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# Physicians and Nurse Practitioners in Collaborative Practice

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A nationwide shortage of primary care physicians has combined with recent changes in health economics and politics to give nurse practitioners (NPs) the opportunity to establish a significant and separate role in health care delivery. The success of NPs in keeping patients healthy and happy has not escaped the attention of health care administrators and patients.

In Massachusetts, where some 2,000 NPs practice, several nursing schools have begun or expanded NP programs in recent years. This is adding hundreds of NPs, mostly in family practice and other primary care areas, to the health care system. Recent legislation,<sup>1-2</sup> including mandated third-party billing at the state level and changes in HCFA and Veterans Affairs regulations federally, should encourage NP training and will likely accelerate this trend.

Over the next few years, medical malpractice claims data will likely reflect the increased role of NPs in patient care and almost certainly parallel physician primary care trends. On the other hand, the aspects of the NPs' approach to patient care that focus on education, communication, prevention, and patient advocacy—areas that some physicians assign lower priority—may help minimize their claims experience.

## Building a Working Relationship

The Boards of Registration in Nursing (BRN) and Medicine (BRM) jointly govern NP practice and collaborative physician/NP arrangements. In Massachusetts, collaborative practice is defined by the BRN as a:

“process and relationship in which a nurse practicing in the expanded role works together with physicians and may work with other health professionals to deliver health care within the scope of the various professionals' experiences and lawful practice and with medical direction and appropriate supervision as provided for in [Massachusetts] guidelines 244CMR 4.22-4.25.”

An effective working relationship between the nurse practitioner and the collaborating physician is central to successful risk management.<sup>3</sup> This includes guidelines that designate the collaborating physician and define the nature and scope of the nurse's practice. If the NP will be prescribing medications, both parties need to develop *those* guidelines as well.

In general, a physician need not be present when an NP is examining a patient, however, the most effective partnerships feature same-site collaborative teams with shared decision making, frequent chart review, and daily discussion of patient management.

Close communication with and immediate availability of a supportive collaborating physician are essential, as is a clear understanding and acceptance of the respective roles and liability. Both the physician and NP must understand and accept the fact that an NP is legally liable for his or her actions. (The collaborating physician will often, but not always, share in any care-related liability.)

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## Guidelines and Supervision

The best initiatives *for* quality care and *against* liability are written guidelines. NP practice guidelines must designate the collaborating physician, define the nature and scope of practice, and—if the NP holds prescriptive privileges—should include provisions for quarterly practice reviews. Additionally, journals and texts that have been mutually agreed upon as providing acceptable scientific knowledge and standards of care for common medical conditions should be included with guidelines for NP practice and made available at the practice site for consultation.

In defining the role of “supervising physician” of NPs with prescriptive privileges, the BRM in Massachusetts says the physician holds:

“a full, unrestricted license and having completed training in a specialty area appropriately related to the NP's area of practice or with hospital admitting privileges in an area appropriately related to the NP's area of practice, holds controlled substance registration, and signs mutually developed and agreed upon guidelines with the NP engaged in prescriptive practice and reviews the NP's practice at least every three months.”

Additionally, physician supervision of a prescribing NP must take into account geographic proximity, practice setting, volume and complexity of the patient population, and the experience, training, and availability of the supervising physician. Lastly, the BRM guidelines state that a supervising physician shall not enter into a collaborative practice unless the NP has proof of malpractice liability insurance coverage of at least \$100,000-\$300,000.<sup>4</sup>

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## Mentorships

Mentorships between NPs within practices are strongly recommended as a tool to foster collaborative, consistent practice and promote education between providers. In such a program, a provider entering the group practice—regardless of previous experience—is mentored by a defined, established practice provider. Mentorships range from three to six months and require that the new practice provider present and discuss each patient case with the mentor during the time of the patient visit. Additionally, the mentor is expected to review the care rendered by the new provider and give constructive feedback regarding standards of care and practice guidelines.

Physician consultation must be available at all times, either in person or by telephone. In general, NPs seek consult in the following situations: 1) an NP has questions interpreting data to make a diagnosis or treatment plan, 2) a patient fails to respond as expected to prescribed treatment, and 3) the initial diagnosis indicates a life-threatening condition.

Each practice setting should additionally develop a listing of potential situations and patient presentations, specific to that practice, that require physician consultation during the time of the office visit (e.g., suspected child or elder abuse, headache with neurologic signs, fever without localizing signs in infants). Adherence to defined consultation guidelines should be appropriately documented by the NP within the patient's chart and reviewed by the supervising physician as part of regularly scheduled NP performance reviews.

To maintain quality patient care in a collaborative practice, provider meetings should be held regularly to discuss both general and specific patient care issues. These discussions may be informal gatherings in which the expertise of the NPs and other clinicians is shared for the mutual benefit of all involved in the care of the patients. Some practices prefer

more formally structured sessions that include case presentations and topic discussions of clinically relevant health care issues. Regularly scheduled provider meetings strengthen the education of the staff, provide for cohesiveness within the provider group, and help ensure consistency in patient care.

Lastly, quality monitoring of NP practice is essential. In addition to reviewing initial prescriptions of Schedule 2 drugs authorized by prescribing NPs, the supervising physician should—at least every 90 days—review 10 records of patients seen by the NP. The reviewer can monitor prescribing decisions and practices of the NP, including: the decision not to prescribe, clinical decision making, adherence to documentation guidelines, and billing practices. The review should be documented and kept on file. ■

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## Notes

- 1 Third party reimbursement provisions in Massachusetts direct insurers to make provisions for direct reimbursement of NPs in all settings. This affects HMOs and other private insurers most directly. Medicaid has had 100 percent reimbursement for evaluation and management services for several years. Medicare has provided reimbursement for services in rural settings and nursing homes.
- 2 Medicare and HCFA made significant changes as part of the 1997 balanced budget act. As of January 1, 1998, NPs and clinical nurse specialists working in collaboration with physicians can bill Medicare regardless of the setting in which care is provided. A physician need not be physically present when the services are provided and Medicare will accept claims either directly from the nurse or from the employing hospital, clinic, nursing facility, group practice, or physician in cities or suburbs—not just rural areas. Medicare will pay NPs 80 percent of the lesser of actual charge or 85 percent of the physician fee schedule, without removing the prior “incident to a physician services” option that previously required on-site supervision for NPs.
- 3 In 28 states, including New Hampshire, no supervision or collaboration with physicians is required, and in 18 states, NPs may prescribe without physician involvement. In Massachusetts, NPs are required to collaborate with physicians in managing patients and be supervised by physicians in writing prescriptions.
- 4 Nurse practitioners insured through Controlled Risk Insurance Company (CRICO) are covered up to \$5 million per claim for activities performed within the scope of their employment with a CRICO-insured medical institution.