Request for Consideration of Scope of Practice Change

Submitted to the Connecticut Department of Public Health
by the Connecticut APRN Coalition:

Connecticut Nurses Association
Connecticut APRN Society
Connecticut Association of Nurse Anesthetists
Connecticut Chapter of the National Association of Pediatric Nurse Practitioners
Connecticut Chapter, American Psychiatric Nurses Association

August 10, 2012

Per P.A. 11-209, the Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) submits a request to change statutory language affecting the requirements for practice by Advanced Practice Registered Nurses (APRNs).

1. Plain Language Description of the Request:

CTAPRNS respectfully requests removal of the mandatory collaborative agreement requirement for APRNs practicing as nurse practitioners or clinical nurse specialists.[1] Nurses licensed to practice in Connecticut do so under the requirements of Section 20-87a. APRNs practice under subsection "a" of this section, relating to registered nursing practice. In addition, APRNs are under the requirements of subsection "b" of this section, which states in relevant part:

> (b) Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of postbasic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section, and shall collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, [...] For purposes of this subsection, "collaboration" means a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between an advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that the advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics,

[1] Certified Registered Nurse Anesthetists (CRNAs) are licensed as APRNs, but have a different practice arrangement; CRNAs are not requesting any change to their scope of practice. Certified Nurse Midwives (CNMs) are not licensed as APRNs in Connecticut, having their own practice act and scope requirements (Chapter 377).

> corrective measures, laboratory tests and other diagnostic procedures that the advanced practice registered nurse may prescribe, dispense and administer. An advanced practice registered nurse licensed under the provisions of this chapter may make the determination and pronouncement of death of a patient, provided the advanced practice registered nurse attests to such pronouncement on the certificate of death and signs the certificate of death no later than twenty-four hours after the pronouncement.

The historical context of health professional scopes of practice greatly informs the understanding of today's regulatory schema. As noted in the 2012 consensus statement about scope of practice issued by the national boards for medicine, nursing, occupational therapy, pharmacy, physical therapy and social work:

> The history of professional licensure must be taken into account if one is to understand the current regulatory system governing scope of practice. Physicians were the first health professionals to obtain legislative recognition and protection of their practice authority. The practice of medicine was defined in broad and undifferentiated terms to include all aspects of an individual's care. Therefore, when other healthcare professions sought legislative recognition, they were seen as claiming the ability to do tasks which were already included in the universal and implicitly exclusive authority of medicine. This dynamic has fostered a view of scope of practice that is conceptually faulty and potentially damaging.[2]

The nature of health professional practice is inherently collaborative, between many types of professionals. One of the leading physician organizations, the American College of Physicians (ACP), agrees: "ACP believes that the future of health care delivery will require multidisciplinary teams of health care professionals that collaborate to provide patient-centered care".[3] Mandating an agreement with a physician does not truly speak to such collaboration, however, despite the statutory terminology. The statute requires that the collaborative agreement be made with a physician "who is educated, trained or has relevant experience that is related to the work" of the APRN.[4] While collaboration with a

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[2] Association of Social Work Boards (ASWB), Federation of State Boards of Physical Therapy (FSBPT), Federation of State Medical Boards of the United States, Inc. (FSMB), National Association of Boards of Pharmacy (NABP®), National Board for Certification in Occupational Therapy, Inc. (NBCOT®), National Council of State Boards of Nursing, Inc. (NCSBN®). (January, 2012). *Changes in Health Professions' Scope of Practice: Legislative Considerations.*

[3] American College of Physicians. (2010). American College of Physicians Response to the Institute of Medicine's Report, The Future of Nursing: Leading Change, Advancing Health, p. 4 (pages unnumbered). See also http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf.

[4] General Statutes of Connecticut, Section 20-87a (b)(a).

physician in the same field does occur, it stems from the natural flow of clinical practice, much as physicians consult with each other or with APRNs about patient care. It does not flow from the mandate to have a physician gatekeeper to the APRN's ability to practice. Often, collaboration on a patient very likely will mean consultation with a physician in the same field who is not the "collaborating physician," or with a specialist outside of the APRN's (and collaborating physician's) field.

In 2010, after a two-year long investigation by a select interdisciplinary committee of health professionals and legal experts, the Institute of Medicine (IOM) issued recommendations regarding the future of nursing practice. The first recommendation is:[5]

> **Recommendation 1: Remove scope-of-practice barriers.** *Advanced practice registered nurses should be able to practice to the full extent of their education and training. To achieve this goal, the committee recommends the following actions [...]*

The Committee details this recommendation further for federal and state policymakers:

> **For state legislatures:**
> Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).

The referenced Model Nursing Practice Act[6] contemplates that APRNs practice with autonomous authority, with full prescriptive authority. Neither IOM nor the National Council of State Boards of Nursing recommend mandatory involvement of other health professionals as a threshold to APRN practice.

Removing the mandatory agreement removes an unnecessary barrier to entrepreneurial nursing practice. Removal of such barriers is frequently termed "independent," "autonomous," or "plenary authority" practice. Parties unfamiliar with APRN practice may unwittingly believe that such terms indicate the APRN would practice in isolation, or without benefit of collegial consultation. This specter is one of the very first rebuttals in the formal response to the IOM report by the American College of Physicians.[7] However, removal of a mandatory agreement as a requirement of practice does not mean that APRNs will practice in

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[5] Institute of Medicine (2010). Future of Nursing: Recommendations.
[6] National Council of State Boards of Nursing (2011). Model Nursing Practice Act and Model Nursing Administrative Rules.
[7] American College of Physicians. (2010). American College of Physicians Response to the Institute of Medicine's Report, The Future of Nursing: Leading Change, Advancing Health, p. 1 (pages unnumbered).

some sort of non-collaborative vacuum. Nineteen jurisdictions allow APRNs to practice without mandatory involvement from medicine or other professions as a threshold to practice, and in none of these jurisdictions are APRNs practicing without collaboration from across the health care team. A more practical view, and one endorsed by the APRN community, is that of the Editor-in-Chief of *The Journal of Family Practice*, addressing the Future of Nursing report's recommendations for full nursing practice:

"...[J]oining forces with APNs to develop innovative models of team care will lead to the best health outcomes. In a world of accountable health care organizations, health innovation zones, and medical "neighborhoods," we gain far more from collaboration than from competition."[8]

2. Public Health and Safety Benefits and Risks

Two important steps for maintaining public safety already exist in the nursing practice act. First, APRNs in Connecticut can apply for licensure only after successfully completing a national board exam in the appropriate area of practice. Second, an APRN cannot sit for the exam without proof that the APRN graduated from an accredited nursing education program in the relevant practice arena. National board exams for health and other professionals are routinely accepted as evidence that the successful candidates are competent practitioners in their respective fields.

Unlike many other health professions, including physicians, APRNs have been thoroughly studied for over five decades[9]. Consistently, they are found to produce patient outcomes comparable or exceeding those of physicians in health status and functional status, the use of the emergency department, and patient satisfaction.[10]

There is no risk to public safety by eliminating the mandatory collaborative agreement as a condition of APRN practice. This is illustrated by national data tracked by the Health Resources and Services Administration (HRSA) of the federal Department of Health and Human Services. HRSA compiles two distinct databases: the National Practitioner Data Bank (NPDB), which records "all licensure actions taken against all health care practitioners and any negative actions or findings taken against a health care practitioner..."[11] The Healthcare

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[8] Susman, J. (December, 2010). It's time to collaborate – not compete –with NPs. *The Journal of Family Practice, 59(12),* p. 672.

[9] Newhouse, R.P., Stanik-Hutt, J., White, K.M., Johantgen, M., Bas, E.B., et al. (2011) Advanced practice nurse outcomes 1990-2008: A systematic review. *Nursing Economics*, 29(5), pp. 1-21.

[10] *Ibid.*

[11] Pearson, L. (2012). Annual Pearson Report NPDB & HIPDB State Ratios.

Integrity and Protection Data Bank (HIPDB) "discloses reports related to final adverse actions taken against health care practitioners..."[12]

Each year, the *American Journal for Nurse Practitioners* publishes an online analysis of this data for nurse practitioners and physicians (including those trained as osteopaths) by state.[13] This data has also consistently indicated the safety of APRN practice. The following table illustrates the 2011 ratios for Connecticut and for the nineteen jurisdictions that allow APRNs full practice without mandatory physician involvement in practice.[14]

Table One

STATE	*NP state ratio for NPDB event*	*DO state ratio for NPDB event*	*MD state ratio for NPDB event*	*NP state ratio for HIPDB event*	*DO state ratio for HIPDB event*	*MD state ratio for HIPDB event*
1. Alaska	1:123	1:8	1:4	1:4	1:5	1:5
2. Arizona	1:74	1:3	1:3	1:521	1:6	1:7
3. Colorado	1:91	1:5	1:4	1:3184	1:5	1:10
4. Wash., D.C.	1:46	1:5	1:5	0	0	1:22
5. Hawaii	1:456	1:7	1:5	1:456	1:13	1:17
6. Idaho	1:73	1:8	1:4	1:82	1:16	1:13
7. Iowa	1:148	1:3	1:3	0	1:6	1:9
8. Maine	1:155	1:7	1:4	1:544	1:7	1:11
9. Maryland	1:134	1:14	1.4	0	1:33	1:16
10. Montana	1:69	1:4	1:2	0	1:11	1:13
11. New Hampshire	1:139	1:15	1:3	1:764	1:15	1:13
12. New Mexico	1:51	1:2	1:2	1:584	1:261	1:11
13. North Dakota	1:238	1:6	1:3	1:475	1:3	1:6
14. Oregon	1:82	1:7	1:5	1:106	1:8	1:12
15. Rhode Island	1:77	1:2	1:3	1:345	1:15	1:17
16. Utah	1:131	1:9	1:3	1:131	1:10	1:13
17. Vermont	0	1:12	1:4	1:250	1:7	1:10
18. Washington	1:91	1:5	1:4	1:36	1:8	1:13
19. Wyoming	1:85	1:2	1:2	0	1:5	1:7
CONNECTICUT	1:685	1:22	1:6	1:95	1:33	1:20

[12] *Ibid.*

[13] Pearson, L. (2012). NPDB & HIPDB State Ratios [part of overall Annual Pearson Report].

[14] Note: 27 jurisdictions do not require involvement of physicians in diagnosing or treatment.

The current provision that an APRN must have collaborative agreement with a physician in order to practice represents a barrier, not a provision for public safety, a fact repeatedly pointed out by the Federal Trade Commission in letters to state legislators when legislation regarding mandatory agreements with or supervision by physicians has been introduced.[15] Eliminating this requirement will not lead to APRNs practicing in isolation, as has been noted in the previous section. Removing this mandate will not alter current APRN practice in the field, and will not lead to decreased collaboration. APRNs collaborate with a wide variety of health professionals based on patient needs, not on legal requirements for a physician's agreement to APRN practice.

There are multiple benefits to allowing APRNs to practice to the full extent of their education, without requiring a physician's agreement to practice. APRNs are known for their emphasis on holistic patient care, prevention, health promotion, and living well with chronic conditions. Removal of the requirement for the mandatory agreement creates an environment in which APRNs can expand current practice, and explore other avenues for delivering these types of services.[16] Additional benefits include:

- Increased access to health care, increasingly important as the number of insured individuals and families is expected to increase with full implementation of the Affordable Care Act; this will be more fully detailed in the following section.
- Increased patient choice of health care provider;
- Decrease in costs over time with increased prevention and health promotion services.

3. Impact on Public Access to Health Care

In 1999, the Connecticut General Assembly removed the requirement for physician supervision of APRN practice, and instituted the collaborative agreement. In the years following the enactment of this law, APRN practice expanded into venues that had proved unrealistic in the setting of supervision, due to the lack of physician presence. APRNs are now routinely found in correctional health and long term care settings, and some have opened successful private practices.

Unfortunately, the requirement to have a collaborative agreement has, over the years, presented a barrier to APRNs who wish to practice without formal physician involvement in the business. Although an APRN legally may open

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[15] See for example Federal Trade Commission. (March 26, 2012). Letter to The Honorable Paul Hornback, Senator, Commonwealth of Kentucky State Senate.
[16] *Ibid.*. See also: Rowe, J.W. (May 7, 2012). Why nurses need more authority. *The Atlantic.*

such a practice with a collaborative agreement, the risks of doing so are high. Should the collaborating physician exit the agreement, however benignly, the APRN is immediately placed in an untenable dilemma of practicing without legal authority, despite the professional ethical requirement not to abandon patients. The suspension of practice has no reflection on the APRN's skill or fitness for practice, but hinges entirely on the vanishing collaborative agreement.

Despite assertions to the contrary from the Connecticut State Medical Society, APRNs who lose a collaborating physician often have difficulty finding an immediate replacement, and sometimes are unable to find ANY replacement. This situation has occurred to several APRNs in the past years, and has created a highly chilling effect on innovative APRN practice. In turn, this inhibited innovation decreases access to care, particularly to patients who have little other avenues to health care.

It is notable that nationally approximately 66% of APRNs practice in primary care settings, and often in areas with large numbers of underserved patients. Removing the mandatory physician "agreement" to APRN practice will undoubtedly lead to increased access to care for many people. The current requirements are stifling much needed innovation.

One innovation that has emerged nationally is Nurse Managed Health Centers (NMHCs). These centers are very similar to community health centers, and serve similar populations in rural or other underserved areas such as housing projects. As the name suggests, the centers are run by APRNs. The "Future of Nursing" report issued by the IOM in 2010 found that 60% of the 2 million annual patient encounters in NMHCs were patients without insurance or on state Medicaid plans.[17] Two barriers exist to establishing functional NMHCs:

- Restrictions on APRN scope of practice (requiring physician presence), and
- Lag in the insurance industry to recognize APRNs as primary care providers.

Connecticut has largely addressed the second barrier in Public Law 11-199. Removing the statutory barrier to full practice would greatly enhance the likelihood that full-fledged NMHCs could come to fruition in our state, giving much needed access.

Examples of barriers created by the mandatory physician agreement to an APRN's practice:

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[17] Kovner, C. & Walani, S. (2010). *Nurse Managed Health Centers.* Robert Wood Johnson Foundation Research Brief.

Case #1: An APRN attempted to use the Connecticut State Medical Society's "APRN Assist" link to find a physician "collaborator" for her geriatric/dementia practice. She faxed the requested information form from the website along with a letter, sent both by mail as well, and followed with a telephone call. The woman who answered said she would try to contact doctors in the APRN's area, but didn't know if any were hiring right now. The APRN explained she was opening a practice, not seeking employment, and the MD could be anywhere in the state. She received no response. After many months, she found a clinical geriatric psychiatrist willing to sign the mandatory agreement for no charge and has opened a practice. Unfortunately, she remains vulnerable should her collaborator leave and she is unable to secure another collaborating MD.

Case #2: An APRN contacted the state Medical Society, and was promised a reference to a collaborating MD for her diabetic practice and never heard back. After several months, she called only to be told "there were no open positions." Unable to open a practice, she accepted employment with a school-based health clinic.

Case #3: An APRN attempted to start a practice providing health care services for people with disabilities living in group homes. She was able to find a physician as a collaborator at a price of $1000 per quarter with the understanding that this price could go up if the practice was successful; however, the high fee ultimately caused the APRN to close her practice. She works now in a general medical practice.

Case #4: An APRN with expertise in endocrinology decided to open her own practice after separating from a physician practice. She was unable to find a collaborator willing to sign for little or no payment. Despite this, demand for her services increased, so she entered an agreement with a "collaborating" physician who required 70% of her reimbursement for her four days of practice. After one year, the physician wanted to increase his percentage and add another day to collect more revenue from the APRN. During that year, she had collaborated on patient care with him three times and asked him three questions. The APRN left this practice due to the unreasonable collaboration fees. She is in the process of establishing an office with a new "collaborating" physician. Of note, the insurance company is interested in establishing long-term care practice with APRNs; the company has not been able to secure collaborative agreements and is thus unable to launch this initiative.

Case #5: An APRN started her own practice and was charged $30,000 per year for collaboration with a physician. The APRN was fortunate to find another physician "collaborator" after one year, who provided the signature on the agreement at no charge.

Case #6: An APRN with psychiatric expertise relocated to Connecticut in 2009 after 16 ½ years maintaining a practice with Medicaid patients in a state where APRNs are not required to have physician presence in the business. In seeking a collaborator in Connecticut, she contacted a physician friend willing to be her collaborator for $6000/year—the amount he stated his malpractice would increase to list her as a collaborator. She has not opened a practice here, and has taken work with a psychiatric practice.

4. Brief Summary of State or Federal Laws Governing the Profession:

Chapter 378 – Nurse Practice Act: governs education, licensure, certification requirements, prescriptive authority and mandates a collaborative agreement with a physician in the same field as a threshold to practice. Relevant sections include:

Section 20-87a: Requires APRNs who are not CRNAs to maintain a collaborative agreement with a physician as a requirement of practice, defines collaboration, and requires the mandatory agreement to be in writing regarding prescriptive authority.

Section 20-94b – Nurse Practice Act: requires APRNs who are not certified as nurse anesthetists to have a written collaborative agreement with a physician in order to prescribe.

Section 20-94c – Nurse Practice Act: requires APRNs who are not certified as nurse anesthetists to hold professional liability insurance "not less than five hundred thousand dollars for one person, per occurrence, with an aggregate of not less than one million five hundred thousand dollars…"

Chapter 420b – Dependency Producing Drugs Act: sets out the legal authority for pharmacists to fill and dispense controlled substances prescribed by authorized providers, including APRNs.

5. Current State Regulatory Oversight of the Profession

The practice of APRNs in Connecticut is subject to State regulation in several aspects:

- The State Board of Examiners for Nursing (SBEN) has jurisdiction in determining whether particular actions or procedures fall within the APRN scope of practice.

- The State Department of Consumer Protection Drug Division has jurisdiction over the APRN's license to prescribe controlled substances (co-existing with a similar federal license from the Drug Enforcement Agency); the agency regulates other prescribing professions in an identical manner.

- The Department of Public Health oversees APRN's eligibility for licensure and investigates complaints regarding APRNs.

6. All Current Education, Training, and Examination Requirements and Any Relevant Certification Requirements Applicable to the Profession

APRNs in Connecticut are required by Section 20-94a to have a master's degree in nursing or a related field allowing the individual to become certified as an APRN.[18] To gain licensure, an APRN must hold a national board certification from one of the certifying bodies recognized in statute, and must provide proof that at least thirty hours of education in pharmacology has been completed. Periodic mandatory recertification by the recognized certifying bodies assures that APRNs maintain currency in their field of practice.

7. Summary of Known Scope of Practice Changes Requested or Enacted Concerning the Profession in the Five Years Preceding the Request

2007 Raised Bill No. 7161 (File #458) AN ACT REVISING THE DEFINITION OF ADVANCED NURSING PRACTICE - Died on House calendar. This bill would have removed the mandate for a collaborative agreement.

2009 Raised Bill No. 6674 AN ACT CONCERNING WORKFORCE DEVELOPMENT AND IMPROVED ACCESS TO HEALTH CARE SERVICES – Died in Committee. This bill would have removed the mandate for a collaborative agreement.

2009 PA09-7 AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING GENERAL GOVERNMENT AND MAKING CHANGES TO VARIOUS PROGRAMS – This Act repealed a deletion in PA09-187 that removed the authority of APRNs to certify disabilities for special license plates (authority that was obtained in PA 04-199).

2010 Substitute Bill No. 192 AN ACT CONCERNING THE LISTING OF ADVANCED PRACTICE REGISTERED NURSES IN MANAGED CARE ORGANIZATION PROVIDER LISTINGS, AND PRIMARY

[18] There is a grandfathering provision for persons certified for practice as an APRN prior to December 31, 1994.

CARE PROVIDER DESIGNATIONS – File #291 Died on House Calendar

2011 PA 11-199 AN ACT CONCERNING THE LISTING OF ADVANCED PRACTICE REGISTERED NURSES IN MANAGED CARE ORGANIZATION PROVIDER LISTINGS, AND PRIMARY CARE PROVIDER DESIGNATIONS – Allows enrollees to choose APRNs as primary care providers

2012 PA 12-197 AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES – Changes some 20 Statutes to allow the signature of APRNs on various certification forms.

8. Extent to Which the Request Directly Affects Existing Relationships within the Health Care Delivery System

Eliminating the need for an APRN to obtain agreement from a collaborating physician as a threshold to practice would alter only the need to obtain such agreement. Actual patient care, collegial consultation and collaboration, specialty referrals and other norms of professional practice would continue without interruption or change. Patient relationships to APRNs would change to the extent that direct access would increase.

The APRN community has documented occasions where obtaining the mandatory agreement has come with an actual price tag. APRNs who are now required in individual situations to compensate a physician to obtain the required collaborative agreement would no longer need to do so, altering the current fiscal relationship once the statutory mandate is removed.

9. Anticipated Economic Impact of the Request on the Health Care Delivery System

No economic impact on the health care delivery system is anticipated as a result of granting the request to eliminate the mandatory agreement. APRNs will not alter current patient care practices, nor is reimbursement for services expected to change.

10. Regional and National Trends in Licensing of the Health Profession Making the Request and a Summary of Relevant Scope of Practice Provisions Enacted in Other States

Nineteen jurisdictions allow APRNs to practice autonomously to the full scope of their education (see Table One, Section Two, above.) In the last several years,

Colorado, Hawaii, Idaho, Vermont, North Dakota and Maryland eliminated all regulatory and statutory requirements for physician involvement in APRN practice. Of the six New England states, only two have not yet removed such practice barriers: Massachusetts and Connecticut. In our region, Vermont was the most recent to grant full scope practice for APRNs, having achieved this through regulatory reform in 2011.

11. Identification of Any Health Care Professions that can Reasonably be Anticipated to be Directly Affected by the Request, the Nature of the Impact, and Efforts Made by the Requestor to Discuss It with Such Health Care Professions

During the thirteen years since the statutory requirement for a collaborative agreement was imposed, the APRN community in Connecticut has several times asked the General Assembly to remove this requirement. Each time, the state Medical Society has objected. The APRN community thus reasonably anticipates that the Medical Society will again object to this current request. The state Medical Society has historically opposed such legislation with concerns of public safety and APRN education; the literature clearly dispels those arguments. There have been several cordial meetings with the Connecticut State Medical Society where they have expressed opposition and we have received no indication that their position has changed. We recently notified the Medical Society that we would be filing a Scope of Practice Request with the Department of Public Health.

The Connecticut Medical Society in the past has argued that lack of attention to the need to continue to develop the physician workforce would occur should APRNs be allowed to practice without the now-required agreement.[19] Connecticut policymakers, however, are aware of the need for increasing the numbers of many types of primary care providers, and have been for many years. Physicians are clearly recognized as vital to the workforce, and multiple policies to support education and retention are detailed in various policy documents.[20] Further, a 2012 study of the fiscal impact on physicians removing barriers of APRN practice found no differences in economic status between physicians practicing in states that had removed barriers to APRN practice and states that had not.[21]

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[19] Connecticut State Medical Society (March 16, 2009). Testimony in Opposition to House Bill 6674 An Act Concerning Workforce Development and Improved Access to Health Care Services, submitted to the Public Health Committee of the Connecticut General Assembly.

[20] *Governor's Hospital Strategic Task Force, Findings and Recommendations*, January 8, 2008; Holm, R., Quimby,S., & Dorrer, J. (2011). *Connecticut Health Care Workforce Assessment.*

[21] Pittman,P. & Williams, B. (2012). Physician wages in states with expanded APRN scope of practice. *Nursing Research and Practice*, (2012, Article ID 671974), 5 pages.

12. Description of How the Request Relates to the Health Care Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

The request to remove the statutory mandate for a collaborative agreement with a physician as a threshold to APRN practice would allow APRNs to practice to the full extent of their education, training and national board certification. APRNs would no longer be placed in the situation of having another profession, by dint of its title alone, serving as a gatekeeper to an APRN's ability to proffer health care to the general public.

The authors clearly identify the fact that the sample was necessarily limited to employee physicians. No evidence exists, however, to suggest in this study or elsewhere that APRNs practicing in full scope have limited physician income where physicians are self-employed.