Do Collaborative Practice Agreements Make APRNs Safe Practitioners?

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The Nebraska Board of Nursing as the Applicant Group for an APRN Credentialing Review in progress has advanced a proposal for APRN Consensus Model alignment (National Council of State Boards of Nursing [NCSBN], 2008) that includes the removal of mandatory collaborative practice agreement (CPA) requirements for two of the four APRN groups in Nebraska (See page 16, this issue). Statutory collaborative practice agreement requirements should not be confused with physician supervision requirements for APRNs mandated for credentialing by payers which are outside the jurisdiction of the Credentialing Review (APRN Credentialing Review Application, 2020).

Safe practice for the protection of the health care consumer from adverse outcomes is the most frequently cited concern as justification for the perpetuation and expansion of mandatory CPA requirements between advanced practice registered nurses (APRNs) and physicians (Martin & Alexander, 2019).

The purpose of this report is to:

1. Describe the frequency of licensure complaints and malpractice awards against APRNs in Nebraska, with and without CPAs as indicators of safe practice.
2. Compare the relative frequency of malpractice awards between APRNs and physicians licensed in Nebraska.

Healthcare Provider Shortages

There are a multitude of challenges facing the U.S. healthcare system. Chief among these are primary care workforce shortages exacerbated by the increasing demand for health care services secondary to payer expansion. Then consider the ever growing aging and chronic disease patient population; as well as, physician retirement and the propulsion of new graduates away from primary care and into specialty practice.

The preceding are readily evident in Nebraska. Medicaid expansion, named the Heritage Health Adult Program, took effect in the state October 2020. Through the end of October, there were over 16,000 Nebraskans made newly eligible for services (Drew Preston, Nebraska Medicaid Public Information Officer).

2020 is also the first year in the history of the state that the population 5 years old and younger was fewer than those 75 years old or more in Nebraska (Figure 1). It is projected that the 75+ age group will exceed those 5 years old and fewer by 115,000 in twenty years.

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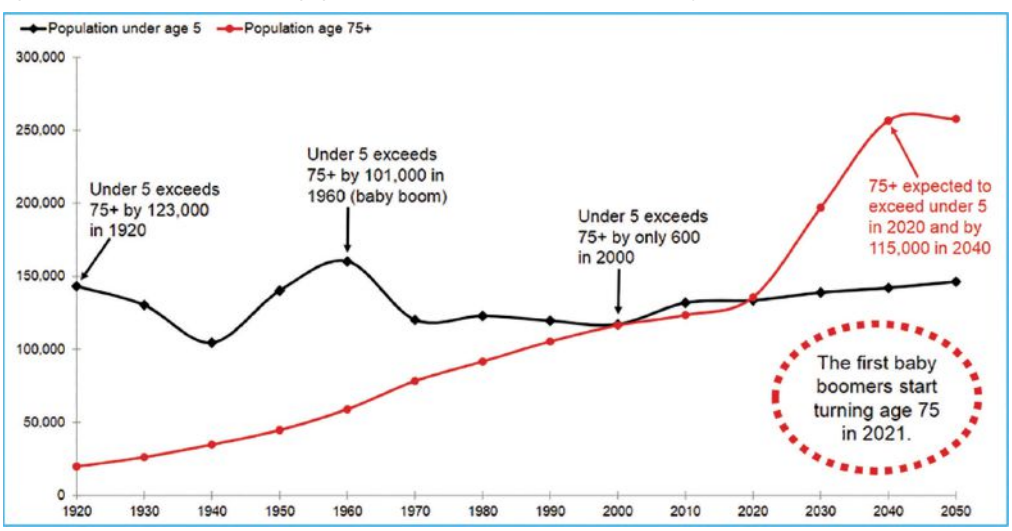
Figure 1: Nebraska population of select age groups (under 5 and over 75): 1990 to 2010 with projection to 2050



Sources: 1920 to 2010 Decennial Censuses. U.S. Census Bureau; June 2013 Population Projections. UNO CPAR (presented by David Drozd at the 2020 Nebraska Data Users Virtual Conference. "Nebraska State and Local Population Trends," August 19, 2020).

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While the number of physicians practicing in Nebraska increased in 2019, continuing the upward trend in the overall physician workforce in the state, a total increase of 22.6 % since 2007, that growth was driven by increases in physician specialty practices. Nebraska is also confronted with a significant maldistribution of the healthcare workforce as more sparsely populated counties are less likely to have the population to sustain viable provider practices (UNMC College of Public Health, 2020).

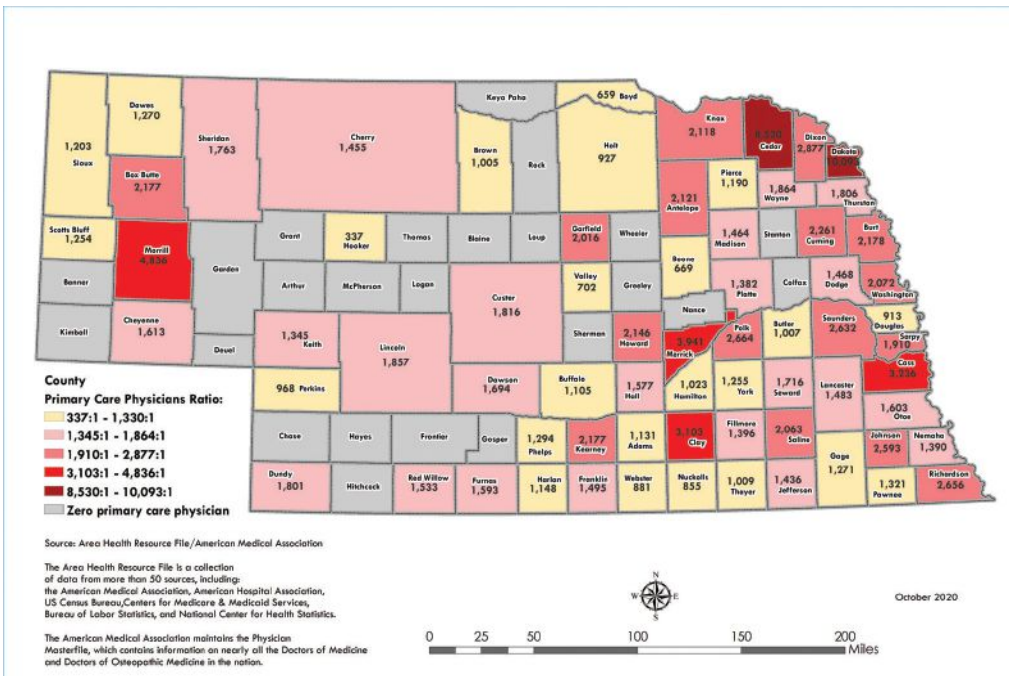
According to the American Medical Association and Area Health Resource File (2017), there are 24 counties in Nebraska without primary care physicians. Counties that have at least one primary care physician (n = 69), 45 counties have more than the U.S. overall average of 1,330 persons per one primary care physician ratio. (Figure 2).

Full Practice Authority

As early as 1991 (Nebraska Board of Health) published a report recognizing APRNs as a potential solution to the shortages and uneven distributions of primary care physicians in the state. Despite the growing demand for APRNs as providers (licensure authority to assess, diagnose and prescribe treatment) and sustained evidence of comparable quality metrics for APRN outcomes and satisfaction scores, 28 states, including Nebraska, currently do not have full practice authority for at least one of the four APRN roles (Figure 3).

Full practice authority means that a written CPA for supervision and/or conditions on practice e.g., restrictions on prescriptive authority, are not required to practice (NCSBN, 2018). The APRN with full practice authority has full accountability for practice under the authority of their individual APRN license. This represents a distinct paradigm shift from a long-standing and a previously inextricable link between physician supervision and needless liability for the practice of the APRN. Early legislative debate describes senators' perception that physician supervision implied liability for the activities of the NP, and that liability actually

Figure 2: Nebraska ratio of population to primary care physicians (2017)



Source: 2017 Area Health Resource File/American Medical Association (University of Wisconsin Population Health Institute. County Health Rankings Key Findings 2020).

afforded the patient a higher standard of care (Nebraska State Legislature, 1996, p. 9598-9599).

A legal case analysis commissioned by Nebraska Nurse Practitioners (Buppert, 2013) found that physicians were found liable in nearly half of cases that a nurse practitioner (NP) and collaborating physician were sued for malpractice. There were no cases from Nebraska that met the review criteria. The reviewer concluded that while collaborative requirements are meant to assure patient safety, "The formal referral process probably is safest for all concerned...a formal referral means that the physician... [has] a duty to care for the patient by personally and thoroughly assessing the patient and making their own medical decision....the responsibility of each party would be far clearer without the mandated collaboration requirement." Likewise, a 2015 RAND report predicted that lifting collaborative restrictions on CNM practice may actually result in lower malpractice costs (Martsolf, Auerbach & Arifkhanova).

Certified nurse midwife

Certified nurse midwives (CNMs) in Nebraska have had a mandatory CPA requirement since 1984. The supervising physician must practice obstetrics (§38-608, Certified Nurse Midwifery Practice Act, 2019) which limits the residence of practicing CNMs to the proximity of supervising physicians in the state (Figure 4). This limitation has been amplified by a record decline in actively practicing Obstetric-Gynecology (OB-GYN) physicians between 2017 and 2019. Currently, only 39 counties have OB-GYN physicians, down from 49 counties in 2017 (UNMC College of Public Health, 2020).

Clinical nurse specialist. The Clinical Nurse Specialist Practice Act (2019) is silent regarding collaborative or supervisory requirements. The APRN Credentialing Review application proposes adding prescriptive authority to clinical

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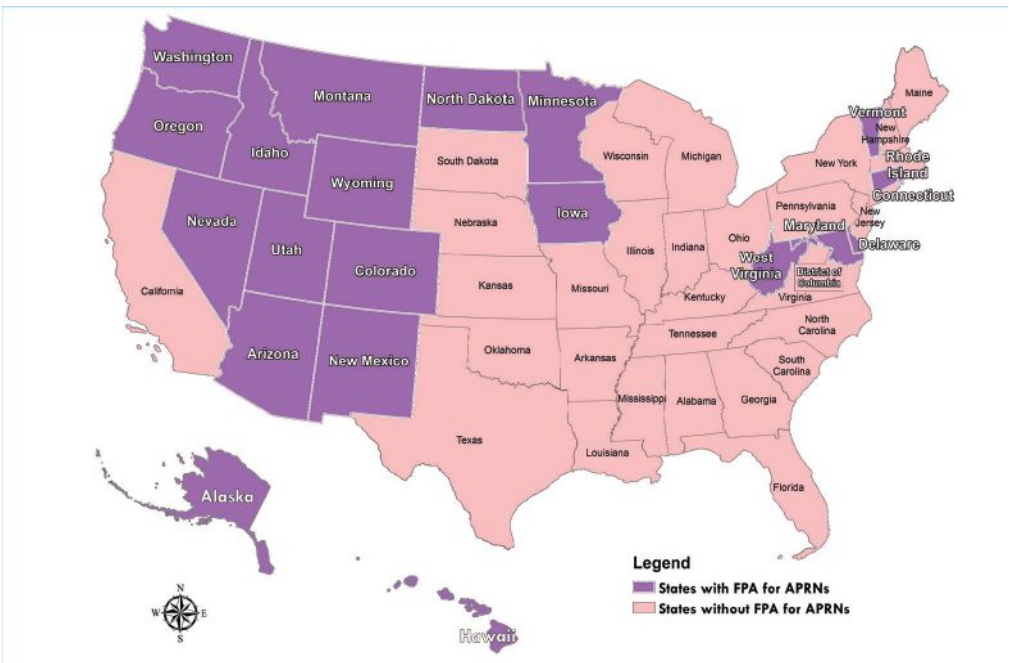
Figure 3: States with and without Full Practice Authority (FPA) for APRNs



Source: https://nursingamerica.org/

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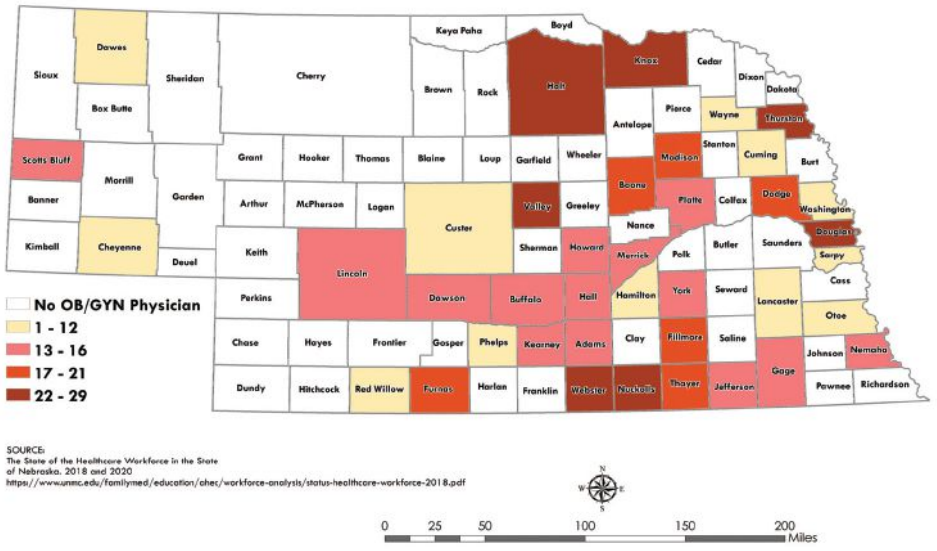
Figure 4: Number of active OB/GYN physicians per 100,000 population by county, Nebraska, 2019



nurse specialist (CNS) scope of practice. Clinical nurse specialists are the only APRN group in Nebraska that does not have prescriptive authority which includes not just pharmaceuticals, but durable medical equipment, supplies and services. Clinical nurse specialists typically practice in interdisciplinary teams with aging and chronic disease populations. They are not able to practice to the full extent of their education and certification in this state without prescriptive authority (Crudden, G., 2020).

Nurse practitioners

In 2015, Nebraska became the twentieth state to retire the CPA requirement for an Integrated Practice Agreement between NPs and physicians (LB 107). The CPA requirement was replaced with a transition to practice (TTP) supervisory requirement for the first 2000 hours of practice by the new graduate NP (§38-2322, Nurse Practitioner Practice Act, 2019). Transition to practice requirements are a variant of CPAs, and largely viewed as legislative concessions. They are not evidence-based, i.e., there are no indicators that they contribute to effective transition and safe practice for the new graduate. Regulatory requirements are arbitrary and highly variable between the 17 states that currently require TTPs. Nebraska requires an attestation from NP applicants that a "formal written agreement" (38-2322, Nurse Practitioner Practice Act) exists between the NP and a supervising provider.

Certified registered nurse anesthetists

(CRNAs) were the first APRN group to obtain statutory authority to practice in Nebraska. Their legislative journey for full practice authority culminated well ahead of NPs when then Governor Johanns signed a federal opt-out in 2002 authorizing practice without physician supervision and independent billing for services.

Certified registered nurse anesthetists and NPs combined represent 96% of licensed APRNs in Nebraska (Table 1). There is substantial evidence regarding the accessibility of health care services provided by CRNAs and NPs in this state (Inset 1).

Table 1: Number and Percentage of APRNs working in Nebraska

Type of APRN	Number	Percentage
Nurse Midwife (APRN-CNM)	40	2%
Clinical Nurse Specialist (APRN-CNS)	79	4%
Nurse Anesthetist (APRN-CRNA)	366	19%
Nurse Practitioner (APRN-NP)	1,480	75%
Total APRNs working in Nebraska	1,965	100%

Source: Nebraska Center for Nursing (2018)

Collaboration or Something Else?

A 2019 survey of APRNs conducted by researchers at NCSBN sought to identify variables associated with CPAs (Martin & Alexander). A primary objective was discernment of the level at which collaboration occurred between APRNs and physicians in formal CPAs. Ninety-four (94) percent of APRNs reported initiating regular discussions with physicians and other professionals in their network, not necessarily their supervising provider. Similarly, about 80% said they regularly referred more complex cases to members of their physician network or team. Conversely, only 50% of APRNs indicated that they had regular in-person contact with their formal supervising provider. About 60% said that they had regular electronic contact such as texts, emails or telephone. About 57% reported regular chart reviews. Viewed collectively, it was evident that 40% to 50% of respondents did not have regular or objective-focused contact with a formal supervising provider.

The ongoing reluctance of physicians to engage with nursing for the retirement of CPAs suggests protection of economic interests. The NCSBN study (Martin & Alexander, 2019) found that APRNs working in rural areas and APRN-managed private clinics, i.e., those with the most limited options for formal collaborative relationships owing to geography and private practice ownership, were one and a half times to six times more likely to assess fees for CPAs.

Nebraska APRNs with Full Practice Authority (FPA)

Certified Registered Nurse Anesthetists

- Practice in 99% of operating rooms (Nebraska State Legislature, 2015)
- Only anesthesia providers > 95% Critical Access Hospital (Hoebelheinrich & Ramirez, 2019a)

Nurse Practitioners (Hoebelheinrich, Ramirez & Chandler, 2019b)

- 47.8% growth in rural Nebraska 2008 –2018 mirrors trend (43.2%) in other full practice authority states
- 91.1% report certification in at least one primary care practice focus compared to 88.6% nationally
- Certification rates in Psychiatric Mental Health practice are 2.8x higher than other states, (8.2% vs. 2.9% respectively)
- Provide 75-100% Emergency Department (ED) coverage in some Critical Access Hospitals (Nebraska Nurse Practitioners Credentialing Review, 2014).

A Federal Trade Commission (FTC) report pointed to a significantly larger economic picture, however, alleging physician restraint of trade by limiting competition with APRNs. The FTC noted that physician supervision and collaborative practice agreements are impediments to competition among health care providers that not only restrict APRNs' ability to practice independently, but lead to decreased access to health care services, higher health care costs, and reduced quality of care (2014).

Measuring Safe Practice

Disciplinary Complaints. The Nebraska Department of Health and Human Services (DHHS) disciplinary process for health care professionals is a complaint-based system. Reporting is a mandatory requirement for alleged behavior that affects patient safety and outcomes, including gross incompetence, patterns of negligence, unprofessional conduct and impaired practice. There are also mandatory self-reporting requirements and/or requirements for reporting by health facilities, peer review organizations and professional associations following employment termination and malpractice payments subsequent to adverse judgment, settlement or award (172 NAC 5). Tabulations of the relative frequency of the reasons for discipline recommendations are not public information so that it is unknown what portion of disciplinary action follows malpractice payments. The public, however, can view disciplinary actions against professional and occupational licenses and form their own conclusions (DHHS, 2020).

Analysis of the number of disciplinary actions based on complaints made against APRNs in Nebraska shows no significant change for the time period 2000 – June 2020 (Figure 5). During this time period, the number of disciplinary actions against NPs (1.2 cases annual average) and CRNAs (0.8 cases annual average) averaged a combined 1.0 case per year. There were no disciplinary actions against CNMs or CNSs. The number of cases for NPs dropped below the average 1.2 cases per year in 2015. The removal of the CPA requirement with physicians became effective August 31 that year. CRNAs have had full practice authority since 2002 which is nearly the entire duration of the analysis time frame. The stability (no increases) in the number of disciplinary actions is especially remarkable since the number of APRNs licensed by the state of Nebraska more than tripled between 2006 and 2020 (Nebraska DHHS, Licensure Unit).

Malpractice Payments. The National Practitioner Data Back (NPDB) is a confidential information clearinghouse operated by the U.S. Department of Health and Human Services that houses reports of medical malpractice payments and other adverse action taken against healthcare professionals. The NPDB serves as an alert or flagging system intended to facilitate a comprehensive review of individual credentials for licensure, employment, payer credentialing and other related activities (U.S. Department of Health and Human Services, 2020). Malpractice payments by APRNs that are reported to the NPDB are tabulated as the number of occurrences for all APRN groups combined.

The number of reported malpractice payments made by APRNs for the time period 2000 - June 2020 (see second paragraph, column 1, this page) is slightly lower (n = 31) compared to the number of APRN disciplinary cases in the state for the same time period (n = 38). The relative frequency of malpractice payments made by both APRNs, physicians and osteopathic physicians was calculated using the number of each group licensed in Nebraska during the 2015-2020

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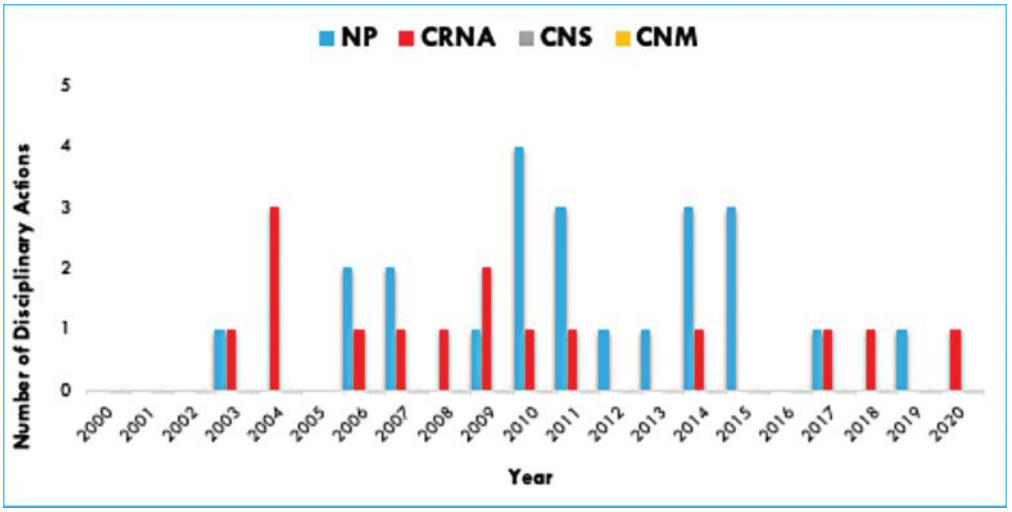
time frame. That time frame was chosen because those are the years that licensure data was available from the DHHS licensure data base. When the relative frequency of APRN malpractice payments was compared with those made by physicians and osteopathic physicians for the same 2015-2020 time period, physicians and osteopathic physicians were nearly 8 and 3.5 times, respectively, more likely to have made medical practice payments. (Figure 6).

This analysis was performed in response to a request by a member of the Technical Review Committee for the Credentialing Review. There is no intended implication that physicians and osteopathic physicians are less safe in practice than APRNs. The NPDB data does not distinguish variables like physician specialty, or the nature of the malpractice complaint so that there are no other conclusions that may be made from this data.

The average annual number of formal disciplinary action against APRN groups licensed in Nebraska 2000 – June 2020 has been historically low, averaging 1.2 cases per year for NPs and 0.8 cases per year for CRNAs (1.0 combined average for NPs and CRNAs).

Figure 5: Number of disciplinary actions by NP, CRNA, CNS & CNM: 2000-2020



Source: Nebraska Board of Nursing.

Summary

The average annual number of formal disciplinary action against APRN groups licensed in Nebraska 2000 – June 2020 has been historically low, averaging 1.2 cases per year for NPs and 0.8 cases per year for CRNAs (1.0 combined average for NPs and CRNAs). There have been no disciplinary cases against CNMs and CNS during this time period. This is despite a tripling of the number of APRNs licensed in the state since 2006. The average number of cases for NPs has actually decreased since 2015 which is the year the CPA requirement was retired by the Legislature. There is no discernable pattern for CRNAs who have the longest tenure (2002) of full practice authority in Nebraska.

Formal malpractice awards against APRNs are reported in aggregate to the NPDB. As expected, reported cases to the NPDB (31) are below the reported number of APRN disciplinary cases in the state (38). Malpractice awards against health care professionals are only one of a wide variety of circumstances for mandatory reporting to DHHS.

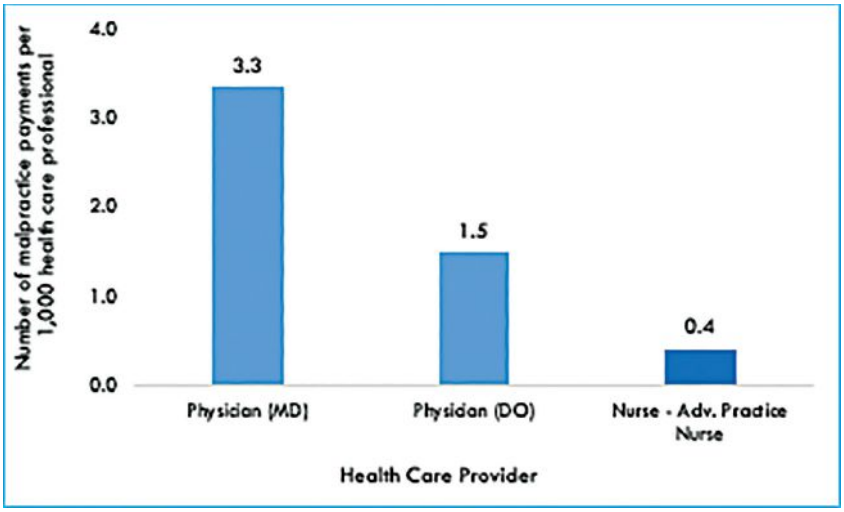
A comparative analysis of physician and osteopathic physician rates of malpractice awards reported to the NPDB (8 times and 3.5 times higher, respectively) stands in stark contrast to APRN rates for the same period, 2015 - June, 2020.

Conclusion

Findings in this report validate safe practice for APRNs based on the low number (average 1.0 case combined for NPs and CRNAs per year) and stable pattern of formal disciplinary action against CRNAs and NP licensees in Nebraska during the 2000 - June, 2020 time period. There were no reports of discipline against CNMs and CNSs during this time. The relative rates of malpractice awards against APRNs licensed in Nebraska based on the cases reported to the NPDB are also low, and in stark contrast to relatively much higher rates reported for physicians and osteopathic physicians licensed in Nebraska.

Findings in this analysis uphold the APRN Credentialing Review proposal by the Board of Nursing for the removal of statutory CPA requirements with physicians. Physician supervision should be the sole purview of the APRN and the employer based on what oversight the APRN requires from a physician to provide safe care for a particular patient population and not a blanket statutory requirement for APRN practice. The Federal Trade Commission (FTC) recommends that CPAs are based on specific needs following scrutiny of "... relevant safety and quality evidence to determine whether or where legitimate safety concerns exist and,

-3 Figure 6: Number of medical malpractice payments per 1,000 MDs, DOs and APRNs - 2015-2020



Sources: 1) NPDB Data Analysis Tool on 10.9.20. Parameters included 2015-2020, Medical Malpractice Payments, all ranges, for APRNs, MDs, DOs in Nebraska. Accessed at https://www.npdb.hrsa.gov/analysistool/; 2) Nebraska Department of Health and Human Services. Public Health. Active licenses of MDs, DOs, and APRNs (2006-2020).

if so, whether physician supervision requirements or other regulatory interventions are likely to address them. That type of scrutiny can be applied not just to the general question whether the state requires physician supervision or collaborative practice agreements, but to the particular terms of those requirements" (FTC, 2014, p. 4).

Team-based care, defined by the Institute of Medicine (IOM) is a systems approach to care and not a licensure or regulatory construct (2010). Health care has necessarily evolved from a physician-centered model of care to patient-centered care provided by a spectrum of qualified professionals (Holmes & Kinsey-Weathers, 2016). In the traditional hierarchal, physician-centered model, laws and regulations that make it illegal for a clinician to practice to the top of their education, or that require licensure or regulation as part of a team to practice needlessly impede individual licensee accountability and reduce the flexibility and efficiency of the health care workforce to meet the diverse health care needs of the public (American Association of Nurse Practitioners, 2020).

In 2010, the Institute of Medicine, now the National Academy of Medicine, released its landmark report *The Future of Nursing, Leading Change, Advancing Health.* Key messages from this report include 1) Nurses should practice to the full extent of their education and training; and 2) Nurses should be full partners with physicians and other health professionals in redesigning health care in the U.S. (IOM, 2010, p. 4). Full practice authority for APRNs in Nebraska is grounded in ample evidence. The retirement of CPA requirements for CNMs and NPs, and prescriptive authority for CNSs for CNSs are much-needed and timely elements for the redesign of traditional models for the delivery of essential health care services in this state.

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