Request for Consideration of Scope of Practice Change

Submitted to the Connecticut Department of Public Health
by the Connecticut Advanced Practice Registered Nurse Society

August 12, 2013

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 post basic 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, corrective measures,

[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).

> 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 physician in the same field does occur, it stems from the natural flow of clinical practice, much as physicians consult

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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).

with each other or with APRNs about patient care. Often, collaboration on a patient will mean consultation with a physician in the same field who is not the "collaborating physician," or even more likely with a specialist outside of the APRN's (and collaborating physician's) field. In a survey conducted with CTAPRNS membership August 1-11, 2013, 72 of 94 respondents (76 %) report collaborating with the MD who signed the mandatory agreement as the APRN deems necessary. They reported collaborating with MDs, NPs and other health care providers in the best interest of the patient as their norm. Several respondents noted that the collaborating physician had never seen any of the APRN's patients. One respondent noted that "I am asked to collaborate on HIS patients."

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.

Since our August, 2012 submission to DPH, other data-based literature has been published supporting the removal of barriers to advanced nursing practice. In December, 2012, the National Governors Association (NGA) issued a white paper on Nurse Practitioners (NPs) entitled "The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care." The NGA concluded "none of the studies in

[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.

NGA's literature review raise concerns about the quality of care offered by NPs."[7] The NGA goes on to suggest "states might consider changing scope of practice restrictions….as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care."[8]

In March, 2013, the Federal Trade Commission FTC) issued a data-based response to Representative Theresa Conroy's invitation to examine the "likely competitive impact" of HB6391, which proposed removing the mandatory agreement requirement for APRN practice. The FTC notes that "collaboration does not necessarily require direct supervision by or accountability to another licensed health care provider." The FTC concludes that removing the mandatory practice agreement would likely increase access and decrease costs while increasing patient choice.[9]

A study published in the July 2013 issue of *Health Affairs*[10] examined a national sample of Medicare beneficiaries served by nurse practitioners (NPs) over the period 1998-2010. Seventy-percent of the nurse practitioners were providing primary care in ambulatory and long-term care settings. The researchers found the greatest growth of primary care NPs (and thus patients enrolled in primary care practices) occurred in states that did not require physician involvement in NP practice and prescribing. This finding reaffirms similar findings from 1994,[11] 2004,[12] and 2012.[13] The 2012 study, by Perry, specifically finds that "NPs do 'vote with their feet.'…an NP in a state that has granted greater practice authority to NPs is less likely to move from the state than otherwise."[14]

Removing the mandatory agreement eliminates a problematic and unnecessary barrier to entrepreneurial nursing practice. Removal of such barriers is frequently termed "independent," "autonomous," or "plenary authority" practice. Parties

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[7] National Governors Association (2012). NGA Paper: The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care, page 7.

[8] *Ibid.*, Page 11.

[9] Federal Trade Commission (March 19, 2013). Letter to the Honorable Theresa W. Conroy, Connecticut State Representative.

[10] Kuo, Y.F., Loresto, F.L., Rounds, L.R., & Goodwin, J.S. (2013). States with the least restrictive regulations experienced the largest increase in patients seen by nurse practitioners. *Health Affairs,* 32(7), pp. 1236-1243.

[11] Sekscenski, E.S, Sansom, S., Bazell, C., Salmon, M.E, & Mullan, F. (1994). State practice environments and the supply of physician assistants, nurse practitioners, and certified nurse-midwives. *The New England Journal of Medicine*, 331(19), pp. 1266-1271.

[12] U.S. Department of Health and Human Services. (2004). A comparison of changes in the professional practice of nurse practitioners, physician assistants, and certified nurse midwives. HRSA Contract 230-00-0099; Kalist, D.E. & Spurr, S.J. (2004). The effect of state laws on the supply of advanced practice nurses. *International Journal of Health Care Finance and Economics*, 4(4), pp. 271-281.

[13] Perry, J.J. (October, 2012). State-granted practice authority: Do nurse practitioners vote with their feet? *Nursing Research and Practice,* vol.12. 5 pages. doi:10.1155/2012/482178.

[14] *Ibid.*, p. 2.

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.[15] However, removal of a mandatory agreement as a requirement of practice does not mean that APRNs will practice in some sort of non-collaborative vacuum. Twenty 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."[16]

2. Public Health and Safety Benefits and Risks

APRNs generally have at least a master's degree in nursing, as is required for licensure in Connecticut, further described in Section 6.

In addition to the educational requirements for APRNs, 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. As noted by the Federal Trade Commission in March, 2013[17], removing the mandatory agreement "does not otherwise change either the scope of APRN practice or established regulatory oversight of APRNs in Connecticut…"[18] The mandatory agreement components only echo the professional standards expected of nurse practitioners and other APRNS, and is not necessary for public safety; see Exhibit A for a detailed listing of professional standards for nurse practitioners.

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[15] American College of Physicians. (2010). *American College of Physicians Response to the Institute of Medicine's Report, The Futu0re of Nursing: Leading Change, Advancing Health*, p. 1 (pages unnumbered).

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

[17] Federal Trade Commission (March 19, 2013). Letter to the Honorable Theresa W. Conroy, Connecticut State Representative.

[18] *Ibid.,* p. 6

Unlike many other health professions, including physicians, APRNs have been thoroughly studied for over five decades.[19] Consistently, they are found to produce patient outcomes comparable to or exceeding those of physicians in health status and functional status, the use of the emergency department, and patient satisfaction.[20] A 2011 systematic review of studies on nurse practitioner outcomes from 1990-2008 determined there is a high level of evidence to conclude that NP outcomes are similar to those of physicians; a total of 59 studies, including 34 randomized control trials, support the finding that NP care equals that of physicians in the following:[21]

- Patient satisfaction with care and provider
- Functional status
- Self-reported perceptions of health status
- Management of blood glucose
- Management of hypertension
- Management of serum lipids
- Emergency department visits
- Hospitalization
- Mortality

A retrospective cross-sectional analysis of data collected from the US Veteran's Health Administration (VHA) from 2005-2010 determined that APRN and physician

[19] 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.

[20] Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, R.S., Gent, M., Kerigan, D.J. et al. (1974). The Burlington randomized trial of nurse practitioners. *NEJM*, 290(5), pp. 251-256; Office of Technology Assessment. (1986) Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis, NTIS order #PB87-177465; Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A., Tsai. W.Y., & Cleary, P.D. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *JAMA*, 283(1), pp. 59-68; 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), pp. 332-351; Horrocks, S., Anderson, E., & Salisbury, C. (April, 2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, pp. 819-823; Laurent, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2004). Substitution of doctors by nurses in primary care: Cochrane Review; Dierick-van Daele, A.T., Metsemakers, J.F., Derckx, E.W., Spreeiwenberg, C., & Vrijhoef, H.J. (2009). Nurse practitioners substituting for general practitioners: randomized controlled trial. *Journal of Advanced Nursing*, 65(2), pp. 391-401; 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. 230-250.

[21] 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. 230-250.

assistant visits were substantially similar to those of physicians.[22] The authors note that NPs in the VHA manage their own patient panels, and do not need physician signature or other involvement for treatments, prescriptions, orders or other documentation. The authors also note the "high burden of chronic disease" in the VHA population.[23]

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…"[24] The Healthcare Integrity and Protection Data Bank (HIPDB) "discloses reports related to final adverse actions taken against health care practitioners…"[25]

In 2012, as in previous years, the *American Journal for Nurse Practitioners* published an online analysis of this data for nurse practitioners and physicians (including those trained as osteopaths) by state representing the latest national data of this type.[26] This data has also consistently indicated the safety of APRN practice. The following table illustrates the 2011 ratios for Connecticut and for the [then] nineteen jurisdictions that allow APRNs full practice without mandatory physician involvement in practice.[27]

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

[22] Morgan, P.A., Abbott, D.H., McNeil, R.B., & Fisher, D.A. (2012). Characteristics of primary care office visits to nurse practitioners, physician assistants and physicians in United States Veterans Health Administration facilities, 2005-2010: a retrospective cross-sectional analysis. *Human Resources for Health*, 10, 8 pages.

[23] *Ibid*., p.2.

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

[25] *Ibid*. Note: As of May 6, 2013, the NPDB and HIPDB were merged, now known as NPDB. See http://www.npdb-hipdb.hrsa.gov/resources/factsheets/MergerQandA.pdf

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

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

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

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.[28] 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.
- Decreased duplication of services

3. Impact on Public Access to Health Care

[28] Rowe, J.W. (May 7, 2012). Why nurses need more authority. *The Atlantic*. See also Newhouse, R., Weiner, J., Stanik-Hutt, J., White, K.M., Johantgen, M, Steinwachs, D., Sangaro, G., Aldebron, J. and Bass, E.B. (2012). Policy implications for optimizing advanced practice registered nurse use nationally. *Policy, Politics & Nursing Practice*, 13(2), pp. 81-89.

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 may legally open 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.

APRNs who lose a collaborating physician often have difficulty finding an immediate replacement, and sometimes are unable to find any replacement. CTAPRNS surveyed members in early August, 2013, with 94 respondents. The average number of patients in an APRN panel was 1050. Twenty-two NPs (23.4%) had a negative experience with the mandatory agreement. Reasons cited include:

- Difficulty finding a collaborating physician
- Collaborating physician retired
- Collaborating physician made unreasonable demands
- Collaborating physician thought "collaboration" meant supervision
- Collaborating physician took too long to respond, and
- Collaborating physician refused to provide coverage for patients in the absence of the APRN.

Twenty-two respondents (23 %) report the mandatory collaborative agreement has a negative impact on their practice, due to the insecurity of a sustainable practice under the current requirement for a collaborative requirement as a threshold to APRN practice. Respondents noted that physician retirement, death, re-location, or other severance of the mandatory agreement, automatically renders the APRN practice illegal, despite the professional requirement of all providers that patients not be abandoned.

CTAPRNS conducted a survey in late July, 2013 of 12 APRNs owning their own practices caring for 15,629 patients. Eight APRNs (66%) had a negative experience with the collaborative agreement. Many fear having to involuntarily abandon their patients. Four APRNs had experienced a loss of the collaborating physician. Two APRNs reported finding another collaborator took a significant amount of time (six to twelve months. The other two APRNs experienced a delay of more than one year to find another collaborating physician. Two had to pay for the physician signature

on the mandatory agreement. Two APRNs saw a significant disruption in the care of their patients.

During the past years several APRNs have been unable to secure a collaborator or to replace a collaborator. According to the CTAPRNSS survey, loss of a collaborating physician occurs for a variety of reasons. These include the relocation of the collaborator out of state, the retirement of the collaborator, the transition of the collaborator to another type of practice such as hospital coverage only; this corroborates the qualitative data we have heard over the years from practicing APRNs in Connecticut (see Exhibit C for specifics). The lack of a collaborator inhibits the ability of the APRN to practice. In addition to not being able to secure a physician signature on the mandatory agreement for practice, the cost of obtaining and keeping this agreement has caused other APRN practices to close. Without a collaborator, access to care disappears for some of the most vulnerable in our state.

It is notable that nationally approximately 68% of APRNs practice in primary care settings, and often in areas with large numbers of underserved patients.[29] A 2013 study reporting on the 2012 American Association of Medical Colleges (AAMC) consumer survey found that patients with annual household incomes less than $50,000 were most likely to have seen a nurse practitioner (or physician assistant) at the most recent medical visit, which was also true for Medicaid recipients.[30] The researchers found that "younger adults were more likely than others to prefer a physician assistant or nurse practitioner or to have no preference at all."[31] Younger adults and patients with lower incomes are the patients most likely to gain insurance through the health reform efforts, with active insurance status as of January 1, 2013. Connecticut anticipates close to 400,000 individuals to obtain health care coverage through the health coverage reforms effective in 2014, including 150,000 additional Medicaid enrollees. Removing the mandatory physician "agreement" to APRN practice will undoubtedly lead to increased access to care for these and other patients, as noted by the National Governors Association[32] and the Federal Trade Commission.[33]

The current requirement for a mandatory agreement before an APRN can practice is stifling much needed innovation and access to care. 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

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[29] American Academy of Nurse Practitioners. (2012) Nurse Practitioner Facts.

[30] Dill, M.J., Pankow, S., Erikson, C. & Shipman, S. (2013). Survey shows consumers open to greater role for physician assistants and nurse practitioners. *Health Affairs*, 32(6), pp. 1135-1142.

[31] *Ibid.*, p. 1138.

[32] National Governors Association (2012). NGA Paper: The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care.

[33] Federal Trade Commission. (March 19, 2013). Letter to the Honorable Theresa W. Conroy, State Representative, Connecticut General Assembly.

are run by APRNs. A Robert Wood Johnson Foundation report issued in 2010 found that 60% of the 2 million annual patient encounters in NMHCs were patients without insurance or on state Medicaid plans.[34] 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 to those who most need it.

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 of the Nurse Practice Act: 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 of the 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 of the 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

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

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.

- In addition to Federal Drug Enforcement Agency licensure, the State Department of Consumer Protection Drug Division has jurisdiction over the APRN's license to prescribe controlled substances; 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 graduate degree in nursing or a related field allowing the individual to become certified as an APRN.[35] Prior to entering a master's or doctoral program to become an APRN, the individual must have achieved a baccalaureate degree (typically in nursing) and passed the national licensure exam for registered nurses.

Master's and doctoral nurse practitioner programs typically consist of approximately 45 credits (two year full time study) and 65 credits (three year full time study) respectively. A minimum of 500 hours in supervised clinical is required for master's programs; the doctoral (DNP) programs require 1,000 hours. Students in both types of programs study advanced health assessment, advanced pharmacology, and advanced pathophysiology in addition to acute and chronic disease assessment and treatment, professional ethics and standards, biostatistics, quantitative and qualitative research, and health policy. Doctoral students, by virtue of the expanded curriculum, have additional opportunity to engage in quality improvement projects, health informatics, and epidemiology. See Exhibits A and B, below, for details on the professional standards and competencies expected of all nurse practitioner graduates.

To gain licensure as an APRN, 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.

[35] There is a grandfathering provision regarding the educational requirements for persons certified for practice as an APRN prior to December 31, 1994.

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 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.

2013 House Bill 6391 AN ACT CONCERNING THE PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES – Died in Committee. This bill would have removed the mandatory agreement for APRN practice.

2013 House Bill 5568 AN ACT CONCERNING TARGETED HEALTH AREAS – had a strike-all amendment filed (LCO #7295) that intended to address the same issue of removing the mandatory collaborative agreement for APRN practice, although it was not called. The amendment had 79 co-sponsors.

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 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, as evidenced by responses to the August 2013 CTAPRNS membership survey, and further detailed in Exhibit C, below. 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

Removing barriers from APRN practice has positive impacts on state and federal health care costs, for several reasons. APRNs have long been documented to provide cost-effective care in primary, long term, occupational and acute care settings.[36] Cost savings include lower drug costs when compared to physicians,[37] lower per-patient costs,[38] lower visit costs,[39] and lower rates of emergency department referrals.[40] This last finding is contained in the 2009 RAND study about the Massachusetts health infrastructure reforms adopted in 2008. The study estimates cumulative state savings of 0.6 to 1.3 percent for the period 2010-2020 by allowing NPs and other "non-physician providers" to practice without mandated physician involvement. Although apparently modest, this equates to $4.2 - $8.4 billion in cumulative savings by 2020.

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[36] American Academy of Nurse Practitioners. (2010). Nurse Practitioner Cost-Effectiveness.

[37] Paez, K. & Allen, J. (2006). Cost-effectiveness of nurse practitioner management of hypercholesterolemia following coronary revascularization. *Journal of the American Academy of Nurse Practitioners.* 18(9), pp. 436-444.

[38] Coddington, J. & Sands, L. (2008). Cost of health care and quality of care at nurse-managed clinics. *Nursing Economics.* 26(2), pp. 75-94.

[39] Eibner, C., Hussey P., Ridgely M.S., & McGlynn E.A. (2009). Controlling health care spending in Massachusetts: an analysis of options. Santa Monica, CA: RAND Corporation.

[40] Traczynski, J. & Udalova, V. (2013). Nurse practitioner independence, health care utilization, and health outcomes. Available at http://www.lafollette.wisc.edu/research/health_economics/Traczynski.pdf

Further, recent research suggests that 50% of health care expenses stem from preventable conditions or preventable exacerbations of chronic conditions.[41] APRNs are known for their ability to successfully manage patients with potential or existing chronic conditions, due to the nursing focus on education, case management, and holistic assessment of the patient, family and available resources.[42]

A keystone element of the Affordable Care Act, the Patient-Centered Medical Home (PCMH) delivery model, has shown APRNs to be cost-effective in delivering care. Data was presented to the American Association of Nurse Practitioners Annual Conference June 19, 2013 by Sean Lyon, APRN and Kitty Kidder, APRN, owners and operators of the Lifelong Care PCMH practice located in New Hampshire. This APRN PCMH demonstrated a Per Member Per Month (PMPM) cost of $105.00 when compared with CIGNA average of $160.00 PMPM. The APRN cost was also less than most physician-run PCMH costs and far better than non-medical home practices. The APRN PCMH consistently performed well over time. Additionally, unnecessary presentation to the emergency room was greatly reduced; patients who presented to the emergency room truly needed to go there.

Any APRN required to pay for obtaining the agreement incurs significant business expenses in doing so, and may end up closing the practice rather than continue to pay for the required agreement. Eliminating the mandatory agreement would remove this economic impact on APRN practice.

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

Twenty jurisdictions allow APRNs to practice autonomously to the full scope of their education. In the last several years, Colorado, Hawaii, Idaho, Vermont, North Dakota, Nevada 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.

During the 2013 state legislative season, twelve states (California, Connecticut, Illinois, Kentucky, Kansas, Massachusetts, Michigan, Minnesota, North Carolina, New Jersey, Nevada, New York and Pennsylvania) sponsored legislation to remove physician involvement from APRN practice per IOM recommendations; Nevada passed its legislation. We expect at least as many states to present such legislation in the 2014 state legislative season.

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[41] Carruth, P. L. & Carruth, A. K. (Fall, 2011). The financial and cost accounting implications of the increased role of advanced nurse practitioners in U.S. healthcare. *American Journal of Health Sciences*, pp 1 – 8.

[42] Institute of Medicine (2010). The Future of Nursing: Leading Change, Advancing Health. Washington, DC: National Academies Press.

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 fourteen 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. As it stands, the removal of the mandated collaborative agreement has no direct impact on any other profession. There is no evidence to support that removing the mandatory agreement will alter APRN patient care or put patients at risk. The quality care and patient responsibility of APRN practice will continue as it exists today. Access to care will be enhanced at a time when more individuals will have health insurance. APRN practices will not be threatened with unnecessary closure and more practices can open. Lastly, cost to the health care system would be reduced by decreasing redundancies, duplication of care and costs to deliver care.

The APRN community 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 .[43] 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.[44] 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.[45]

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[43] 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.
[44] *Governor's Hospital Strategic Task Force, Findings and Recommendations*, January 8, 2008; Holm, R., Quimby,S., & Dorrer, J. (2011). *Connecticut Health Care Workforce Assessment*.
[45] 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. The

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. Removing the requirement for the mandatory agreement removes another profession from serving as a gatekeeper to an APRN's ability to offer much-needed health care to the general public. If the agreement is not sustainable, APRN practice is not sustainable.

Exhibit A - Standards of Practice for Nurse Practitioners
American Association of Nurse Practitioners[46]

I. Qualifications

Nurse practitioners are licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice (AANP 2006).

II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

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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.

[46] American Association of Nurse Practitioners, 1993; Revised 1999, 2003, 2007, 2010, 2013

A. Assessment of health status

The nurse practitioner assesses health status by:

- Obtaining a relevant health and medical history
- Performing a physical examination based on age and history
- Performing or ordering preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process
- Synthesizing and analyzing the collected data
- Formulating a differential diagnosis based on the history, physical examination and diagnostic test results
- Establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests
- Prescribing or ordering appropriate pharmacologic and non-pharmacologic interventions
- Developing a patient education plan
- Recommending consultations or referrals as appropriate

D. Implementation of the plan

Interventions are based upon established priorities. Actions by the nurse practitioners are:

- Individualized
- Consistent with the appropriate plan for care
- Based on scientific principles, theoretical knowledge and clinical expertise
- Consistent with teaching and learning opportunities

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

III. Care Priorities

The nurse practitioner's practice model emphasizes:

A. Patient and family education

The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family

B. Facilitation of patient participation in self care.

The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:

- Promotion, maintenance and restoration of health
- Consultation with other appropriate health care personnel
- Appropriate utilization of health care resources

C. Promotion of optimal health

D. Provision of continually competent care

E. Facilitation of entry into the health care system

F. The promotion of a safe environment

IV. Interdisciplinary and Collaborative Responsibilities

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible and confidential records.

VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

A. Participation in quality assurance review, including the systematic, periodic review of records and treatment plans

B. Maintenance of current knowledge by attending continuing education programs

C. Maintenance of certification in compliance with current state law

D. Application of standardized care guidelines in clinical practice

VIII. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families and other professionals.

IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

Exhibit B - 2012 Nurse Practitioner Core Competencies
National Organization of Nurse Practitioner Faculty (NONPF)
available at
http://www.nonpf.com/associations/10789/files/NPCoreCompetenciesFinal2012.pdf

Scientific Foundation Competencies

1. Critically analyzes data and evidence for improving advanced nursing practice.
2. Integrates knowledge from the humanities and sciences within the context of nursing science.
3. Translates research and other forms of knowledge to improve practice processes and outcomes.
4. Develops new practice approaches based on the integration of research, theory, and practice knowledge

Leadership Competencies

1. Assumes complex and advanced leadership roles to initiate and guide change.

2. Provides leadership to foster collaboration with multiple stakeholders (e.g. patients, community, integrated health care teams, and policy makers) to improve health care..
3. Demonstrates leadership that uses critical and reflective thinking.
4. Advocates for improved access, quality and cost effective health care.
5. Advances practice through the development and implementation of innovations incorporating principles of change.
6. Communicates practice knowledge effectively both orally and in writing.
7. Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.

Quality Competencies

1. Uses best available evidence to continuously improve quality of clinical practice.
2. Evaluates the relationships among access, cost, quality, and safety and their influence on health care.
3. Evaluates how organizational structure, care processes, financing, marketing and policy decisions impact the quality of health care.
4. Applies skills in peer review to promote a culture of excellence.
5. Anticipates variations in practice and is proactive in implementing interventions to ensure quality.

Practice Inquiry Competencies

1. Provides leadership in the translation of new knowledge into practice.
2. Generates knowledge from clinical practice to improve practice and patient outcomes.
3. Applies clinical investigative skills to improve health outcomes.
4. Leads practice inquiry, individually or in partnership with others.
5. Disseminates evidence from inquiry to diverse audiences using multiple modalities.
6. Analyzes clinical guidelines for individualized application into practice

Technology and Information Literacy Competencies

1. Integrates appropriate technologies for knowledge management to improve health care.
2. Translates technical and scientific health information appropriate for various users' needs.

2a) Assesses the patient's and caregiver's educational needs to provide effective, personalized health care.

2b). Coaches the patient and caregiver for positive behavioral change.

3. Demonstrates information literacy skills in complex decision making.
4. Contributes to the design of clinical information systems that promote safe, quality and cost effective care.
5. Uses technology systems that capture data on variables for the evaluation of nursing care.

Policy Competencies

1. Demonstrates an understanding of the interdependence of policy and practice.
2. Advocates for ethical policies that promote access, equity, quality, and cost.
3. Analyzes ethical, legal, and social factors influencing policy development.
4. Contributes in the development of health policy.
5. Analyzes the implications of health policy across disciplines.
6. Evaluates the impact of globalization on health care policy development.

Health Delivery System Competencies

1. Applies knowledge of organizational practices and complex systems to improve health care delivery.
2. Effects health care change using broad based skills including negotiating, consensus-building, and partnering.
3. Minimizes risk to patients and providers at the individual and systems level.
4. Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders.

5. Evaluates the impact of health care delivery on patients, providers, other stakeholders, and the environment.
6. Analyzes organizational structure, functions and resources to improve the delivery of care.
7. Collaborates in planning for transitions across the continuum of care.

Ethics Competencies

1. Integrates ethical principles in decision making.
2. Evaluates the ethical consequences of decisions.
3. Applies ethically sound solutions to complex issues related to individuals, populations and systems of care.

Independent Practice Competencies

1. Functions as a licensed independent practitioner.
2. Demonstrates the highest level of accountability for professional practice.
3. Practices independently managing previously diagnosed and undiagnosed patients.

3a). Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end of life care.

3b). Uses advanced health assessment skills to differentiate between normal, variations of normal and abnormal findings.

3c). Employs screening and diagnostic strategies in the development of diagnoses.

3d). Prescribes medications within scope of practice.

3e). Manages the health/illness status of patients and families over time.

4. Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making.

4a). Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration.

4b). Creates a climate of patient-centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect.

4c). Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care.

4d). Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care.

Exhibit C - Specific Cases of APRN Experience of Practice Barriers Related to the Mandatory Collaborative Agreement

Case #1: An APRN with her own practice learned in late July, 2013 that her collaborator was relocating to another state in two months. Her panel of 400 patients have relied on her since 2005; she has less than 90 days to make arrangements that will either allow her to continue to practice or to steer her patients to another provider. The loss of the collaborating agreement has placed her practice in peril and yet has nothing to do with the quality of her care.

Case #2: An APRN attempted to start a practice providing health care services for people with disabilities living in group homes an underserved population. 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 has gone back to school for her DNP. She would like to open a practice but feels this could never be possible for her based upon current practice restrictions.

Case #3: An APRN lost her collaborating MD, forcing her to leave her position resulting in lost wages, vacation, sick time benefits, retirement and medical insurance. She chose to leave

than to work in an environment illegally. Recently, this APRN opened a practice in Rhode Island stating she could not wait for CT to change their requirements.

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. Of this 40% went to overhead and billing expenses and 30% was his profit. 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. It took her almost a year to find another collaborator with a lapse for her patients in care that was made worse when she had to be re-credentialed on all health plans. She currently has a new practice with another collaborating MD but fears unreasonable demands to maintain this agreement may force her to close her practice once again.

Case #5: An insurance company is interested in establishing long-term care practice with APRNs providing home visits; the company has not been able to secure collaborative agreements and is thus unable to launch this initiative.

Case #6: An APRN started her own practice and was charged $30,000 per year for collaboration with a physician several years ago. The APRN was fortunate to find another physician "collaborator" after one year, who provided the signature on the agreement at no charge. This APRN currently has a successful practice with a collaborating MD serving 2000 patients.

Case #7: 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.

Case #8: An APRN with wound care expertise services patients in long-term, sub-acute and acute care settings. Her collaborating MD is approaching retirement. Given her setting and past experience in the APRN community, it will likely be hard to find a willing physician to be her collaborator; she worries the cost of signing an agreement may force her to close her practice. She saves patients and facilities significant transportation expenses, as she goes to their location. Patients may be faced with having to be transported to a wound care clinic, a cost many patients and facilities may not be able to bear, in addition to likely substantial wait times for access to the specialty clinics.

Case #9: A psychiatric APRN works in a not-for-profit clinic serving 2000 patients. The collaborating MD is close to retiring. There is a great fear these vulnerable patients will be left with a lapse in care. This APRN also has a private practice with a collaborating MD who will be transitioning to New York City; this collaborator also has agreements with 20 other APRNs. It is doubtful another collaborator will be willing to take on these APRNs. This will leave patients with a lapse in care.

Case #10: A Primary Care APRN with 2000 patients has a collaborating MD soon to retire. She has begun the process of location a replacement. Several MDs had concerns after contacting

their malpractice insurance carrier that their costs will increase. One MD offered to sign an agreement for $10,000 per year, a cost too steep for her business and she may be forced to close her practice.

Case #11: A psychiatric APRN had three episodes of collaboration separation. The first, on the advice of her attorney, the collaborating MD abruptly severed the agreement. The second involved the collaborating MD whose license was suspended due to prescribing practices. The next psychiatrist only provided the agreement for a few months. Now there are 7 APRNs with a panel of 2000 patients sharing the same psychiatrist, each paying a stipend for the signed agreement.

Case #12: An APRN provides in-home care to dementia and patients with memory problems. It took her 12 months to find a collaborating MD. These are vulnerable elderly and senior patients who would have difficulty finding care if this APRN practice were to close. She reports that her collaborating MD is currently entertaining offers for his own career which threaten the agreement, thus placing her practice in jeopardy.

Case #13: An APRN had issues with laboratory testing from a hospital that would not recognize her as an ordering provider. They wanted the orders signed by an MD. This resulted in many laboratory results going to another MD delaying care and potentially causing undue harm to patients.

Case #14: A psychiatric APRN had difficulty finding a psychiatrist willing to sign the collaborative agreement. She finally found someone who will sign the agreement for a $300 per hour fee.

Case #15: A psychiatric APRN has a 73 year old collaborating psychiatrist who she is fearful will retire leaving 300 patients with a lapse in care.

Case #16: In 2008, an APRN was without a signed agreement after the MD abruptly left. The newly hired MD refused to sign an agreement. The APRN had to contact the Department of Public Health to intervene. Because the APRN could no longer legally diagnose and treat, patients were turned away from the center. Four months later, an agreement was signed.

Case #17: An APRN left a practice in Waterbury after 15 years to move to Cheshire. It took her several months to find a collaborating MD leaving her patients with a lapse in care.

Case #18: Recently, an APRN was brought before the Department of Public Health for alleged absence of a valid collaborative agreement. The concern stemmed from the lack of a signature on the document by the collaborating MD. Her collaborating psychiatrist met with her on several occasions and the psychiatrist billed her for this service. Both parties were acting in concert with the written collaborative agreement. Following the pre-hearing review, the Nursing board agreed a valid agreement was in place and withdrew any charges. Even a low level disciplinary action in this case could have disproportionate impact on this APRN's livelihood, future employment and third party reimbursement, as well as the patients who could lose a provider, even though there was no issue with the care rendered by the APRN.