

ENHANCE ACCESS TO QUALITY CARE

Eliminate Louisiana's Collaborative Practice Agreement Law



EXECUTIVE SUMMARY

Louisiana consistently has some of the highest rates of maternal and infant mortality in the United States. These alarming trends call for the removal of the collaborative practice agreement (CPA) requirement to improve these outcomes. In the state of Louisiana, a CPA is mandated for Certified Nurse-Midwives (CNMs) and other Advanced Practice Registered Nurses (APRNs) to practice. However, there is no evidence that this requirement increases the safety or quality of patient care.

Instead, the CPA requirement inhibits APRNs' ability to practice and deprives Louisiana citizens of the increased access to care that APRNs' can provide. Research shows that access to CNM care decreases maternal mortality, infant mortality, and preterm birth rates. By removing this requirement, the state of Louisiana can address gaps in the quality of maternity care to women who live in medically underserved and rural areas of Louisiana.

The New Orleans Maternal and Child Health Coalition calls for the Louisiana State Legislature to eliminate the CPA requirement in Louisiana and provide equal and quality care to mothers throughout the state.

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WHO WE ARE

The MCH Coalition is an advocacy group made up of diverse stakeholders in maternal and child health in New Orleans. Our members include researchers, healthcare providers, doulas, individuals employed by local and state government offices, and representatives of community organizations.

Our mission is to improve outcomes, experiences, and access to quality, respectful care during pregnancy, birth, and the postpartum period by centering the experiences of Black birthing people and their infants in New Orleans.

Visit our website for more information: nolamch.org.

INTRODUCTION

A global pandemic has the potential to reveal the shortcomings of healthcare systems and transform them for the better. In the midst of Louisiana's COVID-19 crisis, an [executive order](#)¹ from Governor John Bel Edwards temporarily lifted the requirement that advanced practice registered nurses (APRNs) establish a collaborative practice agreement (CPA) with a physician. In so doing, the state has (perhaps inadvertently) highlighted the need to do away with this requirement altogether.

Louisiana has some of the worst neonatal and maternal mortality rates in the nation. Louisiana was ranked the highest in maternal mortality of any state according to America's Health Ranking 2020 assessment.² Louisiana's rate of 25.2 per 100,000 births was much higher than the national average of 17.4 according to the latest CDC Maternal Mortality Report.³ According to the latest CDC report comparing infant mortality rates per state, Louisiana ranks second to the highest, surpassed only by Mississippi.⁴

For Black Louisianans, infant mortality rates are 2.5 times higher and maternal mortality rates are 4 times higher than the rates for white Louisianans.⁵ Rates of severe maternal morbidities, which often have life-altering consequences, are also much higher in the Black population.

While the Louisiana government recognized the urgent need during the state of emergency caused by COVID-19 to make it easier for healthcare professionals to do their jobs, we maintain that maternal and child health outcomes in Louisiana have long represented a dire emergency—one that warrants the permanent removal of the CPA requirement.

In this paper, we 1) present background on the CPA requirement in Louisiana, 2) discuss the evidence that APRNs provide much-needed care that improves health outcomes, 3) outline the barriers that the CPA requirement erects to quality healthcare and 4) argue for

eliminating this requirement in order to increase access to quality pregnancy and birth care in Louisiana.

1) Background

The Louisiana State Board of Nursing licenses Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs) as Advanced Practice Registered Nurses (APRNs). Other categories of APRNs include Clinical Nurse Specialists and Certified Nurse Anesthetists. NP subspecialties include Family NP, Psychiatric and Mental Health NP, Neonatal NP, Women's Health NP, Pediatric NP, and Geriatric NP. All licensed APRNs in Louisiana are nationally certified by the national boards of their specialty and have a specified scope of practice defined by their professional organization. The Louisiana State Board of Nursing is responsible for ensuring that "advanced practice registered nurses are competent and safe."⁶ They monitor continuing education, investigate all complaints regarding APRNs, and establish disciplinary guidelines.

The laws licensing APRNs vary from state to state. Twenty-eight states give CNMs the authority to practice to the full extent of their education and professional scope of practice, which is referred to as full practice authority (FPA).⁷ In Louisiana all APRNs are required to have a signed, and Board of Nursing approved, CPA with a physician in order to practice their profession. The requirement to obtain permission from someone outside of one's profession is unprecedented in other professions. Other healthcare professionals operate under their professional organizations' guidelines and state regulatory agencies only. No research or public health data has identified any benefit of requiring a CPA for APRN practice. According to the American College of Certified Nurse-Midwives (ACNM), the requirement for collaborative agreements does not guarantee effective communication between healthcare providers or physician availability when needed and there is no evidence that collaborative practice agreements increase the safety or quality of patient care.⁸

2) APRNs Improve Birth Outcomes

A large body of research documents that midwifery care lowers risks for women and their babies. Hemorrhage and sepsis are the two leading causes of maternal mortality and a cesarean section increases a woman's risk of both of these conditions.^{9,10} A study based in California found that cesarean delivery was associated with 2.7 times the risk of severe maternal morbidity compared to vaginal delivery and was estimated to contribute to 37 percent of severe maternal morbidity cases.¹¹ Midwifery care in the United States is associated with a lower cesarean rate. Souter and colleagues looked at outcomes of 23,100 births in 11 U.S. hospitals and compared obstetric and midwifery care. Compared with obstetricians, midwifery care led to significantly lower intervention rates, an approximately 30% lower risk of cesarean delivery in women having their first baby and an approximately 40% lower risk of cesarean in women having subsequent babies.¹² An evaluation of the Consortium on Safe Labor data, which included information from the electronic medical records of 228,438 deliveries in 19 US hospitals, found that women at medical centers that provided midwifery and physician care compared with women at centers with physicians only were 74% less likely to undergo labor induction. The cesarean birth rate was 12% lower at centers that included midwifery care.¹³ Similar results were reported in studies done in California^{14,15} and Colorado.¹⁶

Midwifery care has also been shown to decrease the incidence of preterm birth, a leading cause of infant mortality. A 2016 review of the research by Cochrane, an organization of researchers who are internationally respected for promoting evidence-based care, found that women who received midwife-led care were less likely to experience preterm birth, fetal loss, and neonatal death.¹⁷

The Lancet, a prestigious medical journal, devoted its June 2014 issue to exploring solutions to address the essential needs of childbearing women and their families. In one article, 72 effective practices for quality maternal and newborn care within the scope of midwifery were identified.¹⁸ The reviews of these practices were analysed

further to identify 56 outcomes improved by midwifery care. These outcomes included reduced maternal mortality, reduced postpartum hemorrhage, fewer cesarean sections, reduced risk of infection, reduced perinatal, neonatal and infant mortality, increased breastfeeding rates, and improved satisfaction with childbirth experience. The authors concluded, "There is growing consensus among public health professionals that midwifery care has an essential contribution to make to high-quality maternal and newborn services."¹⁸

NPs are also well positioned to help increase access to care and improve birth outcomes. Some NPs provide pregnancy care, but it is important to note that maternal and child health is influenced by more than pregnancy care. Women who have preexisting conditions are at higher risk for complications during pregnancy. Lifestyle habits that influence health start in childhood. The rapidly developing field of epigenetics, the study of heritable genetic expressions, has increased our understanding of the impact of diet and exposure to environmental toxins, stress and anxiety on generations to come.¹⁹

Likewise, adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood such as exposure to violence, abuse, parental instability. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. Comprehensive health care services that include social services and mental health care throughout the life cycle are needed to prevent ACEs and maximize well being.²⁰ NPs provide quality preventative care throughout the lifespan that has the potential to reduce and mitigate these underlying issues.

3) Louisiana's CPA Rule Hinders Access to Quality Care

The legal requirement for a CPA places unnecessary limitations on APRNs, hindering their ability to thrive as professionals and deterring APRNs from practicing in Louisiana. It is difficult for CNMs and NPs to find physicians willing to sign a CPA with them. Even though there are no specified obligatory tasks or increased

malpractice costs associated with being a collaborating physician, many are leery of potential liability risks and see no benefit to signing the agreement. If an APRN does build a practice with a collaborating physician, they are vulnerable to the whims and circumstances of the physician. If the physician moves or is incapacitated by illness, the APRN must scramble to find another MD to sign a CPA with them or lose their practice. According to the 2017 Louisiana Association of Nurse Practitioners survey of NPs in Louisiana, 69% of the doctors they worked with were compensated for signing the CPA, with 17% being paid by the APRN personally. The range of payment was wide, from \$250 to over \$90,000 paid annually. As shown, 21% reported up to \$5,000 per year, 2% said between \$5,000 - \$10,000 and 6% paid more than \$10,000 to their physician collaborator every year. These costs can be prohibitive, especially for an early-career APRN or someone seeking to provide affordable care to low-income or uninsured individuals.

Additionally, APRNs must contend with bureaucratic hurdles. Physicians who agree to collaborate sometimes must obtain permission from their own hospital systems, administration, and/or malpractice carrier which may cause delays in care or prevent a collaboration. APRNs are also unable to receive admitting privileges at a healthcare facility without a collaborating physician on staff at that facility.²⁵ APRNs subject to these CPA requirements find it difficult to practice their profession and care for patients. Without full practice authority, APRNs cannot maneuver freely through healthcare systems as their training and expertise dictate they should. The CPA requirement creates unfair disadvantages for APRNs, restricting access to the quality care they provide.⁸

4) The Case for Full Practice Authority for APRNs

Contrary to theoretical concerns regarding full practice authority, data shows that health outcomes for mothers and infants are better in the states that give CNMs full practice authority. In 2018, Vedam found that states with integrated midwifery, which included full practice authority, had higher vaginal birth rates, higher vaginal birth after cesarean section rates, increased

breastfeeding rates, decreased preterm births, and a decreased incidence of babies born at low birth weights.²⁶ Research indicates that states with regulations that support autonomous practice have a larger midwifery workforce and more CNM-attended births. For instance, Yang found that the midwifery workforce is doubled per 1000 births in states with full practice authority.²⁷

Eliminating the legal requirement for a CPA would not prevent APRNs from collaborating with physicians. Collaboration occurs frequently among health care professionals.²⁸ APRNs with full practice authority in other states continue to collaborate. In fact, collaboration is taught in nurse-midwifery programs as a “core competency for basic midwifery practice.”²⁹ One of the standards for the practice of midwifery on which CNMs are evaluated is: “Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.”³⁰

According to a 2017 survey of Louisiana NPs, collaboration is not directly tied to the CPA. Significantly, 17% of respondents reported only having contact with their CPA physician monthly and 18% said they had not been in communication with their CPA physician for a year or more. It is also important to note that the NPs also reported frequently collaborating with physicians other than their CPAs: 48% said daily, 35% said weekly and 12% monthly.²⁴

Given that the CPA requirement is unnecessary and ineffective, it should be eliminated to allow APRNs to flourish in Louisiana and fill in existing gaps in healthcare. According to the American College of Obstetrics and Gynecology (ACOG), shortages and maldistribution of maternity care clinicians causes a serious public health problem and they acknowledge that increasing the number of OB/GYNs and CNMs would help to solve this problem.³¹ Indeed, ACOG and ACNM jointly support initiatives that will allow APRNs to establish viable practices, increase access to affordable professional liability insurance, and obtain hospital privileges and equivalent reimbursement from private payers and government programs.³¹

In 2017, there were 28 parishes in Louisiana that had no OB/GYNs at all. Another 19 parishes had fewer than 10 OB/GYNs per 100,000 population.²¹ There are only 52 Certified Nurse-Midwives in Louisiana, which is 1.1 per 100,000 population. The majority of these CNMs practice in Baton Rouge or New Orleans.³² More than 95% of the state of Louisiana is classified as rural.³³ Kozhimannil and colleagues evaluated the role of CNMs in rural areas where workforce shortages limit access to care for pregnant women. They found that “significant variability across states appears to be partially related to autonomous practice regulations: states allowing autonomous midwifery practice have a greater proportion of rural hospitals with midwives attending births.”³⁴

In most areas of the state, Louisiana also has a general health professional shortage that adversely affects the availability of quality pediatric care, family practice, women’s reproductive health care, and mental health care.²¹ Almost 2 million Louisianans are living in federally defined Health Professional Shortage Areas (HPSAs).³³ All 64 of Louisiana’s parishes are designated as an HPSA in mental health. All parishes except one have at least parts of the parish designated as HPSAs in primary care.²¹ As APRNs, nurse practitioners in each of these specialties can best help to increase access to care if they are permitted to practice to the full extent of their education and scope of practice. Research clearly shows that APRNs provide similar and sometimes better care than physicians alone.²² The latest *U.S. News and World Report* state health care rankings corroborate these findings.²³ The five states ranked highest in health care for their citizens all have full practice authority for APRNs. The opposite is true for the five lowest ranked states; they all have restrictive regulations for APRN practice. Moreover, the American Association of Medical Colleges has predicted long term shortages of physicians on a national scale and APRNs could be well positioned to alleviate these shortages once unburdened by unproductive regulations such as the CPA requirement.³⁵

In Louisiana, the importance of full practice authority is increasingly put forth as a path toward greater access to care. The Nursing Supply and Demand Council recently made this recommendation to the Louisiana Health Works Commission: “Allow APRNs full practice authority to increase access to care and continuity of care in the absence of the Governor’s Executive Order.” Likewise, in July 2020, the Louisiana COVID-19 Health Equity Task Force stated: “Allow nurse practitioners, clinical nurse specialists, and certified nurse midwives to practice to the full extent of their licensure and education by removing practice barriers. This will expand access to care in Louisiana’s health professional shortage areas and increase the supply of APRNs in the state and expand Medicaid recipients’ access to care.”³⁹

Additionally, there is a free market case for full practice authority. In an AARP and Robert Wood Johnson Foundation report, a number of think tanks that value free markets are identified as supporting the reduction of barriers to care provided by APRNs.³⁶ The American Action Forum, American Enterprise Institute, Americans for Prosperity, Cato Institute, Florida TaxWatch, Heritage Foundation, and Pacific Research Institute have advocated that states make this change to reduce unnecessary government regulation and spending and increase competition. Three organizations have been directly involved in improving state laws: Americans for Prosperity has actively supported full practice legislation in multiple states, including Nebraska and West Virginia; the Heritage Foundation was widely credited for helping pass West Virginia’s recent full practice legislation; and Florida TaxWatch has advocated for reforms in Florida.³ Addressing another free market perspective, a recent supreme court decision in an antitrust case suggests that when one profession has regulatory control over another, it can have an anti-competitive effect. Data consistently finds that lack of competition is bad for health care consumers.^{37, 38} In a state where policymakers often prioritize entrepreneurship and free market activities, eliminating the CPA requirement should be a goal.

CONCLUSION

The pandemic has revealed many shortcomings of our existing healthcare structures. Among them is the unnecessary legal requirement that APRNs establish collaborative practice agreements with physicians. This requirement imposes cumbersome financial and bureaucratic burdens on crucial healthcare providers, impeding their ability to provide quality care to Louisiana's most marginalized groups. This regulation is particularly damaging in the area of maternal and child health.

Given the dismal state of birth outcomes in Louisiana, not to mention the layered effects of COVID-19, and countless other racialized public health threats, we need to unburden APRNs so that they can practice their profession and care for families. Let's seize the opportunity that this unfortunate global health crisis has revealed in Louisiana and eliminate the CPA requirement altogether.

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