Collaboration: Foundation for a Successful Practice

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Collaboration, by definition, is a joint and cooperative enterprise that integrates the individual perspectives and expertise of various team members. Some commonly identified themes of collaborative relationships include collegiality, teamwork, open communication, recognition of one another's expertise, and a strong level of trust and respect. However, the development of an individual collaborative practice is unique to the practice, should optimize the skills of each party, and allow each participant to provide care within his or her scope of practice. Despite the potential benefits of a collaborative physician-nurse practitioner practice, several barriers also exist. Collaboration should be distinguished from supervision, which implies direct physician oversight of the nurse practitioner (NP) and is a requirement for nurse practitioner practice in some states. This article describes collaborative physician-nurse practitioner relationships in geriatric practice, and guidelines for implementation of a collaborative practice agreement.

GERONTOLOGICAL NURSE PRACTITIONERS

A gerontological NP is a registered nurse with advanced educational preparation and the skills to provide a full range of primary care services to older adults. Gerontological NPs practice under the rules and regulations of the Nurse Practice Act of the state in which they practice. In order to practice they must be nationally certified. Gerontological NPs are currently practicing in all of the 50 states, from rural communities to heavily populated areas such as major cities and retirement communities. In addition to gerontological NPs, adult and family NPs also practice in long-term care settings.

ADVANTAGES OF COLLABORATIVE CARE

The benefits of physician-NP collaborative practice are particularly evident in the field of geriatrics, because older adults commonly present with multiple physical as well as psychosocial needs. Moreover, physicians who participate in a collaborative practice have noted the positive aspects of this collaboration. Based on a survey of approximately 700 physicians working in collaborative practices with NPs, 90% reported that they were very satisfied with these relationships and the care provided.[1] Patients and their families likewise report very high satisfaction (95%) with collaborative care practices. Gerontological NPs' activities are varied in these collaborative arrangements (Table 1), although generally the gerontological NP spends considerable amounts of time communicating with patients, families, and care providers.[1] This is an important function that enhances patients' and families' satisfaction with care and supports the physician's role. A recent survey[2] of NP practice reported that the average patient load per NP in geriatrics was 13 patients per day. This may vary depending on the setting and on the severity of the patients' condition.

The true purpose of collaborative practice is to deliver comprehensive care, in any setting, that best meets the needs of a particular practice population. This is done through the full and effective application of the knowledge and skills of the health care providers involved. The specific advantages focus on decreasing the cost of care while improving quality and access.[3–6] Physicians who work with NPs generally report that the NP allows him or her to have time freed up to see more complicated patients, perform additional surgeries, or engage in teaching or research activities.[7] The NP and the physician bring both shared and unique knowledge and skills to their roles which patients can then access. Practices and managed care organizations that have hired NPs have also reported an improvement in the "bottom line" (ie, the financial benefit) of a collaborative model.[6]

BARRIERS TO COLLABORATIVE CARE

One barrier to collaborative relationships between NPs and physicians is the lack of understanding of the NP's role and how the roles of each provider can complement each other. There is a fear that the NP's knowledge is insufficient for the management of patients, or that the patients may not be optimally treated. In addition, regulatory issues can impede collaborative practice, and payment systems do not always provide appropriate reimbursement. For example, Medicare reimbursement for visits will be 15% less when provided by the NP versus a physician. This loss of income can frequently be offset by the combined ability of both parties to provide additional services and care for a larger number of patients.

Another potential barrier to collaborative practice is the fear of malpractice, and being held responsible and accountable for the actions of another provider. This is certainly an understandable concern, and one many providers have when working in collaborative or supervisory roles. However, the actual number of lawsuits filed against NPs compared to physicians has been small.[8,9] To prove a claim of malpractice

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DOI: 10.1097/01.JAM.0000095256.98046.6A

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Table 1. *Roles and Responsibilities of Gerontological Nurse Practitioners*

Takes calls from facilities or practices; contacts physicians as necessary
Assesses patients with change in condition or inter-current illness
Provides detailed assessment of the patient for physician review
Maintains ongoing and up to date patient information
Provides current updates on patients' general health status
Coordinates and facilitates specialty referrals and communication between specialists and primary care providers
Addresses pharmacy recommendations and rehabilitation referrals
Speaks or meets with patients and families to address any health concerns and answer any questions about the care of the patient
May participate in ongoing education of long term care nursing staff to enhance quality of care delivered to patients
May perform routine procedures in the nursing home as delineated by the collaborative practice agreement

against a health care provider, the patient (plaintiff) must prove four elements: duty, breach of duty, proximate cause, and harm. To establish duty, the plaintiff must prove that the patient and the NP (defendant) had an appropriate provider-patient relationship. Once the plaintiff has shown that the NP had a duty to the patient, there must be proof that the care provided by the NP fell below the acceptable standard of care, that is, that there was a breach of duty. The breach of duty must been shown to be the predominate cause for harm to the patient. All four elements of malpractice must be present in order for the patient to be able to prove a claim. The physician, however, is not liable for any actions of the NP that he did not specify. If the NP breaches his/her duty to the patient and that breach is the direct cause of damages, then it is the NP who is responsible. The physician did not breach any duty to the patient unless he or she has given incorrect information to the NP (E-mail and personal communication with Melanie Goodwin, CRNP, JD, advisory board member, Nurses Service Organization. June, 2003).[9]

Malpractice claims against NPs most commonly focus on situations in which the NP:[1] exceeds delegated authority,[2] exceeds the scope of expertise, or[3] fails to refer the patient when medically warranted.[8,9] In any malpractice suit the physician/NP relationship is likely to be scrutinized. To protect the practice, it is essential that the NP have his or her own malpractice insurance, that a realistic collaborative agreement is developed, and documentation is maintained in terms of how the collaborating partners adhere to the agreement.

LONG-TERM CARE LITIGATION

Concern over medical malpractice claims is increasingly a cause for concern within health care in general, but particularly in long-term care. Aon Risk Consultants, Inc. conducted an actuarial analysis this year for the American Health Care Association (AHCA) on the cost of general liability and professional liability claims to the long-term care industry in the United States.[9a] Generally, the average liability costs have tripled since 1996 from $850 to $2880 per bed. The six states in which costs were the highest were Florida, Texas, Mississippi, California, Arkansas, and Alabama. Unfortunately, the increase in claims, high damage awards and settlement costs are precipitating high insurance premiums, the departure of liability insurers from those markets, and the divestiture of facilities by national companies in certain states where the problem is particularly severe. Some facilities have forsaken malpractice liability insurance entirely, or hold only a minimal policy. The result is that an increasing proportion of available reimbursement for long term-care is diverted away from patient care and toward the cost of insurance or similar liability protection.

Concern has been voiced that as states grapple with this crisis and address it through reform legislation, one response has been a broadening of the range of persons against whom an action might be brought, such as medical directors and/or attending physicians, NPs, or physician's assistants. The cost of malpractice insurance for these individuals is increasing, and access to coverage is more difficult to obtain.[10]

Although individual health care professional malpractice liability exposure is a concern, use of NPs by physicians practicing in long-term care does not appear to be a major factor. In June 2003, the US Congress' General Accounting Office (GAO) published a report entitled, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates."[11] The GAO found that, since 1999, increases in malpractice insurance rates for physicians in some specialties (including internal medicine) have been "dramatic" in a number of states, but this has varied greatly. Factors contributing to the increase include losses on malpractice claims (although the data could not distinguish between verdicts and settlements), perceptions of future losses, the cost of reinsurance, and the return on insurers' investments of reserved funds. No association was made between increased risk of malpractice and collaborative practice relationships between physicians and NPs.

Physicians and NPs practicing in a long-term care facility provide care that may be evaluated in the context of a facility malpractice evaluation. In a collaborative relationship with an NP, the obligation on the physician and NP is to coordinate in the manner set forth in their agreement, which should be consistent with applicable state law. Long-term care facilities must ensure the availability of adequate medical care for residents, and physician/NP collaborative arrangements are an important way this can be accomplished. The physician/NP collaborative model actually allows for care in a manner that diminishes malpractice concerns, because it enables physicians to have the benefit of on-site assessment and

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intervention by the NP, rather than the physician relying solely on telephone reports and test results from nursing staff at the facility. NPs can also ensure that physician and NP telephone orders are followed, and the outcomes of these interventions are communicated effectively. Reducing the risk of a negative outcome for a resident is the best approach to mitigating malpractice risk.

DEVELOPING A COLLABORATIVE PRACTICE

Roughly 50% of NPs work in states that require a collaborative agreement with a physician (Table 2). This requirement should be viewed as a way to delineate the collaborative relationship and facilitate the communication process. However, the need for a collaborative agreement between the physician and NP *does not* mean that the physician must be physically present whenever the NP sees patients. Rather, the collaborative agreement provides the venue for how the physician-NP relationship will operate. Although differences of opinion exist regarding whether or not the collaborative agreement should be required, it is important to adhere to this agreement if the state requires it. Moreover, NPs and physicians have the opportunity to develop and use collaborative agreements to provide the best possible care to patients in all settings.

THE COLLABORATIVE AGREEMENT

Twenty-six states[12] do not require a collaborative practice agreement; the rest specify content required within these agreements based on state regulations.[13] Basically, the requirements describe what a NP can do in a particular practice setting. This generally includes, but is not limited to:[1] the diagnosis, treatment, and management of acute and chronic health problems;[2] ordering, interpreting and performing lab and radiology tests;[3] prescribing medications, including controlled substances;[4] receiving and dispensing stock and sample medications; and performing other therapeutic or corrective measures as indicated.[5]

The relationship between the physician and the NP should be well delineated within the collaborative agreement. While the general guidelines of collaborative agreements indicate that medical direction by a physician should be “adequate” with respect to collaboration, the collaborating team must establish what is adequate. For example, how often the NP and physician will interact, how that interaction will take place (ie, face to face or via the telephone, E-mail, etc.), and how the interaction will be documented (ie, charts signed, log book kept) should be clearly and *realistically* established. The agreement should also address the functions of the NP and the relationship between the providers. As shown in Table 3, the agreements can be used to delineate when the NP should refer a patient to his or her collaborating physician and how “on call” issues will be handled. The guidelines for how to handle emergencies are also important with regard to the risk of malpractice.

The collaborative agreement should outline the NP’s prescriptive privileges. This is usually done by listing drug categories (eg, antihypertensives, antipsychotics, schedule II–IV drugs) rather than specific names of medications. The ability to prescribe scheduled medication should be outlined separately as per state regulations. Finally, in some states, prescribing intravenous medications and fluids must be included separately in practice guidelines.

OPTIMAL USE OF THE COLLABORATIVE AGREEMENT

The collaborative agreement should be used as a way to establish the roles and responsibilities of all parties. In order to optimize use of the collaborative agreement, the agreement should be individually developed and not simply handed down from one NP-physician team to the next. The agreement can be specifically designed to address the strengths of each provider. For example, an NP may have extensive experience related to interpretation of electrocardiograms and management of cardiac disease, suturing wounds, or performing sigmoidoscopies. These skills should be recognized and reflected in the agreement. Conversely, there may be areas of practice in which the NP is less comfortable, and would prefer treatment decisions to be made in conjunction with the collaborating physician. Clear guidelines for when the NP should refer a patient to a collaborating physician will further establish the expectations of the parties in the collaborative practice.

Table 4 provides general guidelines for developing collaborative agreements. The collaborative agreement must be realistic. For example, the agreement should not state that the NP and physician will meet face to face to review charts each week if they are never scheduled to be in the same office on the same day. Conversely, the agreement might describe a plan in which monthly telephone conferences will be done to review complex patients or provide general updates. All parties involved in the collaborative agreement should carefully review this document to be certain they can realistically adhere to the proposed plan. In a court of law, it will not be sufficient to say that either the NP or the physician did not know that they were supposed to meet on a monthly basis. Moreover, a plan should be developed to document, either in charts or a log book, when NP-physician meetings occurred. A simple chart or spreadsheet can also be used to document narcotic prescribing, if this is necessary in the state where services are provided.

COLLABORATION IN DAILY PRACTICE

An initial face-to-face meeting to review and sign the collaborative practice agreement provides an opportunity to discuss other issues related to joint practice, such as practice style, expectations with regard to roles, and formal and informal interactions. These should be discussed whenever a new individual is hired into a collaborative practice. Expectations may vary, depending on whether the NP is experienced or has just completed an advanced degree. For example, a new NP may need to confer with the collaborating physician on a daily or weekly basis for a period of time, whereas an experienced NP might not need that level of interaction.

It should be clear how the physician can be reached, and who will provide backup or coverage when he/she is unavailable. The method for communicating important changes in

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Table 2. *State Requirements for Collaboration or Supervision*

State Requirements				
State	No requirements*	Collaboration required**	Supervision required***	BORN and BOM control****
Alabama				●
Alaska	●			
Arizona	●			
Arkansas	●			
California			●	
Colorado	●			
Connecticut		●		
Delaware		●		
District of Columbia	●			
Florida			●	
Georgia			●	
Hawaii	●			
Idaho			●	
Illinois		●		
Indiana		●		
Iowa	●			
Kansas	●			
Kentucky	●			
Louisiana		●		
Maine	●			
Maryland		●		
Massachusetts			●	
Michigan	●			
Minnesota		●		
Mississippi				●
Missouri		●		
Montana	●			
Nebraksa		●		
Nevada		●		
New Hampshire	●			
New Jersey	●			
New Mexico	●			
New York		●		
North Carolina				●
North Dakota	●			
Ohio		●		
Oklahoma	●			
Oregon	●			
Pennsylvania		●		
Rhode Island	●			
South Carolina			●	
South Dakota				●
Tennessee	●			
Texas	●			
Utah	●			
Vermont		●		
Virginia				●
Washington	●			
West Virginia	●			
Wisconsin	●			
Wyoming	●			
Total	26	14	6	5

BORN = Board of Registered Nurses; BOM = Board of Medicine
*States where the BORN has sole authority in scope of practice, with no requirements for physician collaboration or supervision.
**States where the BORN has sole authority in scope of practice, but has a requirement for physician collaboration.
***States where the BORN has sole authority in scope of practice, but has a requirement for physician supervision.
****States where scope of practice is authorized by the BORN and the BOM.

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Table 3. *Recommendations for Nurse Practitioner to Physician Referrals*

When in consultation or review nurse practitioner feels it is indicated
When situation is out of nurse practitioner's scope of practice
When patient does not respond to treatment in a timely manner
When untoward outcome has occurred
When patient has an uncommon or unstable condition
When patient or family requests physician visit

patient status should be discussed initially. For example, the NP sees a patient who has a sudden and irreversible decline. After a long discussion with the patient and family, new advanced directives are established as Do Not Resuscitate (DNR). Later that night the family has some follow-up questions and calls the patient's physician. If the physician has not received the information from the NP about this patient, this could confuse the family and impact the physician's care decisions. Similarly, timely updates are essential in onsite clinical management. If the NP in a long-term care facility treats a resident for an acute illness such as pneumonia, the collaborating physician should be informed of the diagnostic work-up and treatment plan so that he or she will be ready to intervene appropriately in the event that the resident does not improve, or family or staff call with questions. This will optimize the management of the resident. A clear mechanism (voicemail messaging, E-mail, direct telephone call, etc.) should be agreed upon for sharing updates and patient information. This type of communication will facilitate the development of mutual respect and trust. If providers come to understand and develop a comfort level with each others' practice style, then decisions that are made on behalf of patients are respected by each provider.

Naturally, practice styles, clinical decision making, and judgment may differ in specific cases. Differences of opinion on the plan of care should never be aired in front of other staff, patients, or families. This should, however, be addressed privately as soon as possible between the collaborating physician and gerontological NP. An important aspect of starting a collaborative practice involves a verbal agreement that differences in approach to patient care will be acknowledged and discussed in a nonjudgmental manner, and will be resolved between the two providers. In a large group practice, efforts should be made to discuss differences in practice style and match up teams of physicians and NPs who share a similar practice style or philosophy. Periodically, formal or informal surveys should address job satisfaction related to the collaborative practice relationship for both physicians and NPs. This provides another opportunity to discuss ways to enhance the collaborative relationship and improve patient care.

CONCLUSION

There are several essential elements in the development of a collaborative practice between physicians and NPs. First and foremost is the need to understand the roles, skills, and knowledge of each individual. Interdisciplinary education in medical and nursing programs is an excellent way to facilitate this process. Other important techniques include meeting initially to define shared authority, accountability, and coordination of care, and to develop mutual trust and respect. Collaboration should be viewed as an opportunity to enhance professional relationships, optimize geriatric practice, and protect providers from malpractice. The collaborative practice agreement can provide the structure for a strong, positive working relationship capable of enhancing patient care.

Table 4. *Recommendations for Development and Use of Collaborative Agreements*

Keep guidelines general; avoid specifics except for procedures
Avoid setting specific time frames
Make it realistic
Read, sign, and know what the agreement states and adhere to it
Document evidence of adherence (i.e. keep record of consultations and schedule II prescribing)
Provide a general list of treatable health problems, prescriptive abilities, and types of tests and procedures either ordered for patients or independently performed (or refer to scope of practice as outlined in other documents)
Know the scope of practice for the nurse practitioner within the state and make sure the agreement is in alignment with the current scope of practice
Provide documentation of nurse practitioner skills with regard to specific procedures (i.e. suturing)
Create a new collaborative agreement when a new provider joins the practice and update the appropriate agency (e.g. the State Board of Nursing, Department of Public Health)
Use the document to discuss practice style and communication when new providers join the practice
Review guidelines and requirements of the collaborative practice agreement from the appropriate state board (usually available on the Web)
Review and revise collaborative practice agreements every 1–2 years

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