Physician Supervision over NPs and CRNAs: Myths/Facts

**Myth:** Physician “supervision” over NPs and CRNAs increases patient safety.

**Fact:** There have been no empirical studies noting that physician supervision over advanced practice nurses impacts patient safety. In fact, a 2013 report by the federal Agency for Healthcare Quality and Research identified 22 evidenced based strategies that are proven to enhance patient safety and “physician supervision” is not listed.

**Myth:** “Supervision” means that a doctor is always around to double check on NP or CRNA practice

**Fact:** Regulations by the MA Board of Registration in Nursing and the MA Board of Registration in Medicine limit supervision to a mandated every three month review of a sample of the prescriptions written. There is no mandate or clinical need, for a physician to be “on site” when care is delivered by an NP or a CRNA.

**Myth:** The public is at risk because NPs and CRNAs do not have the same length of education as do their counterparts in medicine.

**Fact:** While it is true that the length of education is not the same, NPs and CRNAs have a minimum of an RN and a Master’s Degree in their related nursing specialty. In addition, they all must maintain national certification and be “authorized” by the Board of Registration in Nursing to practice their specialty.

**Myth:** If a NP or CRNA wanted to practice medicine, they should go to medical school.

**Fact:** NPs and CRNAs share common health care delivery responsibilities, such as primary care and anesthesia care. They practice nursing in these respective specialties, not medicine. This model is not unique, as both MD psychiatrists and PhD psychologists practice in the field of behavioral and mental health and yet there is no “supervision” requirement for these disciplines.

**Myth:** With health care becoming more and more data driven, the NP and CRNA services provided are readily identifiable.

**Fact:** “Supervision” is often used as a proxy for payment. Physician practices can be paid at a higher rate when services performed by the practice are billed under MD provider numbers. The amount of care actually provided by NPs and CRNAs is likely significantly underrepresented in data collected by the All Payer Claims Data Base.
Myth: Nurses are seeking this change to get more reimbursement.
Fact: This bill does not change any insurance or billing statutes. This change of practice was not sought in Chapter 224 of the Acts of 2012, which was focused on payment reform. This bill is focused on removing barriers that are experienced by NPs and CRNAs when supervision is used to limit or control what services they MAY perform rather than what services they CAN perform.

Myth: “Physician supervision” requirements do not affect the cost of care.
Fact: In 2001 CMS ruled that “supervision” of a CRNA was not needed for the purposes of billing for anesthesia care for Medicare beneficiaries. So in those states, that did not have a “supervision” legal requirement, the Governor could “opt-out” of that model of care delivery. Because we now have over a dozen years of experience on both quality of care and costs to compare those states with a “supervision” of CRNA or of CRNA delivery only, what we can confidently tell you is that the care delivery is no different whether the CNRA is “supervised” or not, but that the same care can be as much as 33% higher in a supervised model1, where physicians get reimbursed for “supervising” up to 4 CRNAs at one time, for care they do not deliver.

Myth: The public wants a doctor for their care.
Fact: The public can choose a doctor. Since 2008, the public can also choose an NP as their primary care provider. Many support NPs and the literature substantiates that care delivered by NPs and CRNAs is equal to or better than that delivered by physicians, especially in terms of patient satisfaction.

Myth: Physicians and Advanced Practice Nurses are adversaries.
Fact: In clinical practice, physicians and NPs and CRNAs work well together. However, all health care delivery need not be “headed” by a physician all the time. At some point the social worker, a nurse or a chaplain may be the appropriate team leader for an individual’s care. The National Center for Quality Assurance has recognized in its certification of Patient Centered Medical Homes that a medical home can be led by an NP. This is also true of the MA PCMHI demonstration.

Myth: Physicians are liable for the care delivery by a NP or CRNA.
Fact: Massachusetts NPs and CRNAs carry their own liability insurance and are held accountable to national standards for nursing practice and to the requirements of the Board of Registration in Nursing. This statement is unfounded.

Myth: Guidelines for practice between a physician and an individual NP or CRNA are needed to assure that care is safely delivered.
Fact: Massachusetts is one of only 5 states to require joint promulgation of regulations and “guidelines” between the Board of Medicine and Board of Nursing. The other states include: Georgia, Alabama, Delaware and Florida. The MA Board of Nursing has been unable to update its advance practice nursing regulations since first adopted jointly back in 1995. There is no evidence that joint guidelines increase patient safety. However,

1 Hogan, Paul et al, Nursing Economics, “Cost Effectiveness of Anesthesia Providers”, May-June 2010/Vol. 28/No. 3 pp. 159 – 169.
there are multiple examples of where these guidelines limit the care by telling NPs and CRNAs what they “may do” as defined by a physician, versus what they are educated to do based on their full scope of practice.

**Myth:** “Supervision” and joint promulgation of regulations for the practice of nursing to include an agreement with the Board of Registration in Medicine must be a professionally respectful and productive process.

**Fact:** In recent years, the Board of Registration in Medicine in collaboration with organized medicine has used this statutory provision to create obstacles for the MA Board of Nursing, NPs and CRNA. These include:
- stalling the updating of the nursing regulations of advanced practice nurses for more than 6 years;
- confusing funeral directors on the ability of NPs to sign death certificates, even though NPs have pronounced death for more than a decade;
- proposing billing regulations under MassHealth that would have prevented a surgeon from getting paid for anesthesia care if the surgeon worked with a CRNA to provide anesthesia care to their patient;
- attempting to limit the “supervision of issuing prescriptions” by a CRNA to only an anesthesiologist (MD specializing in anesthesia);
- and further, trying to move towards full supervision of the practice of nurse anesthesia, during the implementation of the CRNAs authority to issue prescriptions to patients.

**Myth:** Removing Supervision and Joint Regulatory Promulgation must be a new concept.

**Fact:** Removal of these barriers is not a new concept and has been promoted since 2007, advocated by the National Council of State Boards of Nursing. Further the model has gained national support from the Institute of Medicine, the AARP, the Robert Wood Johnson Foundation, the Josiah Macy Foundation, the National Governor’s Association and the Federal Trade Commission.