Report. *The American Journal for Nurse Practitioners*, 13:2, 9.
[3] APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee (2008). "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education."

Safety and Quality of Care Provided by Advanced Practice Registered Nurses

The ability of APRNs to provide high quality, cost-effective care has been widely recognized by patients and the health care community and is supported by significant research and critical analysis. Several comprehensive reviews of the research literature, medical malpractice claims data,[4] governmental evaluations,[5, 6] systematic reviews,[7, 8, 9, 10, 11,12] and meta-analyses[13, 14] have been conducted to evaluate APRN practice. All have found that the quality of care provided by APRNs is high and comparable to that provided by MDs. In fact, the editor of the Annals of Internal Medicine determined that the "quality of primary ambulatory care given by NPs was indistinguishable from that given by physicians."[15] "Research conducted by the National Center for Health Statistics examining pregnancy outcomes for more than 90,000 births involving low-risk women found outcomes for nurse-midwives to be better than or similar to those for physicians."[16] Similarly, data from the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reveal overwhelming evidence of the safe care provided by APRNs.

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[4] Jordan, L. M., Kremer, M., Crawforth, K., Shott, S. (2001). Data-driven practice improvement: the AANA Foundation closed malpractice claims study. *AANA J*; 69(4): 301-11.
[5] United States Congress. Office of Technology Assessment (1981). *The costs and effectiveness of nurse practitioners.* Washington, DC: US Government Printing Office.
[6] United States Congress, Office of Technology Assessment (1986). *Nurse practitioners, physician assistants, and certified nurse-midwives: A policy analysis.* Washington, DC: US Government Printing Office.
[7] Sox, H. (1979). Quality of patient care by nurse practitioners and physician's assistants: A ten-year perspective. *Annals of Internal Medicine*, 91, 459 – 468.
[8] Ventura, M., Feldman, M. & Crosby, F. (1991). An information synthesis to evaluate nurse practitioner effectiveness. *Military Medicine*, 156, 286–291.
[9] Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioner working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819-823.
[10] Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., Sibbald, B. (2005). Substitution of doctors by nurses in primary care. *The Cochrane Library*, Issue 4.
[11] Hatem, M., Sandall, J., Devance, D., Soltani, H., Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.
[12] O'grady, E. Advanced practice registered nurses: The impact on patient safety and quality. Vol 2, Chapter 43 (pg 601 – 620). In Hughes, R. (Ed). (2008*). Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (AHRQ Publication No. 08-0043). Agency for Healthcare Research and Quality. Rockville, MD. http://www.ahrq.gov/qual/nurseshdbk/.
[13] Brown, S. & Grimes, D. (1995). A meta-analysis of nurse practitioners and nurse-midwives in primary care. *Nursing Research*, 44(8),332-339.
[14] Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioner working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819-823.
[15] Sox, H. (1979). Quality of patient care by nurse practitioners and physician's assistants: A ten-year perspective. *Annals of Internal Medicine*, 91, 465.
[16] MacDorman, M.F. and Singh, G.K . (1998). Midwifery care, social and medical risk factors, and birth outcomes in the USA. *J. Epidemiol. Community Health*; 52; 310-317.

Contributions of Advanced Practice Registered Nurses

APRNs serve a critical role by filling gaps in primary care. At least 66 percent of NPs practice in primary care settings. Twenty percent practice in remote rural or frontier settings.[17] Nurse practitioners and certified nurse-midwives play an essential role in federally-funded community health centers. Between 2000 and 2006, the number of primary care physicians at these centers grew by 57%, while the combined number of nurse practitioners, physician assistants, and certified nurse-midwives grew by 64%.[18] Both Dr. Nancy Nielsen, AMA President,[19] as well as the American College of Physicians have noted that more nurse practitioners are needed to fill the gaps in primary care.[20]

APRNs have also made a special contribution by increasing access to care for the poor and uninsured, as well as those in underserved urban and remote rural areas. Twenty percent of NPs practice in remote rural or frontier settings.[21] Twenty-four percent of CNMs practice in rural settings.[22] CRNAs administer 65% of the 26 million anesthetics in the U.S. annually and are the sole providers of anesthesia services in 85% of rural hospitals.[23] Unfortunately, the significant contributions of APRNs are not accurately reflected in many key surveys and data systems, because these fail to separately identify or collect data specific to APRNs. As autonomous health care providers, APRNs may bill Medicare and many other payers for their services. However, certain billing practices also render "invisible" much of the care provided by APRNs.

Understanding "Independence" and "Collaboration"

A major obstacle to achieving effective collaboration and inter-professional understanding is that there are different interpretations of key terms. "Independent" practice refers to the ability and responsibility of a provider to utilize the knowledge, skills, judgment and authority to practice to the full extent of their education and licensure. For example, APRNs as well as other health care professionals are often defined as "licensed independent practitioners," by the Joint Commission and other leading forces of health care. *Independent* should not be interpreted to mean "in a

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[17] American Academy of Nurse Practitioners, *Nurse Practitioner Facts*. AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.
[18] National Association of Community Health Centers (NACHC), the Robert Graham Center and the George Washington University School of Public Health and Health Services published "Access Transformed: Building a Primary Care Workforce for the 21st Century," http://www.nachc.com/client/documents/ACCESS%20Transformed%20full%20report.PDF.
[19] Alliance for Health Reform (March 20, 2009). *Pathways to Universal Coverage: Payment Reform Strategies for Containing Costs.* KaiserNetwork.Org: http://www.allhealth.org/briefing_detail.asp?bi=150.
[20] American College of Physicians (2009), *Nurse Practitioners in Primary Care*: 12.
[21] American Academy of Nurse Practitioners, *Nurse Practitioner Facts*. AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.
[22] American College of Nurse-Midwives, *Selected Results of ACNM Compensation & Benefits Survey.* http://www.midwife.org/siteFiles/education/ACNM_salary_survey_2005.pdf.
[23] Pine, M., Holt, K.D., Lou, Y.B. Surgical mortality and type of anesthesia provider. *AANA J* 2003;71(2):109-16.

vacuum." *Independent* practice is also not defined by the place of employment, the business model of the practice, or the method of reimbursement. Like physicians, APRNs collaborate and consult with many other health care providers, often on a daily basis, requesting consultations, and referring patients for specialized care. Like APRNs, physicians do so freely, without any requirement or consideration of a written collaboration agreement. Clearly, we agree that health care in all its current complexity is a team rather than a solitary activity.

The notion that physicians should supervise care provided by APRNs is outdated and dangerous. It is particularly problematic when it creates an unnecessary barrier to access to care in rural and underserved areas. It is inappropriate to expect physicians, or any other provider, to accept responsibility for care they have not provided. Physicians are not responsible for supervising care delivered by registered nurses, (including APRNs), therapists, or any other licensed health care professional. Each APRN is personally accountable for their practice, to patients, their respective licensing board , the nursing profession, and society. When a pediatric nurse practitioner is managing a well-child visit in an outpatient clinic, or a nurse midwife is managing a labor and birth in a hospital, or a family nurse practitioner treats a respiratory infection or manages a patient's diabetes or hypertension in his or her practice, those APRNs are legally responsible for the scope and quality of care which they provide. It is within APRNs' professional judgment to assess and treat those patients within the bounds of their legally authorized scope of practice.

The undersigned organizations would be happy to work with the AMA to establish guidance for physicians in developing interprofessional relationships with APRNs. We also agree that methodologically valid research into the effectiveness of different models of cooperation/collaboration, and identifying characteristics of well functioning teams, could be valuable and we would be happy to collaborate in the development and implementation of such studies. It is our hope that we can work together to have a positive impact on the health of our patients now and in the future.

Thank you for the opportunity to express our viewpoint on Report 28-A-09. Should you have any questions or comments concerning this submission, please feel free to contact Eileen Shannon Carlson, JD, RN, Associate Director of Government Affairs, Eileen.carlson@ana.org, 301-628-5093.

Sincerely,

American Academy of Nurse Practitioners
American College of Nurse-Midwives
American College of Nurse Practitioners
American Nurses Association
National Association of Clinical Nurse Specialists
National Association of Pediatric Nurse Practitioners
National Organization of Nurse Practitioner Faculties