Nurse Practitioners and Physicians: A Collaborative Practice
[Organizations/Networks]

Neale, Jane M.B.A., R.N.

JANE NEALE is currently enrolled in the Family Nurse Practitioner tract. Master's of Science Program and the Ph.D. at the University of Colorado Health Sciences Center, Denver, Colorado. She earned her Bachelor's of Science in Nursing at the University of Northern Colorado, Greeley, Colorado, and her Master's in Business Administration at the University of Colorado, Denver, Colorado. Currently she is working as a Research Assistant for the UCHSC School of Nursing. She has worked extensively as a critical care staff nurse, as a health care management, productivity, and outcomes consultant, and in medical device quality assurance, regulatory affairs, and marketing.

Outline

- Abstract
- BACKGROUND
- CURRENT PERSPECTIVE
- COLLABORATION
  - Barriers to Collaboration
- REIMBURSEMENT
  - Medicaid
  - Medicare
  - Tricare
  - Third-Party Reimbursement
- TERRITORIALISM
- ROLE CONFUSION
  - Strategies for Effective Collaboration
- CONCLUSION
- REFERENCES

Abstract

The rapid evolution of health care delivery within the United States has created increased opportunities for nurse practitioners (NPs) to work in a variety of challenging advanced practice roles and to impact the quality of health care. The NP role was originally developed to meet a perceived shortage of primary care physicians, especially for underserved populations. Today, NPs work in various fields, such as geriatrics and women's and family health care, as well as in various systems such as private practice and health maintenance organizations. Effective collaboration with physician colleagues will promote improved communication, health care management, and positive health outcomes. Barriers to effective collaboration are
reimbursement, territorialism, and role confusion on part of the health care team and the general public.

The rapid evolution of health care within the United States has led to the development and implementation of a variety of primary care roles and health care delivery models. This change has accelerated over the last decade, with evidence of increased opportunities for nurse practitioners (NPs) to promote patient wellness and health as well as increased autonomy and authority. Throughout the literature, the role of the NP has been addressed with a focus on utilization, cost, patient satisfaction, clinical outcomes, effectiveness, collaboration with physician colleagues, reimbursement, and various barriers to collaboration such as territorialism and role confusion. The purpose of this article is to address the development of the NP role and issues surrounding effective collaboration with physician colleagues.

Professional collaboration is a vital component of a successful practice because it brings together the skills and talents of both disciplines, creating an enhanced environment for better health outcomes that ultimately can translate to improved quality of care, quality of life, and cost-effectiveness of health care delivery. Understanding collaborative practice is important for NPs, because it is a concept that is frequently used within different clinical, management, and reimbursement contexts and can be misinterpreted if inadequately defined. Historical and current perspectives are presented, followed by highlights regarding collaboration and its inherent barriers.

BACKGROUND

NPs are a subcategory of clinicians known as advanced practice nurses (APNs). Porcher quotes The National Council of State Boards of Nursing as defining the role of the APN as:

Nursing practice based upon knowledge and skills acquired in a basic nursing education, through licensure as a registered nurse, and in graduate education and experience, including advanced nursing theory, physical and psychosocial assessment, and treatment of illness (p. 181)

Although APN roles have evolved to meet a variety of health care delivery needs, including certified nurse-midwives (CNMs), certified nurse anesthetists, and clinical nurse specialist (CNSs), with a primary focus on acute care of inpatients and ambulatory settings, NPs have traditionally focused on primary care. Although physician assistants (PAs) are in the same provider category, NPs are quite different. First, a PA must practice under a physician's medical license; second, the PA's practice has been traditionally based on the medical model, serving as an extension of the physician. Conversely, the NP has a nursing practice for which she or he is entirely responsible under an individual nursing license. The NP, in many states, can have an independent practice with the autonomy of prescriptive authority.

The first educational program for NPs was originated in 1965 at the University of Colorado, Denver. Loretta Ford and Henry Silver developed the pediatric nurse practitioner (PNP) role as a direct outcome of a perceived shortage of primary care physicians and of the lack of accessible
health care for underserved populations. This role was designed to enable a nurse to practice within an expanded scope of practice that would include primary care for the pediatric patient. Later, other NP programs were developed throughout the country, with various clinical areas of focus, such as geriatrics, school health, and women's and family health. In 1970, Kaiser Permanente's Northwestern Region was the first nonacademic institution within managed care to hire a formally trained PNP with the intent of meeting future primary care staffing needs. Other health care systems and health maintenance organizations (HMOs) followed suit, such as the Geisinger System of Healthcare in Danville, Pennsylvania, and Harvard Community Health Plan in Brookline, Massachusetts.

Since then, many institutions and facilities have used NPs, with a growing number of practitioners providing primary care for a variety of patient populations. Schaffner, Ludwig-Beymer, and Wiggins describe the use of NPs nationwide within 26 large health care systems and multispecialty group practices. Within these health care delivery environments, NPs and other APNs were interviewed regarding their practice. Many respondents of their survey reported that APNs were used throughout the system. Findings from this study indicate that APNs are being used with increasing frequency to provide high-quality and cost-effective care.

Although nurses within managed care organizations can experience enhanced job growth and responsibilities, some have expressed frustration with this work environment. In a survey conducted by Cohen et al, most of the nurses who participated expressed concerns regarding feelings of being the "invisible" providers. Although contributing significantly to organizational revenues, NPs believed their services were not recognized as being major contributing factors. Havens and Evans further describe the source for this frustration, citing testimony at the Institute of Medicine's, Hearing on Primary Care (December 5, 1994, Washington, D.C.) indicating that many NPs find it difficult to practice in states with restrictive laws because of barriers to NP practice within managed care.

Jackson et al present creative mechanisms for patient management and reimbursement that helped to support a collaborative practice between both the nurse and physician. Regarding practice of NPs within an out-patient setting in England, Hill et al describe a study that addressed three areas: the effectiveness, safety, and acceptability of NPs. Over a period of 1 year, 70 patients with rheumatoid arthritis were enrolled in the study with either a NP or a physician consultant managing patient care. Overall, comparisons of the two groups found that patients seen by the NP had fewer complaints of lower back pain, greater levels of knowledge, and more satisfaction with their care.

Last, it is interesting to note the use of the NP within underserved areas. Although the NP role was originally developed to meet the needs of the underserved, statistics indicate that 91% of practice is in metropolitan counties, with few Master's-prepared NPs actually serving underserved urban communities.

The role of the NP is expanding, and with this expansion comes the challenge of addressing the changing environment of autonomy and responsibility. Strategies for effective collaboration within all of these work environments should be to enhance education of the health care team and the general public, resulting in increased accountability, strong relationships with physicians,
and enhanced patient management and outcomes. Understanding the current health care environment as well as the need for physician and patient education regarding the role of the NP should help to further patient welfare and the professional status and acceptance of the NP.

CURRENT PERSPECTIVE

Currently, health care providers focus on key issues such as access, acceptability, quality, and cost. Administrators, managed care organizations, and physician groups have all increased the utilization of NPs in primary care to address these issues.1,19,22 Although the physician practice has been traditionally based on the medical model, the NP's practice focuses not only on disease but on patient and family. Literature indicates that NPs provide health promotion and disease prevention counseling, health education, preventive health and screening services, and use of community services.1,6,23,24 Brown and Grimes 7 describe a meta-analysis in which 38 studies were analyzed for 33 outcomes. Findings indicate that patient satisfaction and resolution of pathologic conditions were higher for the NPs than that for physicians. The overall trend of the study findings indicates that the quality of care delivered by the NP paralleled, if not exceeded, that of the physicians.7 Studies also indicate other favorable clinical outcomes. Starfield 16 describes the function of NPs, with evidence that nurses order fewer expensive tests, conduct more effective patient problem solving, and have higher patient satisfaction and compliance ratings. This was attributed to how NPs recognize and manage certain problems, especially when dealing with nonmedication therapies. In addition, NPs have higher patient satisfaction ratings regarding clinic wait time, provider knowledge about disease, continuity of care, and patient education.5

Although NPs can effectively manage approximately 60% to 80% of primary care cases, there continues to be ongoing resistance to their use by some physicians.25 Varying degrees of effective collaboration occur within group practices and acute care settings, as described by several authors; however, many barriers to collaboration remain, such as scope of practice, legal implications, and role confusion that can ultimately impact patient outcomes. Physicians and nurses conflict when addressing issues surrounding independent nursing practice and its implementation.11 Conversely, Reed and Selleck 23 describe a beneficial environment that is created within a collaborative practice between physicians and midlevel providers. There is often an enhanced sense of cooperation and competence, using individual health care provider strengths and talents to optimize the emphasis on disease prevention. The NPs role within an interdisciplinary practice should be understood by all involved—the physicians, staff, and patients. Examining expert nursing practice and learning, Benner 26 notes that, with the skills of the expert nurse, nurses "can come to terms with boundaries, limits, and possibilities" (p. 168). Although many novice NPs may refer to themselves as "advanced beginners,"7 the seasoned NP may be seen as the expert nurse. Having an understanding and appreciation of this role's capabilities and expectations will facilitate effective collaboration with a clear understanding of its implications. This author proposes a model of professional interdisciplinary collaboration within the NP and physician practice, each using their own talents and skills to meet the health care management needs of a variety of patient populations. To help further the understanding of the nature of true collaboration, a discussion regarding the meaning and application of collaboration is presented.
COLLABORATION

The American Heritage Dictionary defines collaboration as "to work together especially in a joint intellectual effort." Baggs and Schmitt propose that interdisciplinary collaboration is the "sharing in planning, making decisions, solving problems, setting goals, assuming responsibility, working together cooperatively, coordinating and communicating openly" (p. 145). Using this principle, effective collaboration clearly should involve all members of the team (eg, NPs, physicians, CNSs, PAs, physical therapist, clients, patients, families, etc.). Within the context of NPs and physicians, collaboration represents an interaction that focuses not only on quality of care and patient outcomes but on a relationship that enhances professionalism and mutual understanding. When describing the nurse/physician relationship, King et al quote the 1981 National Joint Practice Commission as setting the goal to "make recommendations concerning the roles of physicians and the nurse in providing high quality health care" (p. 147). The commissioners are further quoted as describing collaboration as a "jointly determined relationship," "shared responsibility," and a "climate of trust and respect" (p. 147). By effectively communicating with other health care professionals through mutual referral, consultation, and education, the NP can create and support a collaborative environment. This will continue to transform as the role of the NP evolves in response to changes in societal and professional expectations.

The term collaboration is used extensively throughout the nursing literature, yet it can have different meanings, depending on its context. Collaboration was defined within the Balanced Budget Act of 1997 (HR.2015), signed into law by President Clinton on August 5, 1997, as "a process in which a NP works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed." The rule was later revised and published in the November 2, 1998, issue of the Federal Register to state that "for purposes of Medicare coverage, the collaboration requirement will state that these nonphysician practitioners must meet the standards for a collaborative relationship as established by the State in which they are practicing. In the absence of State law or regulation governing collaborative relationships, these nonphysician practitioners must document their scope of practice and indicate the relationships that they have with physicians to deal with issues outside their expertise." Clearly, the concept of collaboration can be used in more than one context. It is important for the NP and physician to thoroughly understand its meaning.

The collaboration of NPs and physicians is seen within the clinical setting when physicians and NPs work together as a team, allowing the NP to function independently and autonomously while providing routine nurse-physician consultation. Cost-effectiveness may be enhanced by this relationship, with the NP focusing on health promotion and education and the generalist physician focusing on specific diseases. Frequent consultation, sharing of ideas and knowledge, and consistent interaction regarding case load and client needs result in enhanced patient care and satisfaction.

Regarding independent practice, Mundinger states that collaborative professional relationships between NPs and physicians appear to be more effective and comprehensive than
independent practice. The collaborative relationship is more cost-effective and competitive-thus more attractive to primary care providers-and more efficient in the delivery of comprehensive and quality care.

Although cost-efficiencies of collaboration and corresponding economic models have been addressed in the literature, the extent that NPs effect actual cost savings is unclear. According to DeAngelis, NPs spend an average of 50% more time with patients than their generalist physician counterpart, but the physicians' work-week is 50% longer, resulting in approximately equal cost per visit. A study conducted for the American Nurses Association (ANA), however, found that the average cost per patient visit with an NP was 39% lower than a physician visit, whereas patient knowledge was equivalent.

**Barriers to Collaboration**

Although increased use of the NP has been witnessed throughout the United States health care system, some very significant barriers to collaborative practice exist. The issues of reimbursement, territorialism, and role confusion are highlighted as three key areas that impede practice. To further the movement of collaborative practice, nurses must collectively address these issues, thereby enhancing their efforts to provide effective and efficient patient care.

**REIMBURSEMENT**

Since 1948, the ANA has supported the direct reimbursement of APNs. Overall, NPs are reimbursed at a lower rate for the same services provided by a physician. It is clear that without adequate reimbursement of services, the degree of professional autonomy of NPs is limited, as is collaboration with physicians. The NP will continue in a subordinate and dependent role. While lobbying efforts have been in place for several years, strong lobbying strategies must continue to further this component of the APN movement, focusing on scope of practice and prescriptive authority as key areas to further independence.

**Medicaid**

Early in the development and use of the NP role, the federal government established direct Medicaid reimbursement for APNs. Financed through the Health Care Financing Administration, Medicaid (a general fund allocation program in which state revenues match funding on a 50-50 basis per capita income) has 50 different programs that cover over 23 million of the nation's poor. Seen as an alternative role to providing health care in areas of physician shortages, Medicaid directly reimburses APNs for patient services delivered within their defined scope of practice; however, the degree to which reimbursement occurs varies by state with strict restrictions to reimbursement. Direct reimbursement for NPs is only for services specifically within their scope of practice. For CNMs, Medicaid reimbursement is limited to services focused on the management of care of mothers and babies throughout the maternity cycle. Forty-one states reimburse NPs at 60% to 100% of physician reimbursement rates. Idaho and Ohio have no Medicaid reimbursement, because APNs are not considered independent practitioners under current state legislation. In these states, Medicaid payment must be made to the supervisory
physician. \textsuperscript{2,14} Until this legislation is revised to recognize the APN as an autonomous practitioner, it will be difficult to realize a true collaborative relationship in which the NP can practice without control by physicians.

Medicare\textsuperscript{a}

Medicare is a federal insurance program designed to address the health care of the elderly and disabled, covering different services under its Part A and Part B. \textsuperscript{37} Although CNMs have received reimbursement from Medicare since 1988, at a rate of 65\% of the physician fee schedule amount and with or without collaboration with a physician, NPs have not. For NPs to receive direct reimbursement, their services must be within their scope of practice, in collaboration with a physician, or services under an HMO or skilled nursing facility. \textsuperscript{14} The reimbursement climate for NPs is changing, with authorization of direct Medicare reimbursement to NPs and CNSs, regardless of geographic location, put into place within the Balanced Budget Act of 1997. Previously, reimbursement was limited to NPs and CNSs practicing within a rural area. Nevertheless, collaboration with physicians is still necessary for reimbursement, regardless of individual state legislation. \textsuperscript{31} NPs performing professional services are now required to obtain their own Medicare UPIN billing number, with all claims submitted using this number. If an NP is an employee of a physician, meeting the direct supervision requirements, they will be reimbursed at 100\% of the physician fee schedule. \textsuperscript{38}

Tricare\textsuperscript{a}

The federal government, in the form of Civilian Health and Medical Program for the Uniformed Services, is one of the first federal programs to provide full, direct reimbursement for CNMs and NPs. Another program, Federal Employees Health Benefits Plan, also provides direct reimbursement for NPs and PAs who are authorized to practice within their respective states. \textsuperscript{37}

Third-Party Reimbursement\textsuperscript{a}

There is no legal restriction for NPs to practice independently throughout most of the United States, and many insurance companies and HMOs currently cover the services of NPs. Approximately 50\% of the nation's states have provisions that provide direct reimbursement, mandating payment for services that fall within the NP's state-defined scope of practice. \textsuperscript{14}

NPs, working collaboratively within a physician practice or as a consultant, have developed creative mechanisms to facilitate payment. Jackson et al \textsuperscript{10} describe their collaborative relationship and mechanism of reimbursement. The NP within their group practice works as an independent contractor, billing the physician colleague for her services. She receives 50\% of the billed fees, less immunizations and other tests. The other 50\% is allocated to cover office expenses and malpractice insurance. This strategy allows mutual benefit for the NP's and physician's practice. The NP can work collaboratively within a primary care practice while minimizing office management expense issues, and the physician has access to an NP, who theoretically can bring in additional visits. Although the NP has autonomy regarding her patient schedule, the practice has an enhanced degree of financial security. For the NP within this
particular practice, this was an effective manner to receive payments systematically while minimizing the liability of office expenses, labor, and insurance costs.

Although direct reimbursement continues to be an incredible challenge to NPs, considerable progress has been made. Nurses possess the ability to enhance this type of strategy, using their strong intercommunication skills, to further negotiations for better percentages of billed fees. Using their political strength (with numbers of registered nurses close to 2.2 million in the United States and their strong public image), they can work toward legislative reform. The movement toward collaborative practice will require NPs to be effective negotiators with private payors, employers, and legislators to work toward a more equitable level of reimbursement.

**TERRITORIALISM**

Collaboration is also indicated with the American Medical Association (AMA). According to the AMA, physicians generally appreciate, and rely on, the expertise that the NP brings to the care of a patient. The team approach works most effectively between the physician and nurse, but there is great resistance to the concept of NPs performing the same clinical tasks as the physician without direct supervision. The AMA questions this as being "replaced" by a non-physician professional (e.g., nurse, pharmacist, psychologist) and has inquired about the physician's ethical responsibility to demand physician supervision of patient care. True collaboration, however, does not necessarily imply "replacement" but is complementary in nature, supporting an environment of communication and of shared expertise.

When NPs are used within a collaborative, not a substitutive, environment, some physicians have found them to be highly beneficial. Mundinger states that collaboration leads to a comprehensive, cost-effective, and therefore competitive independent practice as well as a primary care practice that is more beneficial to the physician, nurse, and patient. By the formation of a collaborative team, physicians and nurses can avoid turf battles and focus on the delivery of care. Sharing authority equally allows both professionals to practice within their scope of care while working within an environment of respect and understanding. When differences of opinion occur, the individual with the most expertise in that area has authority.

Physicians have adamantly wanted to maintain control of prescriptive authority and direct reimbursement. According to Chavigny, physicians believe that this is not related to greed but rather to the efficiency of managing patient care and that, if reimbursement is directed in multiple directions, an uncoordinated level of patient care will follow. When addressing prescriptive authority, the AMA believes this responsibility belongs solely to physicians because multiple prescribers will hinder continuity of patient care. Critics of NPs also express concern regarding quality of care, stating that it comes down to lack of educational training and judgment.

Physician concern also may be related to "turf battles." Havens and Evans describe a survey of over 1,600 physicians conducted by Kenneth Ferraro at Northern Illinois University in DeKalb and Tammy Southerland at the University of North Carolina at Wilmington that determined that physician reluctance to use NPs may be related, not to their clinical abilities, but
to "the will to control 'more desirable work' for physicians and to favor [non-physician] employment in service to populations less desired by physicians."

Strategies that address territorialism would be those that focus on the specific roles of each discipline, along with corresponding education regarding NP responsibilities and clinical contributions. A clear definition of which patients are appropriate for each discipline, with consultation on a regular and consistent basis, will facilitate an ongoing environment of collaboration.

ROLE CONFUSION

Although NPs practice within a variety of settings, such as acute care hospitals, emergency departments, outpatient clinics, private physician offices, nurse-run clinics, and home health agencies, the professional environment between them and physician colleagues has been complicated and confusing. Often, physicians and patients express confusion about nursing roles that can lead to barriers in developing working relationships.

The phenomenon known as the doctor-nurse game has been well documented within the literature. This game relates to the manner in which doctors and nurses communicate, resulting in a subordinate role for the nurse and one of authority by the physician. The role of the nurse has evolved slowly, from one of subordination to the physician to that of increased autonomy, independence, assertiveness, and accountability. The doctor-nurse game should no longer be the norm; rather, a practice with a complementary nature should be encouraged, in which both disciplines share their knowledge cooperatively. Education of both the medical profession and the public regarding the roles of APNs is warranted to help promote a collaborative practice and to change misconceptions of subordination.

To help diminish the prevalence of the doctor-nurse game, clear definition of roles with effective collaboration can help to improve health care management and positive patient outcomes. Watts et al found in their research, which examined collaboration and decision-making outcomes in transplant ambulatory care settings, that 80% of patient problems in telephone interactions were effectively resolved by a CNS functioning within defined scope of practice and guidelines. Independent decision making was a pivotal component of effective collaboration and communication between the nurse and the physician colleague.

Brown and Olshansky describe a study in which primary care NPs were surveyed regarding their initial year of practice. To help address the issue of role confusion and lack of understanding of the NP role by clinic staff and patients, an informative pamphlet was developed that addressed the NP clinical contributions. This effective educational tool helped inform both colleagues and patients alike.

Strategies for Effective Collaboration

1. To educate the health care team and the public, concise and informative literature should be provided to clients and staff within a clinic setting regarding the NPs' scope of practice and their clinical contributions. This information should be presented in such a manner as to show the complementary nature of a collaborative practice between NPs and physicians (e.g., in
complicated diabetes mellitus disease process control, patient management is provided by the physician and patient teaching, health promotion, and ongoing support by the NP). This literature can be used to supplement other forms of patient education.

2. Regular and consistent sessions for consultation with physician colleagues should be encouraged. This can be accomplished by having regularly scheduled meetings in which patient management and scope of practice are discussed. The unique nature of the NP role in regard to patient education, family assessment and support, and community awareness should be highlighted. This is an area that could nicely compliment the physician's practice while potentially increasing patient visits.

3. Nurses need to become active in legislative and lobbying efforts. Regular communication with House and congressional representatives regarding prescriptive authority and the NP scope of practice will highlight professional presence and accountability. In addition, this will help to maintain, on a legislative level, a presence of APNs and the unique and valuable role they play in today's health care delivery.

4. Nurses also need to be active in their state nurses association to stay informed and to express their opinions regarding various issues.

CONCLUSION^ Perhaps with the changing roles of both nurses and physicians within primary care, a more collaborative approach will be recognized. It is our responsibility and privilege, as APNs, to work within a dynamic and changing health care environment. Collaboration, in the sense of sharing talents and expertise with physician colleagues, will serve to further enhance a professional relationship, while focusing energies of both disciplines toward better patient outcomes, health, and well-being. This is an exciting time for NPs. We are at a critical point in our discipline’s development in which, if we can secure physician and patient understanding and collaboration, we can work together to enhance nursing as a profession is critical to the delivery of quality health care.

REFERENCES^  


23. Reed CA, Selleck CS. The role of midlevel providers in cancer screening. Cancer Screening and Diagnosis 1996;80(1):135-145. [Context Link]


35. Chavigny K. AMA's policies and nursing's role in emerging systems. Nursing Management 1993;24(12):30-34. [Context Link]


Key Words: nurse practitioner; physician; collaboration; reimbursement; territorialism; role conflict

Accession Number: 00002800-199909000-00014
Copyright (c) 2000-2005 Ovid Technologies, Inc.
Version: rel10.2.0, SourceID 1.11354.1.65