CURRENT CONTROVERSIES OVER THE REGULATION OF AND PHYSICIAN COLLABORATION WITH ADVANCED PRACTICE NURSING

Presented by the American Bar Association Health Law Section and Center for Professional Development
Submit a Question

Visit https://americanbar.qualtrics.com/SE/?SID=SV_2uB91twXeymw6FL&pCode=CE1606CCR
to submit a question on the content of this course to program faculty. We’ll route your question to a
faculty member or qualified commentator in 2 business days.

The materials contained herein represent the opinions of the authors and editors and should not be
construed to be the action of the American Bar Association Health Law Section or Center for
Professional Development unless adopted pursuant to the bylaws of the Association.

Nothing contained in this book is to be considered as the rendering of legal advice for specific cases, and
readers are responsible for obtaining such advice from their own legal counsel. This book and any forms
and agreements herein are intended for educational and informational purposes only.

© 2016 American Bar Association. All rights reserved.

This publication accompanies the audio program entitled “Current Controversies over the Regulation of
and Physician Collaboration with Advanced Practice Nursing” broadcast on June 1, 2016 (event code:
CE1606CCR).
Current Controversies over the Regulation of and Physician Collaboration with Advanced Practice Nursing

Wednesday, June 1, 2016 | 12:00 PM Eastern
Sponsored by the Health Law Section and the ABA Center for Professional Development

Panelists:
Melanie L. Balestra, Irvine, CA
Maureen A. Cahill, Associate, National Counsel of State Boards of Nursing, Chicago, IL
Kristin Schleiter, Senior Legislative Attorney, American Medical Association, Chicago, IL

Moderator:
Marc M. Meyer, Magnolia, TX
Current Controversies over the Regulation of and Physician Collaboration with Advanced Practice Nursing
Melanie L. Balestra

Objectives

• Participant will be able to state difference between full practice, reduced practice and restricted practice states for NPs
• Participant will be able to name two federal agencies sporting independent practice of NPs
Definition—Full Practice

State practice and licensure law provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Definition—Reduced Practice

State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State law requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care or limits the setting or scope of one or more elements of NP practice.
Definition—Restricted Practice

State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team management by an outside health discipline in order for the NP to provide patient care.

Full Practice States

Washington  Oregon  Wyoming
– Idaho  Montana  Maryland
– Nevada  Arizona  Delaware
– New Mexico  North Dakota  Alaska
– Minnesota  Iowa  Rhode Island
– Nebraska  Colorado  Hawaii
– Maine  Maine  Connecticut
– Vermont  New Hampshire  D.C.
## Reduced Practice States

- Utah  Kansas  South Dakota-BON,MBOS
- Wisconsin  New Jersey  Delaware
- Illinois  Indiana
- Ohio  Pennsylvania
- New York  Massachusetts
- West Virginia  Kentucky
- Arkansas  Louisiana
- Mississippi  Alabama—Board of
- Arkansas  Medical Examiners

## Restricted Practice States

- California  Georgia
- Texas  Florida—BON & MB
- Oklahoma
- Missouri
- Tennessee
- North Carolina
- Virginia
- South Carolina
States Not Requiring National Certification

- California
- Nebraska
- New York—graduate degree OR national certification

Federal Recognition of NPs

- CMS—NPs get own number, billing 85%
- Medicaid—NPs get own number, billing 85%
- FTC—2014 Policy Paper
  - Competition and the Regulation of APRNs
- VA Bill—Frontlines to Lifetimes Act of 2015
  - SB 297
National Counsel of State Boards of Nursing

- APRN Compact approved May 4, 2015
  - Multistate license—each party state
  - Facilitates exchange of information
  - Uniform licensure
  - Facilitates States’ Responsibilities to protect public
  - Independent practice
    - No collaboration with physician
    - No supervision by physician

References

Senate Bill 297
www.aanp.org
www.cms.gov
www.ncsbn.org
AMA policy

- The AMA opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state’s requirements for licensure to engage in the practice of medicine and surgery in all of its branches.
- Physicians must retain authority for patient care, and is ultimately responsible for ensuring the quality of health care provided to patients
- Physicians are best qualified by their education and training to lead the health care team
Why?

- Education and training
  - Physicians: 10,000 hours / 11 years of education and training (4 year BA/BS + 4 year MD/DO + 3 years family medicine residency)
    - Physicians subject to progressive levels of independence through residency training
  - Nurse practitioners: 6-8 years of education and training (4 year BA/BS + 1 year of practice minimum + 2-3 year MSN/DNP)
- The future of medicine is moving toward coordination, not fragmentation
- Patient preference for coordinated care (98%) and opposition to NP independent practice (78%)
- Liability considerations
- Trends in medical practice, including CME and specialty certification is towards higher standards and more regulation, not less

Why?

- APRN independence is not the solution to access to care
Defining team-based care

- Team-based health care: The provision of health care services by a physician-led team of at least two health care practitioners who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
- Physician leadership: Use of the knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

The structure and function of health care teams

- The physician leader of a physician-led interprofessional health care team should be empowered to perform the full range of medical interventions that she or he is trained to perform.
- All members of a physician-led interprofessional health care team should be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
Physician leaders should…

- Focus the team on patient and family-centered care.
- Make clear the team’s mission, vision and values.
- Direct and/or engage in collaboration with team members on patient care.
- Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
- Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
- Encourage adherence to best practice protocols that team members are expected to follow.
- Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
- Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
- Facilitate the work of the team and be responsible for reviewing team members’ clinical work and documentation.
- Review measures of “population health” periodically when the team is responsible for the care of a defined group.

Patient centered

- The patient is an integral member of the team.
- A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
- Patient and family-centered care is prioritized by the team and approved by the physician team leader.
- Team members are expected to adhere to agreed upon practice protocols.
- Improving health outcomes is emphasized by focusing on health as well as medical care.
- Patients’ access to the team, or coverage as designated by the physician-led team, is available 24 hours a day, seven days a week.
- Safety protocols are developed and followed by all team members.
Teamwork

- Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
- All practitioners commit to working in a team-based care model.
- The number and variety of practitioners reflects the needs of the practice.
- Practitioners are trained according to their unique function in the team.
- Interdependence among team members is expected and relied upon.
- Communication about patient care between team members is a routine practice.
- Team members complete tasks according to agreed upon protocols as directed by the physician leader.

Clinical roles and responsibilities

- Physician leaders are focused on individualized patient care and the development of treatment plans.
- Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
- Care coordination and case management are integral to the team’s practice.
- Population management monitors the cost and use of care, and includes registry development for most medical conditions.
Practice management

- Electronic medical records are used to the fullest capacity.
- Quality improvement processes are used and continuously evolve according to physician-led team based practice assessments.
- Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
- Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.
APRN Education

All APRN programs are based on the similar core framework and core courses

Clinical Training

Clinical hours:

Masters programs have a 500 hour clinical minimum in their role and population. Most programs are closer to 1000 hours and clinical simulation can be added to that

DNP programs are a minimum of 1000 clinical hours in their role and population and clinical simulation can be added to that
Scope Overlap

A Collaboration between:
• Association of Social Work Boards (ASWB)
• Federation of State Boards of Physical Therapy (FSBPT)
• Federation of State Medical Boards of the United States, Inc. (FSMB) National Association of Boards of Pharmacy (NABP®)
• National Board for Certification in Occupational Therapy, Inc. (NBCOT®)

Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations, 2012. NCSBN

“Healthcare education and practice have developed in such a way that most professions today share some skills or procedures with other professions.”

“It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others.”

Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations, 2012. NCSBN
Outcomes

Evidence demonstrates comparable performance between NPs and PCPs on clinical outcomes, including reduction of symptoms, improvement in health and functional status, and mortality
(Naylor & Kurtzman, 2010; Paradise, Dark, & Bitler, 2011).

Patients seen by NPs generally report higher satisfaction (Jennings, Clifford, Fox, O’Connell, & Gardner, 2015).

Supply and Access

24 states are predicted to have a demand for primary care providers above the national average but 17 of them have restrictive scope regulations.
(Huang & Finegold, 2013)
Supply and Access

SOP regulation is one of the most important determinants of staff composition in federally funded community health centers.

NPs tend to be more likely to serve in low-income, minority, and rural areas when compared with PCPs.

(Grumbach, Hart, Mertz, Coffman, & Palazzo, 2003)

Supply and Access

The odds of Medicare fee-for-service beneficiaries having an NP as a primary care provider is higher in states with the least restrictive NP SOP regulation.

(Kuo et al., 2013)
Teams

”Advance practice nursing regulations shall dictate that advanced practice nurses **only** practice as part of a physician-led patient care team.”

MA SB 1179 (2015/2016)

Estimate Savings From Team-Based Care

Enter the amount of time per day spent by physicians on activities that could be eliminated by implementing team-based care and the estimated cost of the specialist. The result will be daily physician time saved and annual savings of implementing team-based care.

AMA Steps Forward, Implementing Team-based Care

Teams

“The team care model includes full integration and understanding of all team members training, roles, and scopes of practice so that each may practice at the top of her or his license.”

Brenza, R. (2016)
Teams

“Primary care physicians report a loss of control and meaning in their work due to increased complexity of patients and inadequate time for visits.”


American College of Obstetrics and Gynecology

“Team leadership is situational and dynamic”

American College of Cardiology

“Team leadership should be flexible, reflecting the specific needs of the patient at a particular time and setting”
## Competition

Physicians in the U.S. are licensed on very broad and general definitions of the practice of medicine, to include everything relating to health.

In contrast other health professions have been regulated based on a 'carve out' of the practice of medicine.

Barbara Safreit (2002)

<table>
<thead>
<tr>
<th>Competition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The FTC staff policy paper:</td>
</tr>
<tr>
<td>“state-mandated &quot;collaborative practice&quot; agreements raise considerable competitive concerns, potentially impeding access to care and frustrating the development of innovative and effective models of team-based health care.”</td>
</tr>
</tbody>
</table>
Economics

- Weinberg, Micah, and Patrick Kallerman, Full Practice Authority for Nurse Practitioners Increases Access and Controls, San Francisco, Calif.: Bay Area Council Economic Institute, Spotlight Brief, April 2014.

References

- 2015 ACC Health Policy Statement on Cardiovascular Team-Based Care and the Role of Advanced Practice Providers, J Am Coll Cardiol 2015;65:2118-2136.
- Huang, E.S., and Finegold, K. (2013). Seven million Americans live in areas where demand may exceed supply by more than 10 percent. Health Affairs (Millwood) 32 (3), 88-94.