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*Agency of Human Services*

January 15, 2008

Representative Steven Maier, Chair  
House Committee on Health Care  
State House  
115 State Street  
Montpelier, VT 05633

Senator Douglas Racine, Chair  
Senate Committee on Health and Welfare  
State House  
115 State Street  
Montpelier, VT 05633

Senator M. Jane Kitchel, Co-Chair  
Representative Steven Maier, Co-Chair  
Commission on Health Care Reform  
State House  
Montpelier, VT 05633

Re: Work Group Report on Advance Practice Nurses

Dear Representative Maier, Senator Racine, and Senator Kitchel:

Section 8(b) of Act 71 (2007-08) requires the Commissioner of Health, the Director of the Office of Professional Regulation, and the Board of Nursing to establish a work group to study and make recommendations on the advisability of eliminating the requirement for an advance practice nurse to work in a collaborative practice with a licensed physician.

The Department of Health was pleased to coordinate the establishment and functioning of the work group.

26 VSA § 1572(4) defines an "advanced practice registered nurse" as a "licensed registered nurse authorized to practice in [Vermont] who, because of specialized education and experience is endorsed to perform acts of medical diagnosis and to prescribe medical, therapeutic or corrective measures under administrative rules adopted



by the [Board of Nursing].” The collaborative practice requirement is in the administrative rules adopted by the Board of Nursing.

The stated goal of Section 8(b) of Act 71 is to evaluate whether advance practice nurses might serve a greater role as primary care providers who provide essential chronic care management.

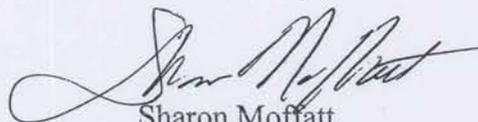
Section 8(b) requires the work group to make its recommendations in a report delivered to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Commission on Health Care Reform by January 15, 2008.

The work group’s majority report includes the opinion of 10 members of the 13 member group. Attached to the majority report is a minority opinion of 3 work group members (Appendix C) and a letter from Dr. David W. Clauss, Chair of the Vermont Board of Medical Practice (Appendix D).

If you have any questions, please do not hesitate to contact me.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Sharon Moffatt", written in a cursive style.

Sharon Moffatt  
Commissioner

Enclosure

Taskforce on Advanced Practice Registered Nurses (APRNs)  
As Primary Care Providers (Act 71)  
Final Report

January 15, 2008

## I. Introduction

This is the final report of the Taskforce on Advanced Practice Registered Nurses (APRNs) as Primary Care Providers (Act 71). It includes the opinion of 10 members of the Taskforce. There is also a minority opinion of 3 members of the Taskforce, so noted at the end of this report.

In 2007, the Legislature passed Act 71, An Act Relating to Ensuring Success in Health Care Reform. One section of the Act, relating to "Support for Primary Care Providers," calls for a taskforce to "...study and make recommendations on the advisability of eliminating the requirement for an advanced practice nurse to work in a collaborative practice with a licensed physician, with the goal of evaluating whether advanced practice nurses might serve a greater role as primary care providers who provide essential chronic care management."

The Taskforce included representatives of the Commissioner of Health (2), the Director of the Secretary of State's Office of Professional Regulation (1), and the Vermont Board of Nursing(1). In addition to representatives of the three agencies listed above, 9 members were included representing the: Vermont Legislature (1), Vermont Consumers (1), the UVM Department of Nursing (1), the Vermont Medical Practice Board (1), the Vermont Medical Society (3), the Vermont Nurse Practitioner Association (1), and the Vermont State Nurses' Association, Inc (1). (See Appendix A for list of all 13 participants)

As directed, this report focuses on APRNs as primary care providers of chronic care management and does not address APRN specialists such as nurse anesthetists.

The Taskforce considered the following issues and questions in discerning the value of requiring an APRN to have a written collaborative practice agreement with a physician and in determining if this was a potentially limiting factor in the ability of APRNs to play a greater role in helping Vermonters manage chronic health conditions:

- Public safety and protection
- Challenges and barriers to providers of necessary APRN care
- Cost
- Access to primary care and the relationship to the Vermont Blueprint for Health Care
- Other states' experiences
- Potential effects of increased APRN independent practice
- Assuring continued collaboration.

## II. Background on the Legal Requirement for a Written Agreement with a Collaborating Physician

Advanced Practice Registered Nurses (APRNs) are primary and specialty clinicians who practice in ambulatory, acute and long-term care settings. According to their specialty, they provide nursing and medical services to individuals, families and groups. In addition to diagnosis and management of acute episodic and chronic illnesses, APRNs emphasize health promotion and disease prevention. Services include but are not limited to physical examinations, obtaining medical histories, ordering and interpreting diagnostic tests, prescribing medications and non-medication

therapies, and self-management of one's health. Teaching and counseling are major components of care provided by APRNs.

The current language of (2004) Chapter 4, Subchapter 8,<sup>1</sup> of the State of Vermont Board of Nursing Administrative Rules was written 23 years ago in 1984, when the requirement may have made a lot of sense. However, in the past 23 years, practice has evolved and different issues have arisen. APRNs were relatively new to Vermont in the 1980's and the 1984 Rule requiring a written collaborative agreement facilitated the early collaboration of physicians and APRNs. It has since created significant challenges and barriers to APRN practice and to access of care for some Vermonters.

The current Rules provide that while an APRN performs medical acts independently, the APRN practices within a collaborative practice with a licensed physician "...under practice guidelines which are mutually agreed upon between the APRN and the collaborating physician and which are jointly acceptable to the medical and nursing professions." Thus this requirement obligates a professionally educated, trained and nationally certified APRN to sign a practice agreement with a physician prior to being endorsed by the Board of Nursing as an advanced practice registered nurse in the state of Vermont.

As described by the rules, practice guidelines for APRNs must include:

- a. A description of the clinical practice, including practice site(s), focus of care, and general category of clients;
- b. An indexed copy of standards for clinical practice<sup>2</sup> including method of data collection, assessment, plan of care, and criteria for collaboration, consultation and referral, including emergency referral;
- c. The name of at least one physician who holds an unencumbered license in Vermont who practices in the same specialty area who will be routinely utilized for collaboration, consultation and referral; and
- d. Methods of quality assurance.<sup>3</sup>

This means that although the nurse can maintain national certification as an APRN, she/he may not have an APRN license in Vermont unless a physician agrees to sign a collaborative agreement and approve the APRN Practice Guidelines.

In addition, the practice guidelines must also be "...reviewed, mutually agreed upon, and signed annually by the APRN and the collaborating physician..." The guidelines must "be reviewed and approved by the Board of Nursing and kept on file in the workplace and be made available to the Board of Nursing at any time upon request." These Practice Guidelines have allowed the Board of Nursing to monitor the practice of these advanced practice nurses and to implement disciplinary proceedings when necessary, although complaints and disciplinary actions have been rare (see Appendix B). The requirement that a physician must review and agree to the Practice Guidelines contributes to the limitation on APRN practice.

### III. Collaboration, Consultation and Referral

All members of the Taskforce agreed that collaboration and teamwork are necessary to safety in health care practice by all providers. Autonomy by medical providers has been identified as a barrier to improving the quality of medical care and clinical practice becomes safer when providers adopt a practice of teamwork.<sup>4</sup> It is important to remember that elimination of the requirement for a

<sup>1</sup> The current language of the State of Vermont Board of Nursing Administrative Rules (2004) Chapter 4, Subchapter 8, III C was updated at least once since 1984 to remove a requirement that APRN guidelines be filed with the Vermont Board of Medical Practice (VBMP). VBMP was supportive of this Rules change.

<sup>2</sup> The nursing board rules require that, national certifying organizations wishing to obtain recognition from the Vermont State Board of Nursing, must "have developed standards and Scope of Practice statements for the nurse in advanced practice." See, <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf>, at page 24

<sup>3</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf>, at page 25

<sup>4</sup> Almaberti R, Auoy Y, Berwick D, Barach P Five System Barriers to Achieving Ultrasafe Health Care, Annals of Internal Medicine 2005 142: 756-764

contractually based collaborative agreement between APRNs and physicians has no effect on the professional collaboration between these two professions. Also, this will not eliminate the responsibility for professional collaboration between these two professions. Both physicians and APRNs are ethically obligated to collaborate with other health care providers when treatment requires expertise beyond their own education, training or experience.

The Vermont Board of Nursing Administrative Rules (2004) define collaboration as *"a process which involves two or more health care professionals working together, though not necessarily in each other's presence, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer."*<sup>5</sup>

The current rules have, over time, limited APRN practice and patient access by narrowly defining collaboration as it pertains to advanced practice nursing: *"The Advanced Practice Registered Nurse acts independently in dealing with the nursing needs of the individual; and independently consistent with practice guidelines with a collaborating physician in the appropriate specialty area for all related medical functions; or by clinical privileges approved by the facility or facilities at which the individual practices."*<sup>6</sup> A "Collaborating physician" is defined in the rules as *"...a physician who holds an unencumbered license and is actively practicing medicine in the State of Vermont who has formally agreed to be available for collaboration, consultation and referral."*

Collaboration between health care providers is the strongly preferred professional norm, as described in 2007 Changes in Healthcare Professions' Scope of Practice: Legislative Considerations.<sup>7</sup> "The expectation is that competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competence, or where greater competence or specialty care is determined as necessary or even helpful to the consumer's condition." (p.9)

The professional expectation is that APRNs collaborate with other health care professionals as appropriate and as defined by Practice Guidelines and Scope of Practice. The general consensus, including the collective experience of all of the health care provider members of the Taskforce, is that collaboration takes place between APRNs and physicians regardless of the presence of a signed collaborative agreement with a physician, just as it does between primary care physicians and specialty physicians and surgeons.

APRN collaboration with physicians, other than their specified 'collaborating' physician, occurs according to the needs of the patient and regardless of the legal requirement. APRNs collaborate with the health professional appropriate to the situation, rather than the specializing physician who signed the collaborative agreement.

While the Taskforce heard APRNs will collaborate with other health care professionals as appropriate, guided by their training, there was no evidence or data found in the literature that defined collaboration or standards for collaboration to allow comparison of APRN care within or without a collaborative agreement. The literature reviewed comparing care between APRN and physicians, and generally showing no substantive differences, did not make clear whether the APRN care studied was within or without a collaborative care relationship or agreement. Unfortunately, this leaves no direct supporting evidence to conclude that collaboration will take place regardless of the presence of a signed collaborative agreement, nor is there direct evidence that the existing requirement of a signed collaborative agreement leads to increased collaboration or improved APRN quality of care.

#### IV. Status of the Current APRN Workforce in Vermont

The need for health care providers, especially in Primary Care, is well recognized. As providers retire, seek more specialized practice areas with higher compensation, and practice in

<sup>5</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> (page 3)

<sup>6</sup> Id.

<sup>7</sup> [http://www.fsmb.org/pdf/2005\\_grpol\\_scope\\_of\\_practice.pdf](http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf);  
<http://www.fsbpt.org/standards/ScopeOfPractice/index.asp>

resource-rich populated areas of the State, Vermont must maximize the resources of providers who will be available to provide services throughout the State. As the population ages, health care needs increase – especially chronic health care needs and elderly care. In 2007, the Vermont Office on Nursing Workforce reported that APRNs are a stable, satisfied workforce with a low (8%) turnover rate and there is a perceived need by employers to have more APRNs to meet the patient needs. Currently, there are approximately 600 APRNs endorsed in Vermont. Their mean age is 50 with about 14% less than 40 years old.

The Office of Professional Regulation (OPR) publishes an Annual Report on Professional Licensing that tracks the numbers of the professional groups licensed by OPR.<sup>8</sup> These reports indicate that the number of APRNs endorsed to practice in Vermont has increased from 346 to 521 between 1996 and 2006. In 2006 about 1/5 resided outside Vermont.

#### **V. Impact of Existing Requirement for a Written Collaborative Agreement: Barriers to Access to Patient Care**

The work of this Taskforce originated in large part due to the impact existing law has on access to APRN practice. It should be noted that because such studies have not been conducted, the Taskforce could find no scientifically validated evidence of increased access to primary care APRNs in states where the written collaborative agreement requirement has been eliminated. However, the key anecdotal, but substantial, evidence received by the group described consequences of the existing law that can be described generally as an obstacle to APRN licensure and endorsement, while it provides little to no public protection or quality assurance benefit.

The Vermont Blueprint for Health Care resulted from the 2003 legislative chronic care initiative. In 2007, the Legislature again, this time in Act 71, recognized primary care providers as essential to the success of the Blueprint. Additionally, care provided by APRNs was associated with the management of chronic diseases for Vermonters. Insufficient access to Primary Care is a major issue and concern facing Vermonters. Access to APRN care has proven to be successful in Vermont and in other states.

The ramifications of the requirement for a written collaborative agreement between a physician and an APRN prior to endorsement as an APRN in Vermont are varied and impact APRNs, physicians, employers, hospital credentialing committees, educational institutions, and especially the citizens of Vermont.

Convincing anecdotal evidence was presented to the Taskforce that this requirement leads to fewer APRNs able to practice in Vermont (exactly how many fewer is unknown) resulting in less access to health care for Vermonters. Specific examples of how the written collaborative agreement creates an obstacle to APRN practice include:

- Patients losing access to their health care provider if their care has been provided by an APRN who no longer has a collaborating physician. Gaps and long recruitment periods force patients to go without care or to travel further to obtain care.
- APRNs in areas such as Franklin County, a rural federally designated underserved area, are unable to secure a physician who will collaborate under the current regulatory system.
- Inability of APRNs relocating to Vermont to receive an endorsement as an APRN due to the obstacle of first obtaining a contract position with a physician who agrees to sign a collaborative practice agreement.
- Inability of nurses with graduate education and national certification as an APRN to have a Vermont endorsement as an APRN if they teach in academic positions or

<sup>8</sup> <http://vtprofessionals.org/opr1/opr/pubs/rpttxt.html>

administrative positions unless they also have a clinical position with a physician who will sign a collaborative practice agreement.

- Physicians requiring APRNs to pay thousands of dollars to have a collaborating agreement. This makes the economic feasibility of practice especially challenging.
- Physicians unwilling to enter into a collaborating agreement for fear of legal liability.
- Physicians at any time severing an agreement (retirement, relocation, death, change of mind etc.) placing APRNs (and their patients' health) in a precarious position since APRNs cannot abandon patients when a collaborative agreement is severed, yet cannot legally under the current Administrative Rule continue to provide care to patients.
- The group, through its members, has heard from a number of APRNs throughout the state about difficulties they have encountered in trying to find a physician willing to sign a collaborative agreement. It should be noted that these instances were not documented and the full reasons behind them not thoroughly explored.

## VI. APRN Education and National Board Certification

Current entry-level education (master's degree) of APRNs prepares these professionals to practice autonomously with the recognition that collaboration with others leads to higher quality of care. In the near future (2015), entry-level education for APRNs will be a doctoral degree (Doctorate of Nursing Practice) and there are already several colleges and universities in the United States offering these programs. National certification as an APRN requires evidence of continuing education in a designated specialty area and Vermont requires national certification as one of the prerequisites to endorsement and biennial renewal as an APRN in Vermont. The changing nature of health care draws upon APRN strengths. Nursing education focuses on care and prevention with an emphasis on helping patients learn to manage their chronic conditions.

## VII. Quality Assurance

Research indicates that when nurse practitioners practice within their areas of expertise, there are no important differences between nurse practitioners and primary care physicians regarding quality of care, number of visits per patient, use of the emergency room, and prescribing practices (Brown et al., 1985<sup>9</sup>; Kane et al., 1989<sup>10</sup>). Furthermore, it is well documented in the literature through randomized clinical trials and meta-analyses, that there is no major difference in patient outcomes. Some research indicates higher patient satisfaction with nurse practitioners over physicians (Brooten et al., 2004<sup>11</sup>; Hooker et al., 2005<sup>12</sup>; Lenz et al., 2004<sup>13</sup>; Mundinger et al., 2000<sup>14</sup>;

<sup>9</sup> Brown, S. A., & Grimes, D.E. (1995). A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care," *Nursing Research* 44(6), 332-339.

<sup>10</sup> Kane, R. L., Garrard J., Skay C.L., Radosevich D.M., Buchanan J.L., McDermott S.M., Arnold S.B., Kepferle L. et al., (1989). Effects of a Geriatric Nurse Practitioner on Process and Outcome of Nursing Home Care, *American Journal of Public Health* 79 (9), 1271-1277.

<sup>11</sup> Brooten, D., Youngblut, J. M., Kutcher, J., & B0bo, C. (2004). Quality and the nursing workforce: APNs, patient outcomes and health care costs. *Nursing Outlook*, 52(1),: 45-52.

<sup>12</sup> Hooker, R. S. & Ciper, D. J. (2005). Physician assistant and nurse practitioner prescribing: 1997-2002. *Journal of Rural Health*, 21(4), 355-60.

<sup>13</sup> Lenz, E. R., Mundinger, M. O., Kane, R. L., Hopkins, S. C., & Lin, S. X. (2004). Primary Care outcomes in patients treated by nurse practitioners or physicians: two year follow up. *Medical Care Research and Review*. 61(3): 332-351.

Roblin et al., 2004<sup>15</sup>) Over a period of five years (2002-2006), the Vermont Board of Nursing disciplined a total of 7 APRNs out of an average of 477 APRNs endorsed each year. Three were suspended, 2 were conditioned and 2 reprimanded. (See Appendix B for more details.)

### VIII. Existing and Continued Regulatory Environment

The Vermont Board of Nursing will continue to license and endorse APRNs who demonstrate professional accountability and have met and maintained national credentialing requirements for APRNs in their specific specialty. This will address the expectation of continuing education and quality monitoring of care provided. Public protection is a priority for the Board of Nursing and will guide their work such that the public will have access to APRNs who practice safely and competently.

In addressing the advisability of removing the collaborative agreement requirement, it is imperative that the regulatory model ensure the continued quality of care provided by APRNs in Vermont. Therefore, the Taskforce notes the existing requirements of the Vermont Board of Nursing and recommends the continuation of the following requirements if the collaborating agreement is eliminated:

- follow practice guidelines and have a method of quality assurance in place
- successfully complete a formal APRN accredited education program
- achieve national certification through education and certification examination in an identified specialty
- fulfill all national certification requirements including Continuing Education requirements
- fulfill clinical practice requirement in the specialty area
- submit re-certification as required (includes completion of continuing education and ongoing clinical practice in the specialty area).

By statute, the Vermont Board of Nursing includes ten members appointed by the Governor, five registered nurses, two practical nurses, one nursing assistant and two public members. One APRN currently serves on the Board; however, there is no statutory requirement that the board membership include any APRNs, a change recommended by this Taskforce, below. There is a provision in the Nursing Board rules authorizing the Board to establish an advisory taskforce of APRNs to assist the Board in the implementation of the Nursing Board rules. Oversight of the Nursing Board is provided by the Office of Professional Regulation (OPR), a division of the Office of the Secretary of State. It is worth noting that the professional regulatory standards for nurses, including APRNs, at 26 V.S.A. § 1582 and 3 V.S.A. § 129a, are virtually the same as those for physicians, at 26 V.S.A. § 1354.

### IX. Other States' Experiences

The profession of nursing continues to evolve and the practice of APRNs has become more autonomous since its inception in the 1960s. Improvement in technology, the growth and expansion

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<sup>14</sup> Munding, M. O., Kane, R. L., Lenz, E. R., Totten, A.M., Wei-Yann, T., Cleary, P. D., Firedewald, W. T., Siu, Al L., & Shelanski, M. L. (2000). Primary Care outcomes in patients treated by nurse practitioners or physicians. *JAMA*. 283(1), 59-68.

<sup>15</sup> Roblin, D. W., Becker, E. R., Admas, E. K., Howard, D. H., & Roberts, M. H. (2004). Patient satisfaction with primary care: does type of practitioner matter? *Medical Care*, 42(6), 579-90.

of information and information technology, changes in societal health care demands, research findings, and graduate education have all contributed to the evolving role of APRNs. Currently, nine states (Arizona, Idaho, Maine, Montana, New Hampshire, New Mexico, Oregon, Washington, and Wyoming) and the District of Columbia have legislated practice for APRNs with no requirement for any kind of collaborative or supervisory relationship with physicians. Some of these states have had this kind of APRN practice for 15 years. In the Northeast, APRNs in Maine and New Hampshire have autonomous practice. In addition to New York, Vermont, California, Connecticut and Illinois have also begun the process to eliminate the mandatory collaborative APRN/physician agreement

**Pearson Report Data:<sup>16</sup> (2007 National Review of APRNs)**

- 23 States do not require physician involvement in the *Diagnosing and Treating* aspects of APRN practice.
- 12 States do not require physician involvement in the *Prescribing* aspects of APRN practice.
- 9 states (Arizona, Idaho, Maine, Montana, New Hampshire, New Mexico, Oregon, Washington, and Wyoming) and the District of Columbia have legislated autonomous practice for APRNs with no requirement for collaborative or supervisory relationships with physicians.
- Several states limit prescription of controlled substances and other specific drugs by APRNs. Some require special licensing endorsements for APRNs who wish to prescribe medications and some states, like Vermont currently, specify educational requirements with respect to prescribing.

**New York**

New York State is investigating the cost that statutory collaboration imposes on the health care system. Joy Elwell, President Elect of the New York Nurse Practitioner Association, reports that there are "...anecdotal reports from industry executives [which] indicate that there is a significant, inflationary impact associated with statutory collaboration...Some clinics have closed, or been sold because of an inability to be profitable; and the lack of profitability is directly related to the costs associated with compensating the collaborating physicians – an extra layer of cost to the health care system. This is important because it speaks directly to the access to health care for consumers..."<sup>17</sup>

**New Hampshire**

New Hampshire APRNs have had autonomous practice since 1991 and do not require a formalized agreement with a collaborating physician. As reported by the Executive Director of the New Hampshire Nurse Practitioner Association there has been no significant changes in practice or in complaints to the licensing board when comparing before 1991 to after.

New Hampshire has established a Joint Health Council<sup>18</sup> made up of three APRNs, three physicians and three pharmacists,<sup>19</sup> which has established the "Exclusionary Formulary"<sup>20</sup> for APRNs who prescribe medication. The formulary identifies individual drugs and classes of drugs that are restricted or approved for use with specific types of collaboration or consultation. Specific

<sup>16</sup> The Pearson Report (2007). *The American Journal for Nurse Practitioners*. 11(11/12).

<sup>17</sup> Elwell, Joy DNP. *Exploring mandatory Collaboration: Opinion Editorial*. New York

<sup>18</sup> New Hampshire Joint Council law:

<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-10.htm>

<sup>19</sup> New Hampshire Joint Council Members:

<http://www.nh.gov/nursing/jhc/JointHealthCouncilMembers.htm>

<sup>20</sup> New Hampshire Joint Council Formulary:

<http://www.nh.gov/nursing/jhc/documents/JHCFormulary8.07.doc>

definitions of “consultation” and “collaboration” are included in the definition section of the formulary. APRNs may submit requests to the Joint Council asking that drugs be added to the formulary or taken off the formulary.<sup>21</sup> New Hampshire also has specific minimum requirements for continuing education for APRNs who prescribe medication.<sup>22</sup>

### Maine

Nurse practitioners in Maine can practice independently, but before newly graduating APRNs can practice independently, the Maine Regulations Relating to Advanced Practice Registered Nursing require nurse practitioners to practice for a minimum of 24 months under the supervision of a licensed physician or APRN, or be employed by a clinic or hospital that has a medical director who is a licensed physician.<sup>23</sup>

Maine also has specific education and experience requirement with respect to prescribing authority for nurse practitioners and formulary regulations.<sup>24</sup>

## **X. Likely Outcomes of Eliminating the Requirement**

The anticipated advantages of eliminating the signed APRN/physician collaborative agreement, as found by the majority of the task force were:

- Increased access to health care associated with a potential increased presence and change in distribution of APRNs throughout the state
- Increased APRN participation as primary health care providers better able to address the current mandate for a chronic care initiative
- More emphasis on prevention of health problems
- Potential decrease in overall health care costs related to APRNs emphasis on prevention and chronic care
- Continuation of quality of care and the collaborative care model of health care.

A minority of the Taskforce perceives advantages to maintaining the legal requirement for a written signed APRN/physician collaborative agreement. They believe the advantages are that the written agreement:

- Assures improved quality and collaboration of APRN practice.  
Experience: In actual practice, the agreement is typically brief and there may be little interaction between the physician who signed the collaborating agreement and the APRN on a regular basis. APRNs collaborate with multiple physicians and other health professionals depending on reason for consultation. Quality of care is a result of professional responsibility, organizational oversight and regulatory processes not the result of a written agreement.
- Assures dialogue between the APRN & the physician.  
Experience: The agreement has been found to have little to do with increased communication.
- Requires APRNs to be connected with a physician.

<sup>21</sup> New Hampshire Joint Council Drug request form:

<http://www.nh.gov/nursing/jhc/documents/JHCRequestforChangeinDrugFormulary9.07.doc>

<sup>22</sup> New Hampshire statutory requirements for continuing education:

<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-31.htm>

<sup>23</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc>

<sup>24</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc> (section 6 & 7)

Experience: While technically true, it is the commitment to professional interdisciplinary collaborative practice that connects APRNs to physicians.

It is imperative that we have a system in place that will ensure the quality of care provided by health professionals in Vermont. Completion of a formal APRN accredited graduate education program and ongoing national board certification in an identified specialty is currently required for endorsement as an APRN in Vermont. National certification requires evidence of completion of a program of graduate study acceptable to the Board of Nursing, including advanced clinical practice in the specialty area and passage of a valid and reliable national board certification examination for nurses in advanced practice. Re-certification is required and includes completion of continuing education and ongoing clinical practice in the specialty area. In addition, the Board of Nursing requires that APRNs use practice guidelines and have methods of quality assurance in place.

## XI. Conclusions

The goal of the Taskforce was to have a consensus recommendation. Unfortunately, this was not obtained. The Taskforce decided to make one report, which reflecting both the majority opinion (10 members) and attach the minority view (3 members) in its entirety rather than try to summarize their objections in this report.

The majority of the Taskforce (9-2-1; 1 member absent for the vote) voted to recommend elimination of the Vermont Nursing Board's requirement that an APRN must have a written signed collaborative agreement with a physician. The majority believes that the requirement:

- 1) potentially limits access to primary health care for Vermonters
- 2) has served as an ongoing challenge and barrier to APRN practice in Vermont
- 3) does not guarantee collaboration or quality of care.

The majority believes that the elimination of the written requirement, which serves no discernable purpose in current day APRN practice, can do no harm and can only serve to increase patient access to APRNs as primary care providers serving critical roles in chronic care management. The requirement should be eliminated, subject to further recommendations of the Taskforce set forth below.

A minority of the Taskforce, consisting of three (3) Vermont Medical Society representatives, find no evidence that the decision to eliminate the requirement will lead to increased access to care and have serious concerns about the effect elimination of this agreement will have on the quality of care. The minority report is attached as Appendix C. Therefore, they do not recommend elimination of the requirement, but would instead explore other ways to make the existing collaboration requirement more effective and less of a barrier to APRN practice. Among the minority conclusions:

- 1) There is currently no supportive evidence that the elimination of the requirement for a collaborative agreement will change access to chronic care in the State.
- 2) While there is anecdotal evidence that the requirement for a collaborative agreement is limiting APRN practice in the State, specific solutions to these issues can be provided without the elimination of the requirement.

Therefore, the minority opinion is that eliminating the requirement for APRNs to work within a collaborative agreement with a licensed physician with the stated goal of APRNs serving a greater role as primary care providers who provide essential chronic care management does not appear to be supported by the information and data reviewed to date. (See attached)

## XII. Final Recommendation of the Taskforce

It is recommended by the Taskforce that the Vermont Board of Nursing:

- 1) eliminate the requirement for APRNs to have a written signed collaborative agreement with a physician in order to be endorsed and licensed as an APRN in Vermont
- 2) propose a change to the law to require an APRN to be a member of the Board of Nursing
- 3) continue to require APRNs to use practice guidelines/national standards of care
- 4) continue to mandate that APRNs monitor the quality of care they provide
- 5) continue to license and endorse APRNs who have completed a formal APRN accredited graduate education program and who have current national board certification in an identified specialty
- 6) continue to license and endorse APRNs who demonstrate professional accountability and have met and maintained national credentialing requirements for APRNs in their specific specialty. This requirement addresses the expectation of continuing education and ongoing clinical practice
- 7) consider the implications of requiring new graduates of APRN programs to have a formal mentored APRN experience with an experienced APRN or MD during their first year of practice.

## XIII. Summary

There was no evidence presented that the written collaborative requirement serves any professional purpose, assures quality of care, or protects the public. There was convincing anecdotal evidence that the elimination of the requirement may increase access to health care for Vermonters without adversely effecting the quality of care.

Elimination of the written collaborative agreement requirement is supported when one considers:

- the potential for increasing access to care for Vermonters
- the opportunity to focus care by APRNs on the chronic care model through the Vermont Blueprint for Health Care
- the extent to which the signed agreement requirement has been a barrier to APRN practice
- the extent to which the requirement has met its original intent from 1984 to facilitate APRN practice with physicians and establish mutual collaborative practice habits
- the continued oversight by the Board of Nursing for APRN practice and protection of the public
- the history of the nationally defined scope and standards of practice for APRNs
- the formal education, training and national certification required of APRNs
- the increased communication and collaborative environment of modern health care
- the supportive evidence of successful quality and outcomes documented in the literature
- the positive experience of other States which do not require a written agreement between APRNs and physicians.

## Appendix A – Taskforce Participants

Participants (13) of the APRN Taskforce include:

- Professional Regulation Christopher Winters, Esq. - Group Facilitator
- Vt Dept of Health Lisa Dulsky Watkins MD/  
Kathleen C. Keleher APRN
- Board of Nursing Anita Ristau RN retired, Linda Rice APRN
- Medical Practice Board John Murray MD
- UVM Department of Nursing Nancy Morris APRN
- Vt Nurse Practitioner Assn Deborah Wachtel APRN
- Vt Medical Society David Johnson MD, David Coddair MD,  
Peter Cherouny MD
- Consumer Alan Weiss
- Vt State Nurses' Assn Inc June Benoit APRN
- Legislator Bill Keogh

**Appendix B – Vermont APRN Disciplinary Information**

	2006	2005	2004	2003	2002
# of APRNs	521	464	475	426	501
Disciplined Type of APRN	1 CRNA	1 Clinical Spec/Psych.	1 FNP	2 1-CNM 2-CNM	2 1-ANP 2-FNP
Sanction Result	Suspend	Suspend	Suspend	1-Condition 2-Reprimand	1-Condition 2-Reprimand
Causal Issue	Diversion	Professional Boundaries	Self-Prescribing	1- Lack of Assessment 2-Did not follow practice guidelines	1-Alcohol Abuse 2- Removed mole without parent's consent

(source VT Board of Nursing)

Appendix C  
Work Group Summary  
Workgroup members – Peter Cherouny, M.D., David Coddair, M.D., &  
David Johnson, M.D.  
Advanced Practice Registered Nurses (APRNs)  
as Primary Care Providers (Act 71)

MINORITY REPORT

December 12, 2007

**Introduction**

In 2007, The Legislature passed Act 71, An Act Relating to Ensuring Success in Health Care Reform. One section of the Act, relating to “Support for Primary Care Providers,” calls for a study of “the advisability of eliminating the requirement for an advanced practice nurse work in a collaborative practice with a licensed physician, with the goal of evaluating whether advanced practice nurses might serve a greater role as primary care providers who provide essential chronic care management.”

The work group was convened by representatives of the Commissioner of Health, the Director of the Secretary of State’s Office of Professional Regulation, and the Vermont Board of Nursing. The work group met four times over four months and, in addition to representatives of the three agencies listed above, included 10 additional members representing the following groups: the Vermont Legislature, Vermont Consumers, the UVM School of Nursing, the Vermont Medical Practice Board, the Vermont Medical Society, the Vermont Nurse Practitioner Association, and the Vermont State Nurses Association. As agreed by the Work Group at its September meeting, the scope of this report is limited to a discussion of whether to change or eliminate the requirement for physician collaboration for APRNs serving as primary care providers, who provide chronic care management. This report does not address APRNs who are qualified as Certified Registered Nurse Anesthetists, or other APRNs from specialty groups.

**Background on Regulation and Oversight of Advanced Practice Registered Nurses in Vermont (APRNs): Requirement for a Practice Guideline and Collaborating Physician**

APRNs are clinicians who practice in ambulatory, acute and long-term care settings. Consistent with their specialization, they provide nursing and medical services to individuals, families and groups. In addition to diagnosis and management of acute episodic and chronic illness, APRNs in certain specialties emphasize health promotion and disease prevention. Services include but are not limited to ordering and interpreting diagnostic tests, prescribing therapeutic medications and non-medication therapies, and

managing uncomplicated labor and delivery. Teaching and counseling are a major part of care provided by APRNs in some specialties.

The current language of the State of Vermont Board of Nursing Administrative Rules (2004) Chapter 4, Subchapter 8,<sup>1</sup> provides that while an APRN performs medical acts independently, the APRN practices within a collaborative practice with a licensed physician “under practice guidelines which are mutually agreed upon between the APRN and the collaborating physician and which are *jointly acceptable to the medical and nursing professions.*”

The requirement that the guidelines be mutually acceptable to the medical and nursing professions is designed to ensure that patients are treated under guidelines that are the same whether they receive treatment from an APRN or a physician and to ensure collaboration of care between the two professions when more complex care is required. This requirement for guidelines is in place in order to help prevent different levels of care or standards of treatment from developing among patients that receive care from APRNs as opposed to physicians. As many new initiatives focus on improving, coordinating and standardizing high quality care, this requirement also helps to coordinate this effort.

As described by the rules, practice guidelines for APRNs must include:

- a. *A description of the clinical practice, including practice site(s), focus of care, and general category of clients;*
- b. *An indexed copy of standards for clinical practice<sup>2</sup> including method of data collection, assessment, plan of care, and criteria for collaboration, consultation and referral, including emergency referral;*
- c. *The name of at least one physician who holds an unencumbered license in Vermont who practices in the same specialty area who will be routinely utilized for collaboration, consultation and referral; and*
- d. *Methods of quality assurance.<sup>3</sup>*

The practice guidelines must also be “*reviewed, mutually agreed upon, and signed annually by the APRN and the collaborating physician and placed on file in the workplace.*” The guidelines must “*be reviewed and approved by the Board of Nursing and kept on file in the workplace and be made available to the Board of Nursing at any time upon request.*”

### **Collaboration, Consultation and Referral**

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<sup>1</sup> The current language of the State of Vermont Board of Nursing Administrative Rules (2004) Chapter 4, Subchapter 8, III C was written 23 years ago in 1984, and updated at least once since then to remove a requirement that APRN guidelines be filed with the Vermont Board of Medical Practice (VBMP).

<sup>2</sup> The nursing board rules require that, national certifying organizations wishing to obtain recognition from the Vermont State Board of Nursing, must “*have developed standards and Scope of Practice statements for the nurse in advanced practice.*” See, <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf>, at page 24

<sup>3</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf>, at page 25

Collaboration is the preferred model of health care practice and clinical autonomy has been identified as a barrier to improving the quality of medical care.<sup>4</sup>

The State of Vermont Board of Nursing Administrative Rules (2004) define collaboration as *"a process which involves two or more health care professionals working together, though not necessarily in each other's presence, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer."*<sup>5</sup>

The rules define "Collaboration as it pertains to advanced practice" as, *"The Advanced Practice Registered Nurse acts independently in dealing with the nursing needs of the individual; and independently consistent with practice guidelines with a collaborating physician in the appropriate specialty area for all related medical functions; or by clinical privileges approved by the facility or facilities at which the individual practices."*<sup>6</sup>

A "Collaborating physician" is defined in the rules as *"a physician who holds an unencumbered license and is actively practicing medicine in the State of Vermont who has formally agreed to be available for collaboration, consultation and referral."*

*Collaboration between health care providers should be the professional norm, as described in 2007 Changes in Healthcare Professions' Scope of Practice: Legislative Considerations.*<sup>7</sup> "The expectation is that competent providers will refer to other providers when faced with issues or situations beyond the original provider's own practice competence, or where greater competence or specialty care is determined as necessary or even helpful to the consumer's condition."(p.9). While the Committee heard that the expectation is that APRNs will collaborate with other health care professionals as appropriate, guided by their training, there was no evidence or data found in the literature that defined collaboration or standards for collaboration in order to compare APRN care within or without a collaborative agreement. The literature reviewed comparing care between APRN and physicians, and generally showing no substantive differences, did not make clear whether the APRN care studied was within or without a collaborative care relationship or agreement. In fact, many of these studies were performed in states that require such agreements. Unfortunately, this leaves no direct supporting evidence to conclude that collaboration will take place regardless of the presence of a signed collaborative agreement. In addition, Vermont has no experience upon which to draw from in this regard.

Section 7(e)<sup>8</sup> of Act 71, of the 2007 General Assembly, establishes a medical home project to facilitate the provision of accessible, continuous, and coordinated care to high-need populations. Primary care providers participating in the project would provide

<sup>4</sup> Almaguer R, Auroy Y, Berwick D, Barach P Five System Barriers to Achieving Ultrasafe Health Care, *Annals of Internal Medicine* 2005 142: 756-764

<sup>5</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> (page 3)

<sup>6</sup> Id.

<sup>7</sup> [http://www.fsmb.org/pdf/2005\\_grpo1\\_scope\\_of\\_practice.pdf](http://www.fsmb.org/pdf/2005_grpo1_scope_of_practice.pdf);

<http://www.fsbpt.org/standards/ScopeOfPractice/index.asp>

<sup>8</sup> <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT071.HTM>

ongoing support, oversight, and guidance to implement a plan of care developed in partnership with patients and including all other physicians furnishing care to the patient.

In the legislation, a primary care provider would provide first contact and continuous care for individuals under his or her care and has the staff and resources sufficient to manage the comprehensive and coordinated health care of each such individual. Thus, under the medical home model, there will be an even greater need for a coordinated team approach within primary care.

#### Physician Requirements for Independent Care

In the state of Vermont, physicians are required by Vermont State law to complete at least one year of supervised postgraduate training (three years for international medical school graduates) in order to attain initial medical licensing. Postgraduate training is well described elsewhere, is subject to intense control and review and is generally a practice in a hospital setting<sup>9</sup> where supervision and review of all provided care by an experienced attending physician occurs. In order to obtain specialty board certification, including primary care specialties, physicians need complete three or more years of supervised residency training. It needs to be recognized that, should the collaborative agreement be eliminated, an APRN would have the ability to immediately enter independent practice without ongoing training or oversight.

#### **Impact of Existing Law Requiring a Written Collaborative Agreement: Barriers to Access to Patient Care**

There were several presented anecdotal examples where the requirement for a collaborative agreement was a barrier to practice by a Vermont APRN. It is important to note that these instances were not clearly documented and the full reasons behind them not well explored. However, these possible identified barriers may be addressed in a variety of ways.

- APRNs in teaching environments are required to have a license and thus a collaborative agreement and need to work a second clinical job in order to be on the teaching faculty: It is suggested that an exception be explored allowing APRNs with national certification who work in academic settings and who do not engage in clinical practice be licensed without a collaborative agreement.
- APRN inability to identify a collaborative physician: Organizations such as VMS, state specialty societies, the Vermont Association of Hospitals and Health Systems (VAHHS) and BiState Primary Care Association could be approached for assistance with locating collaborating physicians.
- Fees, some reportedly excessive, charged for a collaborative agreement in the understanding that such an agreement increased liability exposure: The fees charged by collaborating physicians could be limited by rule or policy after careful study, and a showing of reasonable nexus to increased cost for the physician, if any, such as increased malpractice insurance expense, or time spent in reviewing charts could be required. A position paper could be developed

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<sup>9</sup> 26 V.S.A. § 1396 (a)(3)

addressing the liability of collaborative physicians or in the alternative, state law could provide immunity for collaborating physicians.

- Concern that guidelines are not updated in a timely fashion: National certifying organizations are required by the nursing rules to have “standards and scope of practice statements for the nurse in advanced practice.” Presumably these national organizations regularly update their guidelines and standards. APRNs could forward these amendments to their collaborating physician as well as to the State. The use of technology should make this a rapid and minimally time-consuming event.
- The cost in time and dollars on hospital credentialing committees who must ensure the presence of current practice guidelines when they initially credential and then re-credential APRNs: There is no direct evidence that this is over burdensome at this time. One physician (PHC) currently chairs the credentialing committee for his Health Care Service and does not identify this as a concern for his committee at this time.

### **Other States’ Experiences**

The Committee discussed nine states that have legislated autonomous practice for APRNs with no requirement for a collaborative or supervisory relationship with physicians. More specifics are described below.

#### **New Hampshire**

New Hampshire does not require a written collaboration agreement with a physician, however New Hampshire has established a Joint Health Council<sup>10</sup> made up of three APRNs, three physicians and three pharmacists,<sup>11</sup> which has established the “Exclusionary Formulary”<sup>12</sup> for APRNs who prescribe medication. The formulary identifies individual drugs and classes of drugs that are restricted or approved for use with specific types of collaboration or consultation. For example abacavir is approved for use with an infectious disease consultation and requires collaboration for APRNs working in a HIV clinic. Some drugs are approved for use by APRNs with certain specialties such as Psych/Mental Health or are approved for renewal of a physician-initiated prescription. Some drugs may be prescribed in consultation in certain settings such as institutional or in a Hematology/Oncology setting. Some drugs may be prescribed for treatment of a diagnosis made according to guidelines published by physician specialty organizations. Specific definitions of “consultation” and “collaboration” are included in the definition section of the formulary. APRNs may submit requests to the Joint Council asking that drugs be added to the formulary or taken

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<sup>10</sup> New Hampshire Joint Council law:  
<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-10.htm>

<sup>11</sup> New Hampshire Joint Council Members:  
<http://www.nh.gov/nursing/jhc/JointHealthCouncilMembers.htm>

<sup>12</sup> New Hampshire Joint Council Formulary:  
<http://www.nh.gov/nursing/jhc/documents/JHCFormulary8.07.doc>

off the formulary.<sup>13</sup> New Hampshire also has specific minimum requirements for continuing education for APRNs who prescribe medication.<sup>14</sup>

## Maine

While nurse practitioners in Maine can practice independently, prior to practicing independently, the Maine Regulations Relating to Advanced Practice Registered Nursing require nurse practitioners to practice for a minimum of 24 months under the supervision of a licensed physician, or be employed by a clinic or hospital that has a medical director who is a licensed physician.<sup>15</sup> The APRN applicant must identify and provide a statement of agreement from a licensed physician practicing in the same practice category as the APRN who agrees to provide oversight to the APRN. This requirement is somewhat comparable to the internship and residency training that physicians participate in prior to practicing independently, although it is not required to be in a hospital setting.

In Maine, as described above, nurse practitioners may work as licensed independent practitioners. If, however, they choose to perform medical diagnosis or prescribe therapeutic or corrective measures delegated by a licensed physician, the physician/APRN relationship must be registered with the Board of Licensure in Medicine.<sup>16</sup>

Maine also has specific education and experience requirement with respect to prescribing and dispensing authority for nurse practitioners and formulary regulations.<sup>17</sup>

Many other states limit prescription of controlled substances and other drugs by APRNs. Some methods of regulation of APRN prescribing used in other states follow:

- Schedule II through IV drugs not permitted; collaboration required for other legend drugs (Alabama, Florida, Hawaii, Missouri)
- No Schedule II (Georgia, Illinois, Oklahoma, West Virginia)
- Schedule II only in a hospital, surgical-center or hospice and limited to 7-day post discharge supply
- Schedule II only if approved by Board on an individual basis (LA) spell out states
- Schedule II only if specified in collaborative practice agreement (CT)
- Special mid-level prescribing license required for schedules III, IV or V (Illinois)

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<sup>13</sup> New Hampshire Joint Council Drug request form:  
<http://www.nh.gov/nursing/jhc/documents/JHCRrequestforChangeinDrugFormulary9.07.doc>

<sup>14</sup> New Hampshire statutory requirements for continuing education:  
<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-31.htm>

<sup>15</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc>

<sup>16</sup> <http://www.maine.gov/sos/cec/rules/02/373/373c003.doc>

<sup>17</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc> (section 6 & 7)

In addition to limitations on prescribing controlled substances, all but a handful of states require collaboration for APRN prescribing. Some require special licensing endorsements for APRNs who wish to prescribe medications. And many states impose specific educational requirements with respect to prescribing.

#### **APRN Workforce/ Access to Care**

While there is evidence documenting improved outcomes and lower costs in situations where patients have a primary physician<sup>18</sup>, the Work Group was not presented with any supportive evidence that indicated access to care would improve if APRNs were decoupled from physician collaborative guidelines.

The Office of Professional Regulation (OPR) publishes an Annual Report on Professional Licensing that tracks the numbers of the professional groups licensed by OPR.<sup>19</sup> These reports indicate that the number of APRNs licensed in Vermont has increased from 346 to 521 between 1996 and 2006. In 2006 about 1/5 of those were not residents. Under the current requirements, over the last 10 years, the number of APRNs in Vermont has increased considerably, by approximately 50%.

The Department of Health collects detailed demographic workforce information about physicians, physician assistants, podiatrists and dentists, including information on whether their practices are open to patients, and open to Medicaid and Medicare patients. This information is compiled into statistical reports and summary reports, based on licensing renewal information, that are then posted on the publications section of the Department of Health website,<sup>20</sup> and updated every two years.

In 2002, the Department of Health surveyed APRNs, but since that time due to loss of funding, has been unable to update the APRN workforce survey.<sup>21</sup> According to the Department of Health's 2002 APRN statistical report, with respect to access to primary care provided by APRNs in office settings and community health centers, 88% of adult APRNs, 86% of family APRNs and 95% of pediatric APRNs and 76% of mental health APRN practices were accepting new Medicaid patients. With respect to access for Medicare patients, 92% of adult APRNs had open practices, 84% of family APRNs and 65% of mental health APRNs.<sup>22</sup>

In 2002 the distribution of access for Medicaid patients to primary care APRN practices by county varied from 80% in Bennington County to 100% in several counties. Access for Medicare patients ranged from 71% in Addison County to 100% in several counties.<sup>23</sup>

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<sup>18</sup> Starfield B, Contributions of Primary Care to Health Systems and Health, *Milbank Quarterly*, 2005 83-3: 457-502

<sup>19</sup> <http://vtprofessionals.org/opr1/opr/pubs/rpttxt.html>

<sup>20</sup> <http://healthvermont.gov/pubs/Publications.aspx>

<sup>21</sup> <http://healthvermont.gov/pubs/apn/APRN02BK.PDF>

<sup>22</sup> Id at page 44 of PDF, page 38 printed

<sup>23</sup> Id. at page 45 of PDF, page 39 printed

In some of the most rural areas of the state, like the Northeast Kingdom, in the 2002 report, 100% of APRN practices were open to new patients, including new Medicaid and Medicare patients, perhaps reflecting the prevalence of primary care delivered through Federally Qualified Health Centers (FQHCs) in those areas. FQHCs and Rural Health Clinic (RHCs) are eligible for cost-based Medicaid and Medicare reimbursement, reducing the financial stress on primary care practices.

According to the 2007 Re-licensure Survey and the 2007 Health Workforce Assessment Pilot Survey data, presented to the Work Group at its October meeting, these numbers have changed somewhat, with 88% of APRNs participating in Medicaid in 2007, but only 80% accepting new Medicaid patients and 78 % participating in Medicare but only 71% accepting new Medicare patients. No specialty or geographic analysis of this updated access information was presented to the group.

It appears that, despite the significant increase in the numbers of APRNs licensed in Vermont over the past 10 years, approximately 50%, the percentage of APRNs whose practices are accepting new Medicare and Medicaid patients has declined.

No information was presented to the group as to whether APRNs in independent practice are more or less likely to accept Medicaid and Medicare patients than their colleagues who work for FQHCs, RHCs or in physician practices. Presumably, APRNs in private practice would be subject to more financial pressure than those working for clinics receiving higher reimbursement rates and may be less likely to have open practices to low-income patients.

### **Existing and Continued Regulatory Environment**

The Vermont Board of Nursing will continue to endorse APRNs with a license to practice in Vermont who demonstrate professional accountability and have met and maintained national credentialing requirements for APRNs in their specific specialty. This will address the expectation of continuing education and quality monitoring of care provided. Public protection will be a priority for the Board of Nursing and will guide their work such that the public will have access to APRNs who practice safely and competently.

### **Structural Considerations for Regulatory Board Oversight**

- **Regulatory board expertise**

By statute, the Vermont Board of Nursing includes ten members appointed by the governor, five registered nurses, two practical nurses, one nursing assistant and two public members. One APRN currently serves on the Board; however, there is no statutory requirement that the board membership include any APRNs. There is a provision in the Nursing Board rules that authorizes the Board to establish an advisory committee of APRNs to assist the Board in the implementation of the Nursing Board rules. Oversight of the Nursing Board is provided by the Office of Professional Regulation (OPR), a division of the Office of the Secretary of State.

If APRNs are held to the same standard of care as primary care physicians, the Board must have sufficient clinical expertise to review the care they provide when necessary. Without this type of expertise patients who see APRNs will be at risk of receiving a different level of care from patients who see MDs or DOs. Other states, such as Delaware and New Hampshire, have used multidisciplinary models, involving physicians and pharmacists, in oversight and regulation of APRNs particularly with respect to prescribing.

For efficiency of administration and expertise, the Work Group should explore whether APRN oversight should be transferred to the VBMP. One or more APRNs could be added by law to the VBMP, which includes 9 physicians, one podiatrist, one physician assistant and 6 public members. Oversight of the VBMP is performed by the Department of Health. Location of the Board in the Department of Health allows for coordination and collaboration between the licensing entity and other important health initiatives such as Emergency Preparedness, the chronic care initiative the Office of Alcohol and Drug Abuse Programs (ADAP), and the Vermont Advanced Directive Registry (VADR).

- **Unprofessional conduct requirements**

If laws and regulations are changed to permit independent practice, the unprofessional conduct standards for APRNs in the current Vermont rules and laws should be reviewed to determine that they afford appropriate public protection, particularly in the areas of standard of care and prescribing,<sup>24</sup> and appropriately address situations that might arise when APRNs are practicing independently as primary care clinicians. The workgroup could consider whether the unprofessional conduct requirements for physicians should apply to APRNs who serve as primary care providers, to prevent creation of a double standard.

- **Patient disclosure requirements**

It is in the public interest to ensure that patients are informed of the level of education and credentials of the professionals treating them and the process for making complaints to the appropriate regulatory board. APRNs in private practice should provide this of information to their patients in a manner similar to the disclosure required in Vermont for psychologists and other mental health practitioners.<sup>25</sup> Detailed information about physicians' education, training, board certification, practice location, and whether their practices are open to new patients with covered by public and private insurance, is available about all MDs licensed in Vermont in the Physician Profiles section of the Department of Health website. The profiles also include information or links to information about

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<sup>24</sup> <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=028&Section=01584>  
<http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=028&Section=01595>  
<http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=03&Chapter=005&Section=00129a>  
<http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> Rules: See, Subchapter 4. Discipline II Definitions, D. "Conduct likely to deceive, defraud, or harm the public"

<sup>25</sup> <http://vtprofessionals.org/opr1/psychologists/psychrules.pdf> Psychologist rules at Page 15. See also, rules for other allied mental health professionals.

hospital and board discipline and malpractice judgments and settlements.<sup>26</sup> Should oversight of APRNs be transferred to the VBMP, similar profiles could be created for APRNs.

## CONCLUSION

This Committee was charged with evaluating “the advisability of eliminating the requirement for an advanced practice nurse work in a collaborative practice with a licensed physician, with the goal of evaluating whether advanced practice nurses might serve a greater role as primary care providers who provide essential chronic care management.”

- 1) There is currently no supportive evidence that the elimination of the requirement for a collaborative agreement will change access to chronic care in the State.
- 2) While there is anecdotal evidence that the requirement for a collaborative agreement is limiting APRN practice in the State, specific solutions to these issues can be provided without the elimination of the requirement.
- 3) Physicians are currently required to have a minimum of one year of postgraduate medical training for State licensing, and thus independent practice with most physicians providing primary care completing at least three postgraduate training years.

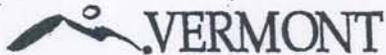
Therefore,

- A) Without evidence of a positive impact on primary care access for the provision of essential chronic care management and;
- B) Without data supporting equitable quality of APRN provided care in a non-collaborative model and;
- C) Given the current licensing requirement for physicians of a minimum of one year postgraduate medical training (three years for international medical graduates) and the necessity of at least three years of specialty training for primary care physician providers and;
- D) Given that the anecdotal hardships regarding the requirement for a collaborative agreement for APRN practice can be separately addressed;

Eliminating the requirement for APRNs to work within a collaborative agreement with a licensed physician with the stated goal of APRNs serving a greater role as primary care providers who provide essential chronic care management does not appear to be supported by the information and data reviewed to date.

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<sup>26</sup> <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=023&Section=01368>  
[http://healthvermont.gov/hc/med\\_board/profiles.aspx](http://healthvermont.gov/hc/med_board/profiles.aspx)



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Board of Medical Practice  
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[tty] 802-657-4227

Agency of Human Services

January 9, 2008

Dear APRN Work Group Members,

The Vermont Board of Medical Practice has reviewed your 12/3/07 draft report to the Legislature and the 12/12/07 alternative report drafted by three of your physician members. After considerable discussion, the Board has directed me to write this letter to summarize and express the Board's interests and concerns.

First of all, the Board would like to note its appreciation of the valuable and necessary service that APRNs provide to the people of Vermont. Most of us know and have worked with highly competent APRNs with whom we would trust our own health and well being. It is the opinion of the Board that Advanced Practice RNs possess a unique and valuable skill set. It must be noted, however, that this skill set does not represent the same set of skills or knowledge base obtained through the training, supervision, and testing required of a physician licensed to provide medical care in an independent setting. As such, the Board feels that the skills and knowledge exemplified by APRNs are best utilized in a collaborative health care setting where, as stated in the State of Vermont Board of Nursing Administrative Rules "The APRN acts independently in dealing with the nursing needs of the individual, and independently consistent with practice guidelines with a collaborating physician in the appropriate specialty area for all related medical functions...".

Your 12/13/07 draft report asserts that collaboration should be the professional norm, and refers to a "general consensus" that collaboration will take place regardless of the presence of a signed collaborative agreement. While we acknowledge that the majority of APRNs would likely maintain effective informal collaborative relationships with physicians regardless of whether the legal requirement remained, we do not feel this assertion sufficiently protects the citizens of Vermont from a regulatory standpoint. Regulatory standards should not be based on the likely behavior of the well-intentioned majority. They must be designed to prevent the possibility that inadequately trained clinicians practice in a setting with inadequate (or absent) supervision.

To maximize the access of Vermonters to high-quality medical care by APRNs and to minimize the public safety risk of any statutory change that removes the collaborative agreement requirement, the Board urges your consideration of the following:

- 1) If APRNs are to be licensed to provide primary care independently, their scope of practice must be limited to primary care and they must have had significant specialized training in this field. This should include supervised clinical rotations undertaken through accredited training programs as well as standardized testing of

Appendix D



both knowledge base and clinical skills. The minimum acceptable duration of training should approximate that required for physician licensure.

2) Before APRNs are licensed to provide primary care independently, they must first practice for a considerable period, perhaps four years, under a formal collaborative agreement that has been reviewed by their licensing Board and found to be appropriate to maximize their preparation for independent practice. No APRN should be permitted to practice independently, without showing evidence of successfully completing this extended period of monitored and supervised clinical experience. In the case of APRNs who have practiced in other states, a demonstration of clinical experience should be required that is deemed equivalent by the licensing Board.

3) A formulary should be established by a multidisciplinary group to govern the prescribing authority of independent APRNs.

4) Medical professionals who are fully licensed to provide primary medical care without supervision should be regulated by the Medical Practice Board or, in the alternative, by a Board made up primarily of medical professionals with at least the same level of training as the professionals being regulated. All statutory definitions of unprofessional conduct for physicians should apply to APRNs practicing in an independent setting. If APRNs are to be regulated by the Board of Medical Practice, they should be numbered in the Board's membership. If Vermont is going to address the shortage of primary care providers by placing APRNs in the role of independent provider, then it must do so in a manner that does not create a double standard of care and of professional regulation.

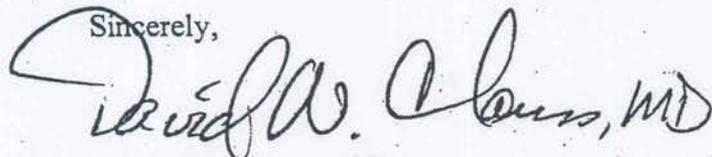
5) If independent APRNs are to be regulated by the Board of Nursing, at least one APRN should be involved in investigating any complaint of unprofessional conduct involving medical care that is filed against an independent APRN, and at least one other APRN should be involved in adjudicating any resulting charges.

6) If an independent APRN has a non-medical doctorate, that person should be prohibited under the terms of his or her license from using the title "Doctor" or "Dr." in a clinical setting, or to in any way represent to patients or other members of the public that he or she is a medical doctor.

We acknowledge the arguments being made in favor of removing the collaborative agreement requirement. We also are aware of the very real risks to the public health and safety if regulatory laxity allows well-meaning clinicians to practice in a role for which they were not trained, or less well-intentioned clinicians to evade regulatory requirements. If the model of collaboration being currently practiced in Vermont does not allow the public to fully reap the benefits of what APRNs have to contribute in our state, then we must work to improve and facilitate professional collaboration rather than abandon it.

On behalf of the Board I thank you for allowing us to be involved in this important matter. We urge you to proceed with caution. The unintended consequences of a well-meant revision to the status quo could be significant.

Sincerely,

A handwritten signature in black ink that reads "David W. Clauss, MD". The signature is written in a cursive style with a large initial "D" and "C".

David W. Clauss, M.D.

Chair, Vermont Board of Medical Practice