

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
(Reference Committee B)

EXECUTIVE SUMMARY

The provision of health care in the United States today is a complex proposition. The American Medical Association (AMA) recognizes the vital role that all health care providers play in ensuring that patients receive high quality, cost-effective care. This is especially the case with advance practice nurses (APRNs). Over the last 40 years, APRNs have enjoyed great support from federal and state governments. Their scope of practice has significantly broadened, with the anticipation that such expansions would result in expanded access to care. Although the evidence shows that those expectations have not necessarily been met, it is undeniable that APRNs play a particularly important role in the delivery of health care today. The practice environment today supports the concept of a fluid consultative model between physicians and APRNs despite the lack of objective evidence and research to support one method of physician-APRN collaboration over another. Entering into a collaborative agreement is not an simple decision. State laws vary greatly as to issues that must be contemplated and agreed to when creating such agreements. Nevertheless, the AMA believes that there are important considerations that ought to be considered by any physician contemplating entering into a collaborative agreement with an APRN. The two-part analysis proposed in this report includes: (1) making a business case for entering into a collaborative agreement; and once step (1) is complete, (2) contemplating additional points of consideration that assess whether such an agreement will increase access to care and improve the quality of the care provided.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-09

Subject: Collaborative Practice Agreements between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio (Resolution 716, A-08, and Resolution 211, I-08)

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Referred to: Reference Committee B (Monica C. Wehby, MD, Chair)

1 INTRODUCTION

2
3 At the 2008 American Medical Association (AMA) Annual Meeting, the House of Delegates
4 referred Resolution 716 for a report back at the 2008 Interim Meeting. Resolution 716, (A-08),
5 presented by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont
6 Delegations, recommended that:

7
8 That our AMA develop criteria or elements that should be contained in agreements with
9 Advanced Practice Nurse Clinicians (APRNs), Nurse Practitioners, (NPs), and Clinical
10 Nurse Specialists (CNSs); and

11
12 Such model agreements, at a minimum, address quality of care, continuity of care, the
13 scope of practice of APRNs/NPs/CNSs within a specific collaborative agreement, the
14 verification and ongoing maintenance of the skills, education and training of the
15 APRNs/NPs/CNSs and the responsibilities of the collaborative physicians.

16
17 At the 2008 AMA Interim Meeting, the House of Delegates referred Resolution 211 for a report
18 back at the 2009 Annual Meeting. Resolution 211 (A-08) was introduced by the Indiana
19 Delegation and asked:

20
21 That our AMA policy reflect that the number of full-time equivalent nurse practitioners
22 supervised by a single physician not exceed the level above which objective evidence
23 based data indicates maintenance of good quality medical care would be endangered.

24
25 Given the complexities of the issues raised by these resolutions, the House of Delegates was
26 informed at the 2008 Interim Meeting of the creation of a task force consisting of members from
27 the AMA Council on Medical Service (CMS), Council on Legislation (COL) and Board of
28 Trustees (BOT). This report contains the recommendations of the task force. Specifically, this
29 report defines subsets of advance practice nurses (APRNs); analyzes state laws related to
30 collaborative practice agreements between physicians and APRNs, as well as state laws addressing
31 the physician-APRN supervisory ratio; discusses the two-step process physicians should follow
32 when contemplating the establishment of a collaborative agreement with an APRN; reviews AMA
33 policy and advocacy related to Resolutions 716 (A-08) and 211 (I-08).

1 BACKGROUND

2
3 With the creation of Medicare and Medicaid in the mid 1960s, the federal and state governments
4 were caught short in their new missions to provide health care services for those who had
5 previously been unable to afford or find medical care. The country looked to nurses who were
6 already experienced in patient care to fill the access gaps. Seasoned registered nurses completed
7 additional coursework and training to become APRNs. Appendix 1, entitled “Definitions: What is
8 an Advance Practice Nurse?,” contains a list of definitions for subsets of APRNs. The schooling
9 needed for an advance practice nursing degree involved paths ranging from a four-month university
10 continuing education program to a two-year nursing school master’s program. Eventually, these
11 professionals were sanctioned by Medicare to offer – under physician supervision and often,
12 written protocols – general medical and preventive, safety-net care to people in rural and inner-city
13 areas experiencing a shortage of physicians. Each state had (and continues to have) the authority to
14 determine the level of prescribing authority and physician supervision it would require for an
15 APRN to practice.

16
17 The number of APRNs practicing in the United States continues to rise. In 1970, for example,
18 there were 250 nurse practitioners (NPs), one subset of APRNs, practicing in the United States.
19 That number leapt to 15,400 in 1980 and 23,600 in 1992. In 1997 the Balanced Budget Act created
20 Medicare managed care and authorized NPs to bill Medicare for their services anywhere (not just
21 underserved areas) and in any practice setting allowed by state law. As a result, by 2000 there
22 were almost 88,000 NPs practicing in the United States and today, it is closer to 140,000.

23
24 APRN scope of practice varies widely by state. The majority of states now allow APRNs broad
25 prescribing authority. Moreover, many state regulations that required APRNs to be supervised by
26 physicians have now been amended to permit “collaborative practice agreements” with physicians,
27 the definitions of which vary from state to state. Finally, ten states, as well as the District of
28 Columbia, specifically permit NPs to practice independently, without physician involvement.

29
30 Despite the dramatically increasing numbers of APRNs in the United States, the expectations set
31 out in the 1960s for expanding patient care via the use of nurses have not been met. Moreover, as
32 the Baby Boom generation ages, both professions are facing undeniable workforce shortage issues.
33 As a result, the country finds itself today having come full circle, looking yet again at how to best
34 provide high quality health care services to those that are unable to afford or find medical care and
35 how to fill “access gaps.”

36
37 In today’s complex health care delivery system it is imperative for physicians and APRNs to work
38 together to ensure that patients receive optimal patient-centric care. Both professions bring with
39 them great strengths and unique perspectives which ought to be utilized when looking at how to
40 provide the safest, best possible care to all Americans.

41
42 STATE STATUTORY SUMMARIES

43
44 *How States Address Collaborative Practice Agreements Between Physicians and APRNs*

45
46 As stated above, state laws related to APRN scope of practice vary widely from state to state. A
47 2007 survey by the Center for Health Professions at the University of California, San Francisco¹,
48 that focused on NPs, illustrates this variation:

¹ Web. Center for the Health Professions website.
http://www.futurehealth.ucsf.edu/pdf_files/NP%20Scopes%20discussion%20Fall%202007%20121807.pdf

- 1 • 10 states² and the District of Columbia permit NPs to practice independently, without
- 2 physician involvement;
- 3 • 27 states³ require NPs to practice in collaboration with a physician;
- 4 • 21 states⁴ require a written practice protocol between the physician and NP;
- 5 • 10 states⁵ require MD supervision of NPs;
- 6 • 43 states⁶ and the District of Columbia allow NPs the explicit authority to diagnose;
- 7 • 20 states⁷ allow NPs the explicit authority to order tests;
- 8 • 32 states⁸ and the District of Columbia allow NPs the explicit authority to refer;
- 9 • 50 states and the District of Columbia allow NPs to prescribe in collaboration with a physician;
- 10 • 10 states⁹ and the District of Columbia allow NPs to prescribe drugs independently;
- 11 • 34 states¹⁰ require NPs to first secure a written prescriptive protocol with a physician; and
- 12 • 47 states¹¹ and the District of Columbia allow NPs to prescribe controlled substances.

13
14 Not surprisingly, a wide variation exists regarding state statutes addressing collaborative practice
15 agreements between physicians and APRNs, as well. One example is the definition of
16 “collaborative practice” itself. This term of art and how it is defined are not uniform across state
17 lines. While Alabama requires that the physician be available for direct communication, Delaware,
18 Illinois and Pennsylvania mandate a combination of direct personal contact and indirect contact via
19 telecommunication. Moreover, not all states refer to these arrangements as “collaborative practice
20 agreements.” Nebraska, for example, refers to “integrated practice agreements,” while Mississippi
21 refers to “collaborative/consultative agreements.”

22 The level of detail statutes provide with regard to the elements of collaborative practice agreements
23 also varies from state to state. Some states like Louisiana provide great detail with respect to the

² The states that allow for NP independent practice include Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon and Washington.

³ States that require collaborative practice between a physician and an NP include Alabama, Arkansas, California, Connecticut, Delaware, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, Virginia, West Virginia and Wyoming.

⁴ The following states require a written practice protocol: Alabama, California, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, South Carolina, Texas, Vermont, Virginia, West Virginia and Wyoming.

⁵ States that require physician supervision include Florida, Massachusetts, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia and Wisconsin.

⁶ The following states do not provide that NPs have the explicit authority to diagnose: California, Michigan, New Mexico, Ohio, Rhode Island, Tennessee and Virginia.

⁷ The following states allow NPs the explicit authority to order tests: Alabama, Arizona, Arkansas, Delaware, Florida, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Oregon, Washington and Wisconsin.

⁸ Alaska, Arkansas, California, Florida, Georgia, Illinois, Massachusetts, Michigan, Missouri, New Mexico, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia and Wyoming do not allow NPs the explicit authority to refer patients.

⁹ States where NPs have independent prescribing authority include Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon and Washington.

¹⁰ Of the 40 states that allow NPs to prescribe with physician collaboration, the following require a written protocol: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin and Wyoming.

¹¹ The following three states do not allow NPs to prescribe controlled substances: Alabama, Georgia and Missouri.

1 elements to be included in their “formal written collaborative agreement.” Specifically, Louisiana
2 law requires that these agreements include the following: (1) availability of the collaborating
3 physician for consultation or referral, or both; (2) methods of management of the collaborative
4 practice which shall include clinical practice guidelines; and (3) coverage of the health care needs
5 of a patient during any absence of the APRN and physician. Louisiana law goes further by laying
6 out the responsibilities of the collaborating physician with respect to the granting of controlled
7 substance authority to an APRN, providing consultations, using a back-up collaborating physician,
8 etc. Finally, this law also addresses the “mutual obligations and responsibilities” of the
9 collaborating physician and APRN and a “plan of accountability among the parties.”

10
11 In contrast to Louisiana, some states provide very little guidance as to what should be included in a
12 collaborative agreement between a physician and APRN. Iowa’s statute, for example, simply
13 states that the collaborative agreement ought to reflect both independent and cooperative decision
14 making and should be based on the preparation and ability of each practitioner practicing together
15 within the framework of their respective professional scopes of practice.¹²

16
17 As noted above, while 21 states require a written protocol, states like Minnesota only require a
18 written agreement for an APRN to exercise prescriptive authority.¹³ Some states, such as
19 Arkansas, California and Connecticut, specify the prescriptive or diagnostic authority of APRNs,
20 while others, like Georgia, specify that the supervising physician specialize in the same area of
21 practice in which the APRN seeks to provide health care to patients. For example, an ob/gyn or a
22 family practitioner should supervise a nurse midwife instead of an anesthesiologist or orthopaedic
23 surgeon.

24
25 Furthermore, some states limit collaborative practice agreement authority to certain practice sites
26 such as hospitals. Some states (e.g., Alabama, Arkansas and Mississippi) require the collaborative
27 agreements have specific quality assurance provisions and form specific oversight committees for
28 annual or biannual reviews of the terms of the agreement and the collaborative practice relationship
29 between the physician and the APRN. Most states, however, are completely silent on this issue.

30
31 Finally, a few states (e.g., Massachusetts, Nebraska and Pennsylvania) specifically require
32 professional liability insurance for the nonphysician provider. Only Massachusetts, however, sets
33 minimum requirements for insurance coverage. Specifically, Massachusetts law requires that a
34 supervising physician not enter into such an agreement, unless the nurse has professional
35 malpractice liability insurance with coverage of at least \$100,000 per claim, with a minimum
36 annual aggregate of not less than \$300,000.¹⁴

37 38 *How States Address the Physician to APRN Supervisory Ratio*

39
40 Of the states that do allow collaborative practice agreements, a small number of states provide
41 statutory guidance on the exact physician to APRN supervisory ratio. Alabama law, for example,
42 provides that a physician may enter into collaborative agreements with certified registered NPs not
43 exceeding a cumulative 120 hours (or three full time employees) per week, while California law
44 specifies that no physician shall supervise more than four NPs at once. However, some states make
45 very specific distinctions. While New York’s law does not allow physicians to enter into practice
46 agreements with more than four NPs who are not located on the same physical premises as the
47 collaborating physician; Pennsylvania does not allow a physician to supervise more than four

¹² See Iowa Admin. Code 655-7.1 (152) (West 2009).

¹³ See Minn. Stat. Ann. § 148.235 (West 2009).

¹⁴ See 243 Mass. Code Regs. 2.10 (2009).

1 certified registered NPs who prescribe and dispense drugs. Further, some states, like South
2 Carolina, require state board of nursing and board of medical examiners' approval where an
3 application is made for more than three APRNs to practice with one physician or when an APRN is
4 performing delegated medical acts in a practice site greater than 45 miles from the collaborating
5 physician. Importantly, of the states that set such parameters, some allow for a waiver of the
6 physician to APRN supervisory ratio. In Colorado, for example, the supervisory ratio can be
7 waived when there is a finding that quality patient care can be maintained.¹⁵

8
9 **DISCUSSION: CONSIDERATIONS FOR ENTERING INTO A COLLABORATIVE**
10 **AGREEMENT**

11
12 Long-standing AMA policy supports the need for a fully integrated multidisciplinary health care
13 team to ensure that patients get the best possible care. The need for a fully integrated
14 multidisciplinary health care team is especially true today in light of the workforce shortages
15 projected in both the medical and nursing professions. Physicians and nurses have common goals
16 that are integrated in their respective professions. These goals include ensuring that patients
17 receive safe and high quality health care and that patient outcomes reflect such care. While the
18 AMA recognizes nurses as valuable members of the health care team, the multidisciplinary health
19 care team should be led by a physician because physicians are in the best position to provide
20 coordination of disciplines to assure delivery of high quality patient care.

21
22 Physicians contemplating the addition of an APRN to their practice are faced with a difficult
23 decision with at least two dimensions. First, a physician must go through a business case
24 assessment in order to determine whether a case exists for creating a collaborative agreement with
25 an APRN. This is not a "one size fits all" analysis and the outcome will be practice-specific.
26 Second, once a physician determines that a business case exists for entering into a collaborative
27 agreement with an APRN, there is a series of subsequent issues that should be considered while
28 establishing this type of agreement. This second set of issues focuses more specifically on the
29 ability of this agreement to increase access to care for patients and ensure that patients continue to
30 receive optimal patient care.

31
32 *Step 1: Make a Business Case for Entering into a Collaborative Agreement with an APRN*

33
34 As discussed in detail above, state laws vary greatly when addressing collaborative agreements
35 between physicians and APRNs. Nevertheless, there are several critical issues that a physician
36 ought to initially consider when contemplating entering into such agreements. The following
37 checklist is a list of 11 issues for a physician to contemplate when making a business case for
38 entering into a collaborative agreement with an APRN. Notably, this list does not include guidance
39 on *what* ought to be contained in such agreements:

¹⁵ See Colo. Rev. Stat. § 12-36-106 (2008).

CHECKLIST: IS THERE A BUSINESS CASE FOR ENTERING INTO A COLLABORATIVE AGREEMENT WITH AN APRN?

| | |
|---|--|
| Check state laws | A physician should check for applicable state laws, including but not limited to, laws related to scope of practice, the corporate practice of medicine, the hiring of physicians by APRNs. |
| Get legal advice | A physician should discuss this contemplated relationship with an attorney, especially in light of the potential liability for a violation of the laws governing APRN scope of practice. |
| Contact insurance carrier | A physician should contact his/her professional liability carrier. (In addition to requiring the APRN to carry a minimum amount of professional liability insurance, a physician should consider maintaining coverage for any additional liability arising out of this contemplated relationship.) |
| Contact all private payers | A physician should contact all of payers he/she has a contract with, in order to understand their payment policies for the provision of care by an APRN in a collaborative agreement |
| Medicare and state Medicaid programs | A physician should be familiar with the Medicare and state Medicaid program payment policies for the provision of care by an APRN in a collaborative agreement. |
| Contact state and national medical specialty society | A physician should contact his/her state and specialty medical association, state medical board, state board of nursing, and state board of pharmacy to determine if any minimum standards have been set by any of these entities. |
| Analyze current work environment | A physician should give serious consideration to his/her current work environment to determine if the collaborative agreement being contemplated complements his/her existing practice (i.e. number of employees in the office, time allotted to the contemplated relationship, number of practice sites, is there physical space available, how would billing and administrative issues be handled, time available for consultation and referral, temperament, patient population, etc.). |
| Assess cost | A physician should assess if there are any resources for determining competitive salary, benefit packages, etc. A physician ought to think through what other resources an APRN might need. |
| Determine type of relationship | A physician should decide whether or not to form an employer-employee relationship, as opposed to an independent contractor relationship, with the APRN and fully understand the consequences of this decision. |
| Check clinical experience | A physician should familiarize him/herself with the clinical experience of the APRN being considered, including prescribing experience and experience managing patients, to make certain that the APRN being considered has experience in providing care to patients with the same or similar medical problems as the physician. |
| Conduct a background check | A physician should conduct a background check, including education, licensure status, prior employment history, and existence of any formal complaints or lawsuits arising out of professional services rendered, on the APRN being contemplated. |

1 *Step 2: Once a Business Case is Made, Review Additional Points of Consideration*

2
3 Building a business case for a collaborative agreement between a physician and an APRN is the
4 first step in this analysis. Next, when a physician is contemplating such an agreement he/she must
5 consider whether such an arrangement will expand access to care and improve the quality of the
6 health care being provided. After analyzing all state laws addressing collaborative practice
7 agreements, between physicians and APRNs, the AMA has developed a comprehensive
8 compilation of “additional points of consideration.” This document is not meant to be an
9 exhaustive list; rather, a resource for: (1) individual physicians when contemplating entering into
10 these types of agreements; and (2) the Federation when faced with legislation addressing these
11 agreements. This document can be tailored to fit the needs of individual physicians, as well as state
12 and national medical specialty societies. See Appendix 2, entitled “Additional Points of
13 Consideration – Physician-APRN Collaborative Agreements.”

14
15 RELEVANT AMA POLICY AND ADVOCACY

16
17 *AMA Policy Related to Resolutions 716 (A-08) and 211 (I-08)*

18
19 The AMA has several policies related to the relationship between physicians and APRNs and other
20 nonphysician providers. The AMA strongly advocates that physician supervision be a requirement
21 of any practice arrangement involving nonphysician providers (H-35.988, H-35.989, H-160.947,
22 H-160.949, H-160.950, H-360.989, AMA Policy Database), and that services delivered by an
23 advanced practice nurse (or other non-physician provider) be within the scope of each
24 practitioner’s medical license, and consistent with his or her training, experience and demonstrated
25 competence (H-35.989, H-160.947, H-160.950).

26
27 AMA policy also supports efforts to identify ways to effectively use NPs and other non-physician
28 providers as part of a multidisciplinary care team that can improve patient care (D-160.995,
29 H-280.967). With respect to Resolution 716 (A-08), Policies H-160.947 and H-160.950 each offer
30 a set of specific guidelines to help guide discussions of the roles and responsibilities of physicians
31 and allied health providers. Guidelines specifically developed to apply to integrated physician-NP
32 practices are outlined in H-160.950 as follows:

- 33
34 1. The physician is responsible for the supervision of nurse practitioners and other advanced
35 practice nurses in all settings.
36
37 2. The physician is responsible for managing the health care of patients in all practice
38 settings.
39
40 3. Health care services delivered in an integrated practice must be within the scope of each
41 practitioner’s professional license, as defined by state law.
42
43 4. In an integrated practice with a nurse practitioner, the physician is responsible for
44 supervising and coordinating care and, with the appropriate input of the nurse practitioner,
45 ensuring the quality of health care provided to patients.
46
47 5. The extent of involvement by the nurse practitioner in initial assessment, and
48 implementation of treatment will depend on the complexity and acuity of the patients’
49 condition, as determined by the supervising/collaborating physician.

- 1 6. The role of the nurse practitioner in the delivery of care in an integrated practice should be
2 defined through mutually agreed upon written practice protocols, job descriptions, and
3 written contracts.
4
- 5 7. These practice protocols should delineate the appropriate involvement of the two
6 professionals in the care of patients, based on the complexity and acuity of the patients'
7 condition.
8
- 9 8. At least one physician in the integrated practice must be immediately available at all times
10 for supervision and consultation when needed by the nurse practitioner.
11
- 12 9. Patients are to be made clearly aware at all times whether they are being cared for by a
13 physician or a nurse practitioner.
14
- 15 10. In an integrated practice, there should be a professional and courteous relationship between
16 physician and nurse practitioner, with mutual acknowledgment of, and respect for each
17 other's contributions to patient care.
18
- 19 11. Physicians and nurse practitioners should review and document, on a regular basis, the care
20 of all patients with whom the nurse practitioner is involved. Physicians and nurse
21 practitioners must work closely enough together to become fully conversant with each
22 other's practice patterns.
23

24 With respect to Resolution 211 (I-08), Policy H-35.975 states that the appropriate supervisory ratio
25 of physician to physician extenders should be determined by physicians at the practice level,
26 consistent with good medical practice and state law.
27

28 *Current and Future AMA Advocacy Related to Resolutions 716 (A-08) and 211 (I-08)*
29

30 The AMA's Advocacy Resource Center (ARC) devotes one full-time attorney to cover state scope
31 of practice issues. This attorney also staffs the Scope of Practice Partnership (SOPP), a
32 collaborative effort within the Federation that was formed to coordinate organized medicine to
33 oppose scope of practice expansions by nonphysician providers that threaten the health and
34 safety of patients. In addition to monitoring legislative and regulatory activity related to APRN
35 scope of practice issues, including collaborative agreements, in all 50 states and the District of
36 Columbia, the AMA's ARC is in the process of developing a series of advocacy tools relevant to
37 Resolutions 716 and 211, including but not limited to: (1) state statutory analyses; (2) state laws
38 charts; (3) one page educational overviews of various APRNs; (4) geo-maps¹⁶ for all 50 states and
39 the District of Columbia; and (5) a monthly reporting tool on legislative and regulatory activity.

¹⁶ The AMA's Geomapping Initiative was developed in order to ascertain a factual and visual depiction of the practice location of physicians and corresponding nonphysician providers. Phase I of this project involved collecting and mapping the data for physicians in the United States. This collection was stratified even further into mapping for the ten physician specialties most affected by the claims asserted by these nonphysician groups. Phase II of this project involved mapping the practice locations of the corresponding nonphysician groups. Organized medicine now has a useful visual tool to demonstrate to law- or policy-makers the geographic extent of the medical care provided by physicians in each state, as well as the areas in which physician coverage is lacking--as contrasted with the nonphysician practice patterns. Not surprisingly, the AMA has found these maps to be very successful tools for showing that nonphysicians practice primarily in the same urban/suburban areas that physicians do, thereby dispelling the argument, in the scope of practice arena, that expanded privileges necessarily result in expanded access to care. These geo maps are available to AMA members at www.ama-assn.org/go/geomaps.

1 The ARC will continue to proactively work with the Federation on all of the issues that arise in the
2 context of collaborative practice agreements between physicians and APRNs. Finally, it is notable
3 that the SOPP has identified the issues raised in Resolutions 716 and 211 as critical issues that
4 deserve continual monitoring. As such, the SOPP has pledged to devote both time and resources to
5 assisting the Federation in ensuring that any legislation that addresses collaborative agreements
6 between physicians and APRNs reflects the issues raised in both the business case checklist and the
7 additional points of consideration document discussed in this report. The legislative and regulatory
8 activity monitored by the ARC, as well as the available advocacy tools related to collaborative
9 practice agreements between physicians and APRNs are available to AMA members at [www.ama-](http://www.ama-assn.org/go/arc)
10 [assn.org/go/arc](http://www.ama-assn.org/go/arc).

11

12 CONCLUSION

13

14 The provision of health care in the United States today is a complex proposition. The AMA
15 recognizes the vital role that all health care providers play in ensuring that patients receive high
16 quality, cost-effective care. This is especially the case with APRNs. Over the last 40 years,
17 APRNs have enjoyed great support from federal and state governments. Their scope of practice
18 has significantly broadened, with the anticipation that such expansions would result in expanded
19 access to care. Although the evidence shows that those expectations have not necessarily been met,
20 it is undeniable that APRNs play a particularly important role in the delivery of health care today.
21 The practice environment today supports the concept of a fluid consultative model between
22 physicians and APRNs despite the lack of objective evidence and research to support one method
23 of physician-APRN collaboration over another. Entering into a collaborative agreement is not a
24 simple decision. State laws vary greatly as to issues that must be contemplated and agreed to when
25 creating such agreements. Nevertheless, the AMA believes that there are important considerations
26 for any physician contemplating entering into a collaborative agreement with an APRN. The two-
27 part analysis proposed in this report includes: (1) making a business case for entering into a
28 collaborative agreement; and once step (1) is complete, (2) contemplating additional points of
29 consideration that assess whether such an agreement will increase access to care and improve the
30 quality of the care provided.

31

32 RECOMMENDATIONS

33

34 The Board of Trustees recommends that the following be adopted in lieu of Resolutions 716 (A-08)
35 and 211 (I-08) and the remainder of the report be filed:

36

- 37 1. That our American Medical Association continue to work with the Federation in developing
38 necessary state advocacy resource tools to assist the Federation in: (a) addressing the
39 development of collaborative practice agreements by practicing physicians; and (b) responding
40 to or developing state legislation or regulations governing collaborative practice agreements,
41 and that the AMA make these tools available on the AMA Advocacy Resource Center Web
42 site. (Directive to Take Action)
- 43
- 44 2. That our AMA support the development of methodologically valid research comparing the
45 methods of physician-APRN collaboration and their respective effectiveness. (New HOD
46 Policy)
- 47
- 48 3. That our AMA reaffirm Policy H-160.950, which states “[o]ur AMA endorses the following
49 guidelines and recommends that these guidelines be considered and quoted only in their
50 entirety when referenced in any discussion of the roles and responsibilities of NPs: (1) The
51 physician is responsible for the supervision of nurse practitioners and other advanced practice

1 nurses in all settings. (2) The physician is responsible for managing the health care of patients
2 in all practice settings. (3) Health care services delivered in an integrated practice must be
3 within the scope of each practitioner’s professional license, as defined by state law. (4) In an
4 integrated practice with a nurse practitioner, the physician is responsible for supervising and
5 coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality
6 of health care provided to patients. (5) The extent of involvement by the nurse practitioner in
7 initial assessment, and implementation of treatment will depend on the complexity and acuity
8 of the patients’ condition, as determined by the supervising/collaborating physician. (6) The
9 role of the nurse practitioner in the delivery of care in an integrated practice should be defined
10 through mutually agreed upon written practice protocols, job descriptions, and written
11 contracts. (7) These practice protocols should delineate the appropriate involvement of the two
12 professionals in the care of patients, based on the complexity and acuity of the patients’
13 condition. (8) At least one physician in the integrated practice must be immediately available
14 at all times for supervision and consultation when needed by the nurse practitioner. (9)
15 Patients are to be made clearly aware at all times whether they are being cared for by a
16 physician or a nurse practitioner. (10) In an integrated practice, there should be a professional
17 and courteous relationship between physician and nurse practitioner, with mutual
18 acknowledgment of, and respect for each other’s contributions to patient care. (11) Physicians
19 and nurse practitioners should review and document, on a regular basis, the care of all patients
20 with whom the nurse practitioner is involved. Physicians and nurse practitioners must work
21 closely enough together to become fully conversant with each other’s practice patterns. (CMS
22 Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240 and Reaffirmation A-00).” (Reaffirm
23 HOD Policy)

24
25 4. That our AMA reaffirm Policy H-35.975, which states “[t]hat the AMA endorse the principle
26 that the appropriate ratio of physician to physician extenders should be determined by
27 physicians at the practice level, consistent with good medical practice, and state law where
28 relevant.” (Reaffirm HOD Policy)

29
30
31
32
33 Fiscal Note: \$10,836 to conduct state advocacy efforts, including the development of state
34 advocacy resource tools

Appendix 1:

DEFINITIONS: WHAT IS AN ADVANCE PRACTICE NURSE?

Advance practice nurses (APRN) are typically defined as registered nurses who have a current license to practice professional nursing in a state, and maintain certification from a national nursing certifying body as a nurse practitioner (NP), certified nurse-midwife (CNM), certified registered nurse anesthetist (CRNA) or clinical nurse specialist (CNS). State regulations may require that an APRN obtain a master's degree or may place other requirements on candidates for APRN licensure.

Nurse Practitioner (NP)

A NP is a licensed registered nurse who has advanced nursing credentials demonstrated through formal education and/or training. Most states now specify in their nursing practice acts that NPs must obtain a master's degree in nursing to be authorized for advanced practice nursing in their state. Some states, however, require only such advanced training as a post-basic program certificate in a clinical nursing specialty or a certificate program.

Official definitions of "NP" consistently state that NPs receive training beyond that of a registered nurse, but otherwise the definitions diverge with regard to NP duties and/or responsibilities. The California Board of Registered Nursing, for example, states, "[t]he nurse practitioner is a registered nurse who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health and illness needs in primary health care."¹⁷ In another example, the United States Department of Health and Human Services defines NPs as registered nurses who have advanced academic and clinical experience that enables them to diagnose and manage acute, episodic and chronic illnesses.¹⁸ The American Association of Nurse Practitioners, a professional organization representing NPs, defines NPs as advanced practice nurses who ". . . provide high-quality health care services similar to those of a doctor" and who "diagnose and treat a wide range of health problems. They have a unique approach and stress both care and cure."¹⁹

Certified Nurse Midwife (CNM)

According to the American College of Obstetricians and Gynecologists' Guidelines for Implementing Collaborative Practice (1995) ("the Guidelines), CNMs have been educated in both nursing and midwifery and their practice focuses on "pregnancy, childbirth, the postpartum period, care of the newborn, family planning and gynecologic needs of women." According to the Guidelines, the American College of Nurse-Midwives (ACNM) establishes requirements for certification that are implemented by the ACNM Certification Council, Inc. Further, educational programs for CNMs are accredited by ACNM's Division of Accreditation and are reviewed regularly for program quality. Finally, since 1971, national requirements for certification of CNMs

¹⁷ Web. California Board of Registered Nursing. The certified nurse practitioner. Retrieved March 25, 2008. www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf.

¹⁸ Web. The Health Resources and Services Administration, United States Department of Health and Human Services. www.bhpr.hrsa.gov/healthworkforce/reports/nursing/changeinpractice/chapter4.htm. Retrieved November 30, 2007.

¹⁹ Web. American Academy of Nurse Practitioner (AANP). Find a nurse practitioner/what is a nurse practitioner. Retrieved November 30, 2007. www.aanp.org.

include “graduation from an accredited nurse-midwifery program and passing the examination administered by the ACNM.”

Certified Registered Nurse Anesthetist (CRNA)

The Centers for Medicare & Medicaid Services (CMS) defines a CRNA as a registered nurse who is licensed as a registered professional nurse by the state in which the nurse practices; meets any licensure requirements the state imposes with respect to non-physician anesthetists; has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs or such other accreditation organizations; and has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other organization that may be designated.²⁰ The United States Government Accountability Office defines CRNAs as “registered nurses who have completed a two- to three-year master’s degree program in nurse anesthesia and who typically provide anesthesia care in health care settings with anesthesiologists and surgeons.”²¹

While the American Association of Nurse Anesthetists, the professional organization representing CRNAs, reports on its Web site that “some CRNAs have chosen to specialize in pediatric, obstetric, cardiovascular, plastic, dental, or neurosurgical anesthesia,” subspecialty board certifications for CRNAs do not exist at this time.²² Additionally, no United States Department of Education-recognized accreditors of nursing educational programs accredit training programs in any of the above-mentioned specialties within the field of nursing anesthesia. Finally, there are several states that do not recognize CRNAs as APRNs including Arizona, Alaska, Indiana, California, New York, Pennsylvania and Virginia. In New York, for example, CRNAs are referred to as “registered professional nurses” in statute.

Clinical Nurse Specialist (CNS)

CMS defines a CNS as a registered nurse who is currently licensed to practice in the state where he or she practices and is authorized to perform the services of a CNS in accordance with state law; has a master’s degree in a defined clinical area of nursing from an accredited educational institution; and is certified as a CNS by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary of CMS.²³

²⁰ Web. Centers for Medicare and Medicaid Services (CMS). “Services of a certified registered nurse anesthetist or an anesthesiologist’s assistant: basic rule and definitions.” 42 CFR Ch. IV § 410.69 (10-1-02 Edition). http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr410.69.pdf. Retrieved September 21, 2008.

²¹ Web. United States Government Accountability Office (GAO). Report to Congressional Requesters. “VA Health Care: Many Medical Facilities Have Challenges in Recruiting and Retaining Nurse Anesthetists.” December, 2007: 1. www.gao.gov/new.items/d0856.pdf www.gao.gov/new.items/d0856.pdf. Retrieved May 15, 2008. However, note that not all licensed, practicing nurse anesthetists have obtained a master’s degree.

²² Web. AANA. Qualifications and Capabilities of the Certified Registered Nurse Anesthetist. www.aana.com/becomingcrna.aspx?ucNavMenu_TSMMenuTargetID=102&ucNavMenu_TSMMenuTargetType=4&ucNavMenu_TSMMenuID=6&id=112&terms=subspecialty. Retrieved May 12, 2008.

In its Standards for Accreditation (2006) and Accreditation Policy and Procedures (2007), the Council for Accreditation of Nurse Anesthesia Educational Programs makes no mention of clinical fellowships, residencies or specialty training.

²³ Web. Centers for Medicare and Medicaid Services (CMS). http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.75.pdf

The National Association of Clinical Nurse Specialists (NACNS) further defines their members as expert clinicians in a specialized area of nursing practice. NACNS identifies this specialization in terms of: (1) a population (e.g. pediatrics, geriatrics, women's health); (2) a setting (e.g. critical care, emergency room); (3) a disease or medical subspecialty (e.g. diabetes, oncology); (4) a type of care (e.g. psychiatric, rehabilitation); or (5) a type of problem (e.g. pain, wounds, stress).²⁴ While a CNS can obtain certification by examination in some specialties, for many, no such exam exists. According to the NACNS, the American Nurses Credentialing Center (ANCC) offers the "CNS-BC" credential to individuals who successfully complete clinical nurse specialist exams in: Adult Health CNS; Adult Psychiatric & Mental Health CNS; Child/Adolescent Psych & Mental Health CNS; CNS Core Exam; Diabetes Management – Advanced Gerontological CNS; Home Health CNS; Pediatric CNS; and Public/Community Health CNS.²⁵

²⁴ Web. AACNS website. <http://www.nacns.org/AboutNACNS/FAQs/tabid/109/Default.aspx>

²⁵ Web. AACNS website. <http://www.nacns.org/AboutNACNS/FAQs/tabid/109/Default.aspx>

Appendix 2:

ADDITIONAL POINTS OF CONSIDERATION PHYSICIAN-APRN COLLABORATIVE AGREEMENTS

- Verify the APRN's licensure status;
- Conduct a thorough background check of the APRN at issue, in order to determine the following:
 - The APRN's education;
 - The APRN's licensure status;
 - The APRN's prior employment history; and
 - The existence of any formal complaints or lawsuits arising out of professional services rendered;
- Ensure that the agreement entered into is commensurate with the education, preparation, and ability of each practitioner;
- Ensure that the collaborating physician at issue (as well as any back-up physician) holds an unencumbered license and actively practices medicine in the state at issue;
- Obtain written verification of health care facility approved clinical privileges;
- Conduct an analysis on whether the contemplated agreement requires an employment relationship between the collaborating physician and APRN;
- Take into account the following related to the collaborating physician's practice:
 - Geographical proximity;
 - Practice setting;
 - Volume and complexity of the patient population; and
 - The experience, training, and availability of both the collaborating physician and the APRN.
- Require that APRN complete a minimum number of hours of practice under the supervision of the collaborating physician before entering into agreement;
- Require that the agreement be in writing and signed by both parties;
- Identify all sites where APRN will practice;
- Identify the primary practice location for the collaborating physician;
- Ensure that the agreement is available at all sites where collaborating physician and APRN are practicing;
- Ensure that transport and back-up procedures are in place for the immediate care of patients who are in need of emergency care beyond the APRN's scope of practice for such times when the collaborating physician is not on the premises;
- Identify a back-up plan for medical coverage by other physician (where collaborating physician is unavailable);
- Create standardized procedures/protocols for drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered, and implemented by APRN;
- Create a standardized process for physician evaluation (i.e. every three, six months), where patient is prescribed medications or therapeutics by APRN;
- Establish clear protocols related to the following:
 - Notifying patients when they are being treated by the collaborating physician or APRN;
 - Considering the use of nametags that clearly identify the APRN as an APRN;
 - Informing patients about how to access care when both the APRN and/or collaborating physician are absent from the practice setting;

- Confirming that APRN is in a comparable specialty area or field as collaborating physician;
 - Creating written protocols specific to specialty practice area of collaborating physician;
 - Specifically identifying what APRN may do and under what circumstances;
 - Identifying a formulary describing the categories of medications to be prescribed and/or issued by the APRN;
 - Defining the extent of collaborating physician's supervision;
 - Requiring documentation of all acts of prescriptive authority;
 - Establishing availability of collaborating physician for consultation on medical problems, complications, or emergencies or patient referral;
 - Establishing a method to resolve disagreements between the collaborating physician and APRN regarding matters of diagnosis and treatment;
 - Identifying which authorized procedures require the presence of the collaborating physician as the procedures are being performed;
 - Identifying a method of periodic review of orders, services provided, and patient outcomes, including but not limited to: (1) review of medical therapeutics; (2) review of corrective measures; (3) review of lab tests and other diagnostic procedures; (4) peer review; and (5) review of the provisions of the standardized procedure;
 - Creating a procedure for identifying conditions that require direct evaluation or specific consultation by the collaborating physician; and
 - Creating mechanisms for effective case management, including but not limited to appropriate record keeping.
- Establish a plan for keeping information in the protocol updated, i.e., a yearly review by all parties to the agreement;
 - Specify a referral process to a physician other than the collaborating physician;
 - Specify a plan for quality assurance management with established patient outcome indicators for evaluation of APRN's clinical practice:
 - Ensure that all quality assurance monitoring is documented and readily accessible;
 - Establish a plan of accountability among the parties to the agreement;
 - Consider requiring continued nursing education coursework;
 - Consider requiring a minimum of professional liability insurance to be carried by the APRN – in addition to the additional coverage the physician ought to carry for any liability he/she may incur;
 - Establish clear employment arbitration dispute procedures;
 - Register the agreement, where necessary per state law, with state board of medicine, board of nursing, department of health, board of pharmacy, or any other state agency or department;
 - Ensure the contemplated agreement is consistent with state scope of practice laws; and
 - Ensure the contemplated agreement is consistent with any rules promulgated by the state board of medicine, state board of nursing and/or state board of pharmacy.