Introduction: Who is an APRN?

While Nurse Practitioner (NP) is most common and may be accurately used, APRN is a broader term. An Advanced Practice Registered Nurse (APRN) is a Registered Nurse with advanced training including:

- NP: Nurse Practitioner (NP plus area of specialty, e.g., Family Nurse Practitioner-FNP)
- CNS: Clinical Nurse Specialist (CNS plus area of specialty e.g., CNS-Medical Surgical, CNS-Diabetes, CNS-Cardiology)
- CRNA or RNA: Certified Registered Nurse Anesthetist
- CNM: Certified Nurse Midwife

Nurse Practitioners or APRNs are licensed and regulated by their respective State Boards of Nursing. The process of specialty certification is carried out by various Advanced National Certifying Organizations for each specialty.

The minimum requirements to be designated as an APRN in most states include:

- RN licensure, AND
- Masters of Science in Nursing with a concentration in the respective advanced practice nursing specialty
APRN State Regulation Models: Independent Practice, Collaborative Relationship and Supervisory Relationship

As shown in the map in Figure 1, APRNs may practice independently in almost one-half of the states and the District of Columbia. In many others, they are required to work in a collaborative role with a physician under a collaborative practice agreement. In a few states, a supervisory relationship with a physician is required, and additional restrictions on practice may apply, such as:

- Limitations on the practice settings where an APRN may practice
- Limitations on the physical distance of the physician from the APRN’s site
- Requirements for onsite visits by the supervising physician
- Limitations on the number of APRNs a single physician may supervise

Figure 1. 2017 State Regulation of APRN Practice

Adapted from Reference 1
Physicians working with APRNs may access the specific state regulations at the respective state nursing board website or at http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment.

The trend toward independent practice by APRNs is being fueled by:

- More advanced training of APRNs preparing them for independent practice
- The inclusion of APRNs as primary care providers in major insurance networks
- The granting of some level of prescriptive authority to APRNs by all 50 states
- The shortage of primary care physicians, especially in underserved areas
- The Medical Home model of primary care in government healthcare plans

The Institute of Medicine (IOM) issued a report entitled The Future of Nursing: Leading Change, Advancing Health. This publication presented a review of legislative activity, Nursing Research Network data, and expert opinions from diverse stakeholders in healthcare delivery, and it recommended that federal and state governments remove scope-of-practice barriers that prevent APRNs from practicing to the full extent of their education and training. The IOM report spurred license reform, and many states have now granted APRNs full practice authority.

The National Council of State Boards of Nursing has published a Consensus Model providing guidance to make the 50 states’ regulations uniform. The state-by-state variation and the continuing changes in these regulations make it important for the physician, group or hospital to check annually for changes. Each state nursing practice act is available at the website of each state nursing board, or all 50 may be viewed at the website of the American Association of Nurse Practitioners.

**Physician-APRN Practice Arrangements**

There are many practice arrangements between physicians and APRNs, including these:

1. Physician or physician practice group employs the APRN
2. Hospital employs the APRN
3. Physician or physician practice group contracts with the APRN
4. Physician or physician group shares office or clinic space with APRN

Regardless of the type of arrangement, the collaborating physician and the APRN should agree on the nature and terms of the physician-APRN relationship in a written document in the states that require it. These contracts are most often called Collaborative Practice Agreements or Plans of Accountability.
A Collaborative Practice Agreement defines the relationship between an APRN and the collaborating physician. It may serve as a contract. It spells out the reporting structure, the accountability, and the division of labor between physician and the APRN. It states what the APRN does and does not have authority to do. It spells out the physician’s supervisory responsibilities and availability to the APRN for consultation. Done well, it is a risk management tool.

What are the Risks?

In the states that require that the APRN collaborate with or be supervised by a physician, the question most frequently asked by physicians contemplating a business relationship with an APRN is, “Can I be held responsible for the acts of the APRN?” While medical malpractice claims against APRNs are not common, the answer is, “Yes, you could be legally responsible for the APRN’s malpractice.”

Medical malpractice claims based on the acts or omissions of an APRN may include the collaborating or supervising physician as a co-defendant. Such claims are often based on the following legal theories:

- **Vicarious Liability**

  Vicarious liability is a legal doctrine that imposes liability on a party for the actions of the party’s agent. Most often used in the employment context, vicarious liability means that employers are liable for the improper actions of their employees if the actions were within the course and scope of the employment. An employed APRN’s malpractice will thus increase the risk exposure of the physician in the agreement. However, vicarious liability can also be imposed outside of the employee-employer relationship. In agency vicarious liability, the APRN may be alleged to be acting as the physician’s agent, even if he or she is not actually employed by the physician. The physician’s potential liability will depend on the level of supervision of the APRN required by the agreement, whether exercised or not. For example, using agency vicarious liability, the patient/plaintiff alleging that an APRN failed to properly diagnose will likely also allege that the physician co-defendant also failed to properly diagnose. That allegation is based on the legal theory that the APRN is the agent of the physician, regardless of whether or not the physician exercised actual supervision of patient care in that particular case.
Inadequate Supervision

When a physician’s agreement with an APRN requires or implies that the physician has oversight over the medical judgment of the APRN, the physician may be named as a co-defendant under a separate legal theory of inadequate supervision. This is similar to liability of a supervising physician over a resident in a teaching hospital. Failure to supervise, according to the terms of the agreement, exposes the physician to this separate liability. The physician should carefully review the APRN agreement and document his or her compliance with the agreement’s supervisory aspects. For example, if the agreement requires that the physician review a set number of records a month, those reviews should be consistently recorded. Each patient’s record should reflect the details of the collaboration with the physician consistent with the agreement. If the agreement specifies the terms of the physician’s availability to the APRN, the physician should be available on those terms. The physician should arrange for coverage during times when he or she is unavailable or out of town. It will help protect both the APRN and the physician from liability if the APRN is comfortable consulting with the covering physician and is able to easily reach him or her. (“Incident-to” billing for 5 APRNs is beyond the scope of this monograph, but these billing practices have their own supervisory requirements.)

Improper Delegation of Authority

Like physicians, APRNs are obligated to act within their scope of practice. Physicians should delegate to APRNs only those tasks that are consistent with the APRN’s own licensed scope and level of expertise as well as the authority delegated in the agreement. For example, generally it would be beyond the scope of a midwife to attend a high risk birth. A physician delegating an APRN to such a birth would increase his or her own risk of liability, even if the physician did not supervise or attend the birth. In the event of an adverse outcome, the delegating physician would likely be named as a co-defendant under this legal theory.

Non-Disclosure of Assignment

The patient must always be aware of, and consent to, treatment by an APRN. The information should be disclosed to the patient at the time the appointment is made and should be clearly stated by the APRN when the patient is treated. Non-disclosure of assignment is not a discrete legal theory of liability in itself; however, a patient receiving care from an APRN while believing it to be from a physician is more likely to sue in the event of unwanted outcomes.

While a business relationship with an APRN can increase a physician’s liability risk, liability risks are also increased if a physician is overbooked, overstretched and unable to pay adequate attention to patients. Many physicians find associating with APRNs a manageable risk and a cost-effective way to increase patient volume.
Employing, collaborating with, or supervising one or more APRNs is a business decision. Here are some ways to reduce the risks of working with an APRN.

The Physician’s Risk Management Guide to Working with an APRN

Perform Credentialing
Prior to engaging in an APRN agreement or professional relationship, the physician should ensure that proper credentialing is performed, whether by the physician, practice group or institution, including the following steps:

1. Verify the APRN’s licensure using primary sources. Licensure can be checked online at most state board of nursing websites by entering basic demographic information. Licensure should be checked initially and annually. Billing for services performed by unlicensed providers could require repayment to Medicare, Medicaid or other federal payors.

2. Contact the educational institutions directly to verify graduation from basic, graduate and APRN programs.

3. Perform a criminal background check, if allowed by state law or relevant administrative agency.

4. Verify the APRN’s eligibility as a provider to federal beneficiaries if he or she will be providing care to and billing any Medicare beneficiaries. Check the federal Office of Inspector General (OIG) Provider Exclusion List to make sure the APRN is not on the list. This exclusion list can be found online at [http://exclusions.oig.hhs.gov](http://exclusions.oig.hhs.gov). Also check your state’s Provider Exclusion List. Each list should be checked initially and again annually.

Require Coverage for Professional Liability
If the APRN carries his or her own professional liability insurance, the physician should verify coverage annually. Retain a copy of the insurance policy for your files. Make continuous coverage a contractual requirement of the relationship. If the physician or group will be providing coverage, contact the liability insurer. The insurer can inform the physician about obtaining an extended reporting period (tail coverage) for APRNs who are terminating professional liability coverage under a prior claims-made policy.

Many states, including Louisiana, provide reinsurance for large losses through public patient compensation funds. In states with these excess-risk or Patient Compensation Funds, ensure that the APRN has coverage under the fund.
Define the APRNs’ Prescriptive Authority Based on Your State Law

APRNs are able to prescribe in all 50 states with some limitations, and they may qualify for authority to prescribe controlled substances. Prescriptive authority is renewed annually through each state’s board of nursing. In many cases, the APRN must complete a required number of educational hours to maintain privileges. The Collaborative Practice Agreement should define the APRN’s prescribing authority, and it should include a requirement that the APRN maintain and provide evidence of his or her prescriptive authority annually.

Define the Protocols/Clinical Practice Guidelines Based on Your State Law

Some state guidelines refer only to the APRN prescriptive authority, while others are broader. They may require guidelines to be followed in the individual specialty of practice; they may specify what circumstances require the APRN to notify the physician; or they may establish criteria for when to hospitalize a patient or when the patient may be treated in the ambulatory setting.

Specify the Physician’s Availability for Consultation with the APRN Based on Your State Law

Verify any state requirements for availability of the collaborating or supervising physician. The agreement should address:

- Physician availability to the APRN for advice or referral and arrangements for coverage when the physician is out of town or unavailable
- What actions the APRN is empowered to take in the event that the collaborating physician is not available
- How patients are to access care when both the APRN and/or the collaborating physicians are absent from the practice setting
- The frequency of onsite visits to be performed by the physician
- The number of medical records that need to be reviewed or co-signed by the collaborating physician or the frequency of review
- The physician and APRN requirements for documentation for the APRN to maintain prescriptive authority in the state

Do I Need Other Agreements in Addition to a Collaborative Practice Agreement?

You may wish to enter into additional formal or informal agreements about other APRN responsibilities. These may include
other clinical duties and limitations, hours of work, licensure requirements, requirements to maintain liability coverage, maintenance of good standing with the state licensing board and certifying bodies, and compliance with local, state, federal, laws and practice policies and procedures. Formal written employment agreements can have both advantages and disadvantages to the employer.

If you choose a formal agreement, consider a mutual indemnification clause and hold-harmless clause in any of these agreements. This would require the APRN to indemnify (reimburse) you and your practice from the costs of any negligent or intentional acts or omissions made by the APRN during his or her association with your practice.

Check your state nursing board law to determine if any of these additional agreements can be included in the collaborative practice agreement, or if they must be separate documents. It is always a good business practice to obtain a legal review of any employment agreement or contract by an attorney familiar with healthcare law and employment law.

A Dubious Request: “Just Sign Off on the NP’s Records”

Physicians have reported receiving requests from hospitals and others to “sign off on the records” of APRNs “just as a formality,” without a written agreement, without a formal relationship, and sometimes without the APRN and physician ever even having met.

There is no such thing as “just signing off on the records.” A remote relationship with an APRN who is a stranger to the physician is a liability risk. Physicians should insist that the relationship be genuine or refuse to be a party to it.

What is a genuine relationship? It is one that is documented in writing and includes all the elements discussed in this monograph. It should be signed by all parties, with each party retaining a copy. Just as an agreement should begin in written form, it should also be terminated in written form. It is never “just a formality”; it is a real legal affiliation.

If the hospital or requesting party has made this type of request, you must verify that:

- You are, or can become familiar with the APRN’s skill level and can personally observe the APRN on site.
- You can take the time to periodically monitor the APRN’s performance consistent with the agreement. (That is, you have the time capacity and willingness to periodically observe the APRN, document your observations and review the APRN’s records.)
- You have read and you understand the requirements of the agreement and are prepared to comply with all the terms.
You can confirm that the agreement specifies how and when the APRN will refer to the supervising or collaborating physician. It should list the skills and procedures that the APRN may perform, including prescribing.

You are generally familiar with the state law regarding these agreements or have resources to assist you. You should discuss any clauses that go beyond the basic elements of the state requirements or impose additional legal burdens.

If the details are not in place or if you do not understand the legal requirements that may be imposed, do not agree to the practice. Contact your professional liability insurer or healthcare attorney with questions.

Summary

There are benefits to collaborating with APRNs, depending on the business needs of your practice. Any related liability risks may be reduced by following these steps:

1. Learn your state APRN regulations.
2. Verify credentials.
3. Require coverage for medical professional liability.
4. Become familiar with the APRN’s skill level and monitor performance.
5. Require that the APRN make his or her credentials clear to the patient.
7. Define protocols, guidelines, and prescriptive authority.
8. Substantiate this working relationship in a written document.
Bibliography - APRNs and the Collaborative Practice Agreement: What Physicians Need to Know

Note: Web links can change over time. If link no longer works, web-search the article by title.

Quick Links to Key Resources


- American Nurses Association (ANA). The state law and regulation section includes links to additional considerations related to the Scope and Standards of Practice, state law and regulation for various states, institutional policies and procedures, self-determination, and professional liability and risk management concerns. http://www.nursingworld.org/statelawandregulation.


References