
Colorado Collaborative Scopes of Care Study

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Objectives

- Discuss the factors leading to the commissioning of the study and the creation of the Advisory Committee
- Review the project, processes, results and outcomes
- Discuss learnings
 - » What were the surprises
 - » Where was there consensus
 - » Where were the lines of disagreement drawn
- Discuss advice for consideration of such a project
- Present a few cautionary notes

Factors leading to the study

- Certified Registered Nurse Anesthetists have “independent” practice authority under the Nurse Practice Act (NPA) and want the Colorado Governor to “opt-out” of Medicare part A supervisory requirements
- Advanced Practice Nurses must have a “collaborative agreement” with a physician in order to have prescribing authority
- Dental hygienists can’t “diagnose” dental conditions

Factors leading to the study

- Scope expansion bills are brought forward to the general assembly with increasing frequency resulting in bitter turf battles
- Nurse Practice Act is up for “sunset” or required re-authorization (2008-09 session)
- Nurses announce their proposed deletion of the required collaborative agreement citing unnecessary restraint of trade, and
- Physicians announce their opposition citing quality of care and inadequate education

Factors leading to the study

- The chair of the Senate Health and Human Services Committee became concerned about the scopes fight as well as about reports out of Massachusetts that they had an inadequate workforce to meet the demands for primary care associated with the expansion of health care coverage
- He proposes a systematic evidence review to assess the potential benefits and harms of scope expansion for advanced practice nurses and dental hygienists
- Governor Ritter agrees to commission the study and create an advisory committee by Executive Order

Advisory Committee

- Anesthesiologist and CRNA
- OB/GYN and CNM
- Family Medicine doctor and FM nurse practitioner
- Pediatrician and Pediatric nurse practitioner
- Physician assistant, Registered Nurse
- Dentist and dental hygienist
- R and D senators and representatives
- Relevant state agency representatives
- Governor's policy office representative
- Chief Medical Officer as chair

Research entity

- Colorado Health Institute—non-partisan health research non-profit funded by health foundations
- CHI staffed advisory committee meetings, performed the systematic evidence review, produced the report
- Cost: \$140,000 (a typical SER could cost 3-4 times this)

Systematic Evidence Review

- Develop key questions
- Use electronic literature search
- Pull related research articles
- Review study and rate quality
- Extract study findings
- Synthesize findings

Key questions

- What are the quality, safety, efficacy and cost-effectiveness issues related to utilizing advanced practice nurses (APNs), physician assistants (PAs) and dental hygienists (DHs) as primary care providers, paying particular attention to the provision of primary care provided to underserved populations?
- What is the quality, safety and efficacy evidence for utilizing independent practice certified registered nurse anesthetists (CRNAs) in anesthesia settings?
- Are there models of care, care settings or aspects of care settings including relationships between different providers that have been shown to improve access to quality primary health care when employing APNs, PAs and DHs?

APN results

- 1,116 articles (778 NPs, 191 CNMs, 147 CNRAs)
- 122 qualified for full review
- 17 met criteria to provide evidence (12 NPs, 4 CNMs, 3 CRNAs); three systematic reviews
- 12 in primary care settings, 1 in hospital setting, 1 in Colorado, 2/3 of the systematic reviews from the UK

Additional helpful items

- Key informant interviews and summary
- GIS mapping of provider availability
- Survey of statutes from other states
- Comparison of education programs
- Comparison of reimbursement policies
- Discussion of liability issues

Map 3. Colorado's Primary Care Workforce: Practicing Physicians and registered Advanced Practice Nurses (APN) by County and below 200% of Federal Poverty Level (FPL)



Primary care types

- Primary care physicians
- ▲ APNs

Percent of population with household incomes below 200% of the Federal Poverty Level

- 0% - 10%
- 10.1% - 25%
- 25.1% - 35%
- 35.1% - 50%
- >50%

Source Information

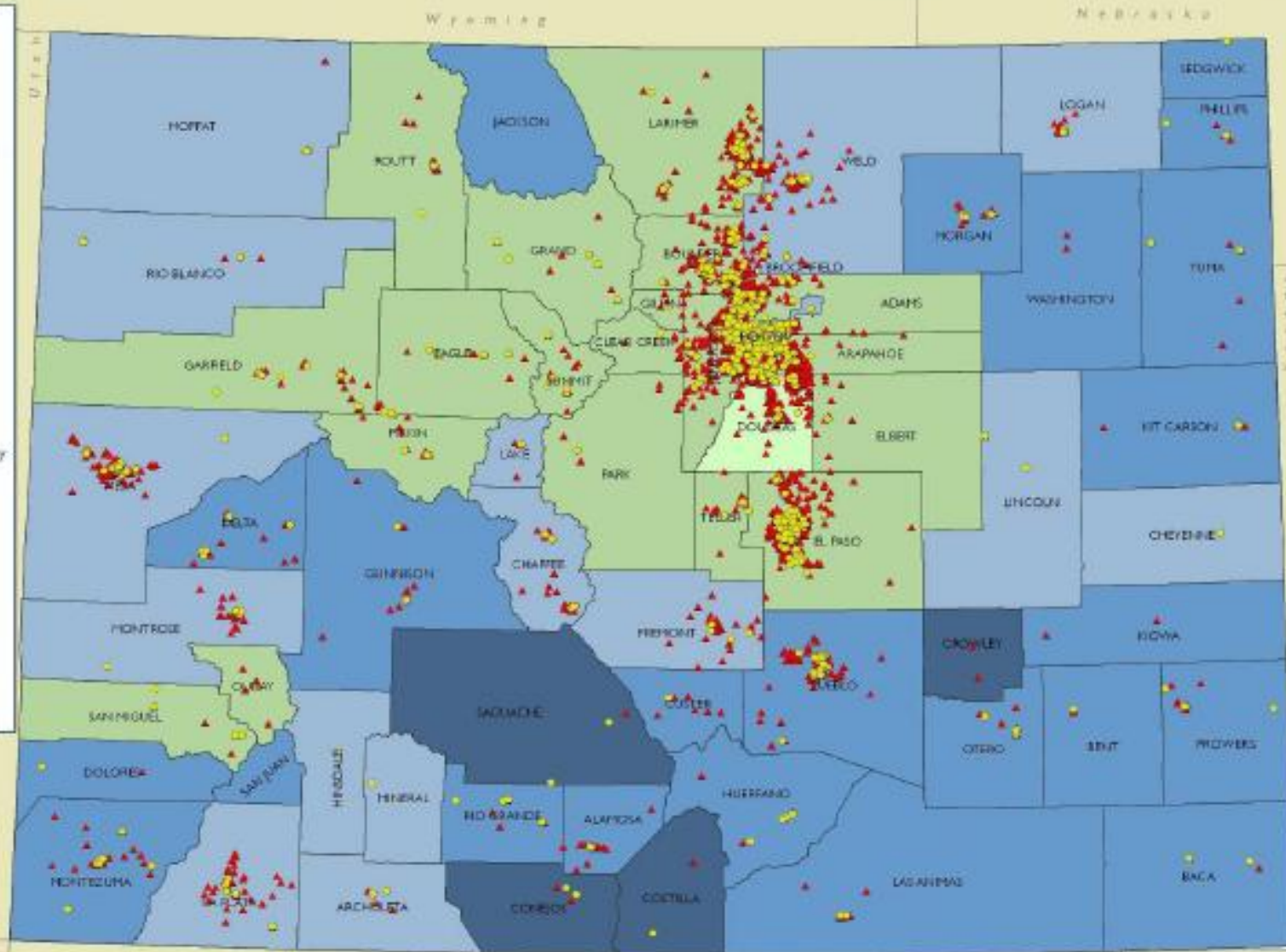
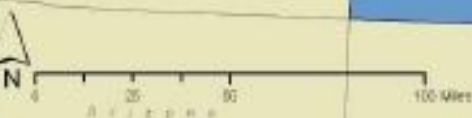
Advanced practice nurses include NPs, CRNAs, and CNMs. Data downloaded on 12/9/2008 from the Colorado Department of Regulatory Agencies (DORA), www.dora.state.co.us

Practicing primary care physicians include family medicine, general practice, internal medicine, and pediatrics. Data provided on 9/30/2008 by Peregrine Management Corporation, www.peregrine.us

Poverty data were tabulated by the U.S. Census Bureau at the request of the Colorado Health Institute. Data are based on a sample from the 2000 U.S. Census.

Map created December 2008

Map prepared by the Colorado Health Institute
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Notes: Some individuals who are actively licensed as an Advanced Practice Nurse may be working less than full time or not at all in the profession. In addition, counts are based on the mailing address in the licensure file, and it is unknown whether this address is a home or a practice location; thus, it is not known with certainty that counts are representative of Colorado or a given county practice location.

Table I.4. Nurse Practitioner Scope of Practice: 7-State Comparison

	Oversight Requirements				Practice Authorities			Prescribing Authorities				
	No MD Involvement Req'd	MD Supervision Req'd	MD Collaboration Req'd	Written Practice Protocol Req'd	Explicit Authority to Diagnose	Explicit Authority to Order Tests	Explicit Authority to Refer	Authority without MD involvement	Authority with MD certification	Written Protocol Required	Authority Controlled Substances	National Certification Required
AZ	X				X	X	X	X			X	X
CO					X	X [5]	X		X	X	X	-
NM	X				X	X	X	X			X	X
OR	X				X	X	X	X			X	[1]
WA	X				X	X	X	X			X	X
WI[2]												
WY [4]	X				[6]	X	X	[4]			[4]	X

Sources: University of California, San Francisco, Center for the Health Professions (2007); State regulatory agency contacts

http://www.futurehealth.ucsf.edu/pdf_files/Chart%20of%20NP%20Scopes%20Fall%202007.pdf

- [1] Not required for state licensing, but practically necessary in order for independent practitioners to receive reimbursement from Medicaid and Medicare
- [2] Wisconsin recognizes two types of nurses that may be compared to Nurse Practitioners in other states -- one (NP) under the broader category of Advanced Practice Nurses, another called Advanced Practice Nurse Prescribers (APNP). The former group is not licensed by the state.
- [3] Limited Schedule II authorities, e.g., no amphetamines
- [4] WY rules are being updated to reflect current statutory authorities. NPs may apply for authority to prescribe (Schedule II-V) in areas of expertise after attaining 30 CEUs in pharmacology and 400 hrs as an APN
- [5] Colorado; test ordering authority not cited in UCSF table; included in draft table provided
- [6] Waiting to hear back from Wyoming contact

Evidence table: NP and physician collaboration

Citation	Title	Purpose and Area Studied	Sample, Setting and Methods	Findings	Barrier Themes	Strategies to Improve Collaboration
Cairo ²²	Emergency physicians' attitudes toward the emerging role of NPs: validation versus rejection	Examined emergency department physicians' attitudes about collaboration with NP Examined misconceptions about NPs scope of practice; examined how ED physicians conceptualized the NP role	5 emergency physicians in an ED in a city hospital Interviews: Open-ended questions	<ul style="list-style-type: none"> Some physicians accepted NP role Some physicians reluctant to accept NP role Physicians thought collaboration was more independent NPs viewed their role as more independent 	Lack of knowledge about NP role Poor physician attitudes with regard to NPs	Increased contact between NP and medical students while still in education And establishing collaborative practice agreements
Hallas et al. ²³	Attitudes and beliefs about effective pediatric NP and physician collaboration	Explore PNP and physician attitudes and beliefs about collaboration in a primary care setting Identify common themes of collaboration	24 PNP and pediatrician teams PNP (n=34) Pediatricians (n=24) Questionnaire: 8 open-ended questions using a Likert scale	<ul style="list-style-type: none"> Collaboration defined as working together, consulting, sharing common goals and complementary practice Critical components of a collaborative practice: trust, mutual respect, communication, shared practice, competence and similar vision Red flags to collaboration: lack of respect, territorial issues, poor attitude, incompetence, professional inflexibility, ineffective communication The word consultation versus independent or supervision should be used to describe NP-physician collaboration 	Barriers: Lack of knowledge about NP role Lack of knowledge about NP scope of practice Poor physician attitudes about nurses Lack of respect	Incorporate collaborative practice opportunities in medical and nursing education programs

Findings

- APNs working as members of interdisciplinary health care teams deliver quality health care comparable to physicians in a variety of settings while receiving high patient satisfaction ratings
- CNMs and CRNAs provide quality specialty care without the direct supervision of a physician, often operating under specific practice protocols developed in consultation with a licensed physician
- Consultation and referral to other appropriate providers consistent with training and scope of practice is a necessary component of primary health care to be exercised by all primary care providers

Recommendations

- APN Recommendations
 1. Evaluate the efficacy of changes to APN law and regulations that would allow more flexibility in, or other changes to, the collaborative agreement requirement for prescriptive authority by APNs that would address the identified barriers.
 2. Evaluate and recommend policies that would support and enhance the delivery of health care through interdisciplinary teams including physicians, APNs and other health care professionals.
- CRNA Recommendation – Evaluate the efficacy of implementing changes currently authorized under the federal opt-out provision for Medicare Part A reimbursement to allow Colorado hospitals to bill for CRNA services directly taking into account hospital location and CRNA practice experience.

Outcomes

- Collaborative agreement requirement removed
- Added additional year of physician mentorship after year of physician preceptorship
- Added articulated plan for practice to be signed once by physician mentor and reviewed annually only by APN
 - » Consultation and referral plan
 - » Decision support plan
 - » Ongoing learning plan
- Created ongoing physician/nurse advisory panel (advisory to the licensing boards)

Lessons learned

- Surprises
 - » Physician participants were able to objectively assess research data and agree on a reasonable set of recommendations
 - » Group came together as a cohesive working group over time
- Surprising because there was a strong sense of distrust evident in the early meetings

Lessons learned

- Areas of consensus
 - » Advance practice nurses provide high quality care
 - » Physicians have more supervised training in drug prescribing
 - » All providers practice within a setting requiring consultation and referral (no such thing as “independent” practice)
 - » Hard to design statute that regulates collaboration or assures professional relationships
 - » No research evidence of quality of care issues
 - » We should try to support health care delivery by integrated teams

Lessons learned

- Areas of no consensus
 - » There is no good evidence that the current system is broken
 - » Physicians feel they have better training and provide better care
 - » Nurses see additional requirements as unnecessary

Advice

- Need a respected, unbiased research group to staff the process and do the research
- Need a skilled facilitator
- Process must be seen as objective and without a pre-determined outcome
- Get consensus about process early on
- Get consensus about no minority report (a commitment to strive for consensus)
- Involve relevant stakeholders; ask for a number of potential members to allow for choice that avoids zealots

Advice

- Stay true to agreed upon methods
- Allow for sufficient discussion of research results and assessment (acknowledge all opinions)
- In crafting a recommendation, don't let perfect be the enemy of good, and don't allow the recommendation to exceed that supported by the evidence
- Pilot programs and program requirements for follow-up reports are compromises that can help diffuse opposition

Advice

- Don't re-invent methods from scratch (use existing evidence review methodology and tools)
- Spend time on the process to translate the results of the evidence report into a recommendation

USPSTF recommendation grid

Certainty of Net Benefit	Magnitude of Net Benefit (Benefit Minus Harms)			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	I — Insufficient Evidence			

A & B: recommend use

C: recommend against routine use

D: recommend against use

I: no recommendation; insufficient evidence

Cautions

- Is there a sufficient evidence base to support a review?
 - » Remember that no evidence of benefit is different than evidence of no benefit
 - » And, no evidence of harm is different than evidence of no harm
 - » What will the policy recommendation be if the review result is “insufficient evidence”?

Cautions

- Even systematic evidence reviews involve judgments, even when applying accepted rules
 - » Is the study relevant to the question?
 - » Are the study results valid (what is the quality of the study)?
 - » Are the results applicable to your setting (generalizability)?
 - » What is the balance between potential benefit and threats of harm?
 - » Is the certainty of the results sufficient to support policy change?
 - » What are the risks and ramifications of being wrong?

Five stages of evidence acceptance

- The data are wrong
- OK, but the data don't apply to us
- OK, but we need time to assess the situation for ourselves
- OK, but we can fix this ourselves
- OK, but we need to be part of the solution

Be wary

- “Hell hath no fury as special interest disguised as righteous indignation”
- “If you don’t want to do something, one reason’s as good as another”

