

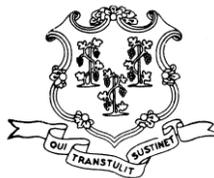


Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on
Advanced Practice Registered Nurses

Jewel Mullen, MD, MPH, MPA, Commissioner
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State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

State of Connecticut
Department of Public Health
Report to the General Assembly

An Act Concerning the Department of Public Health’s Oversight
Responsibilities relating to Scope of Practice Determinations for Health Care
Professions: Advanced Practice Registered Nurses

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Executive Summary

In accordance with Connecticut General Statutes, Sections 19a-16d through 19a-16f, inclusive, the Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) submitted a scope of practice request to the Department of Public Health to eliminate the requirement for the mandatory collaborative practice agreement with a physician. In doing so, one of their goals is to allow licensed advanced practice registered nurses the flexibility to establish independent practices while continuing to collaborate with a variety of health care providers, including physicians. CTAPRNS asserts that the mandatory collaborative agreement serves no public safety or quality assurance purpose, and presents significant negative impacts on health care cost and access to care.

In 2010, the Institute of Medicine (IOM) issued its report entitled “The Future of Nursing: Leading Change, Advancing Health.” This report included specific recommendations to Congress, state legislatures, the Centers for Medicare and Medicaid Services, the Federal Trade Commission and others aimed at addressing several key messages including, but not limited to, the concept that nurses should practice to the full extent of their education and training. Specific recommendations relevant to this scope of practice discussion include:

- *Remove scope of practice barriers*
Advanced practice registered nurses should be able to practice to the full extent of their education and training
- *Expand opportunities for nurses to lead and diffuse collaborative improvement efforts*
Private and public funders, health care organizations, nursing education programs and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These organizations should also provide opportunities for nurses to diffuse successful practices.
- *Implement nurse residency programs*
State Boards of Nursing, accrediting bodies, the federal government and health care organizations should take action to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a pre-licensure or advanced practice degree program or when they are transitioning into new clinical practice areas.

The scope of practice review committee reviewed and evaluated all of the information provided in CTAPRNS’ scope of practice request as well as additional information that was requested and provided as a result of committee discussions. In reviewing and evaluating the information presented, the scope of practice committee focused on assessing any public health and safety risks associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession’s education and training.

The Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) provided documentation from numerous studies demonstrating that advanced practice registered nurses provide safe, high-quality care. These studies found that APRNs produce patient outcomes that are comparable to, or in some instances exceed, those of physicians in areas such as patient health status and functional status, use of emergency departments and patient satisfaction. Additionally, evidence provided from practice experience in other states where there is no requirement for a physician collaborative agreement demonstrates that removal of the agreement creates an environment in which APRNs are able to expand current practice and explore other options for delivering primary care services.

The documentation reviewed by the committee supports that an APRN's ability to practice independently should be directly linked to the APRN's education, training and maintenance of competency through national board certification. Several committee members expressed significant concerns with the proposal to remove the mandatory collaborative agreement, including, but not limited to, issues related to what they believe to be deficiencies in the education, training and certification requirements for APRNs when compared to those required for physicians and physician assistants. There was however no evidence or data provided as part of the scope of practice review process to validate that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk, or that that patients are at risk or care has deteriorated in other states where there is no required collaborative practice agreement. The committee also discussed the importance of mentoring newly licensed and certified health care providers, whether they are APRNs, physicians or other practitioners, to the practice environment and requiring some type of residency or other "transition-to-practice" program to provide a mechanism for the practitioner to optimize clinical competency in the practice environment before they practice independently. Working toward establishing residency or "transition-to-practice" programs for nurses, after they have completed advanced practice degree programs or when they are transitioning into new clinical practice areas, aligns with the recommendations included in the 2010 Institute of Medicine report on the future of nursing. In states where the requirement for the mandatory collaborative agreement has already been eliminated and where there is documentation demonstrating that patient outcomes have been favorable, residency programs have not been established.

Documentation of practice experience in other states where there is no requirement for a physician collaborative agreement supports removing barriers that negatively impact an APRN's ability to practice to the full extent of her or her education and training, and enhances access to quality and affordable health care. The evidence provided by CTAPRNS in support of their scope of practice request also revealed that there can be substantial risks for the APRN as well as his or her patients associated with establishing a private practice with the current requirement for maintaining a written collaborative practice agreement. For example, if the collaborating physician abruptly terminates the collaborative agreement for any reason, such as death or retirement, the APRN is placed in an untenable dilemma of practicing without legal authority despite the professional ethical requirement not to abandon patients. Some of these barriers have been mitigated in settings such as group practices, hospitals or other large health systems. Physicians who practice in settings such as group practices, hospitals or other large

health systems where physicians, APRNs, physician assistants and others work together as a team, indicated that it is not the mandatory collaborative agreement or “piece of paper” that drives their collaborative practice with APRNs but rather the mutually respectful, educational and responsible team relationship that develops over time working together and the need for collegial interactions to ensure patients’ health care needs are being met. Committee members agree that a team approach to providing care that includes multidisciplinary collaboration is critical. Although the mandatory physician collaborative agreement does not in and of itself necessarily limit an APRN’s ability to practice to the full extent of his or her education and training, evidence was provided during the scope of practice review process to demonstrate that the required collaborative agreement has become a barrier to practice for many APRNs and that eliminating barriers enhances access to quality and affordable health care.

In 2012 the National Governors Association (NGA) issued a paper titled “*The Role of Nurse Practitioners in Meeting increasing Demands for Primary Care.*” Findings from this report include:

- Nurse practitioners may be able to mitigate current and projected shortages of primary care services.
- Existing research suggests that nurse practitioners can perform a subset of primary care services as well as or better than physicians.
- Expanded utilization of nurse practitioners has the potential to increase access to health care, particularly in historically underserved areas.

The NGA report also indicates that none of the studies included in their literature review raised concerns about the quality of care offered by nurse practitioners and that most of the studies they evaluated showed that care provided by nurse practitioners is comparable to physician-provided care on several process and outcome measures. The report indicated that the evaluated studies suggest that nurse practitioners may provide improved access to care. Evidence provided in support of the CTAPRNS’ scope of practice request also demonstrates improvements in access to care in states where there is no requirement for a physician collaborative agreement. There was no documentation or evidence provided to refute these findings.

Documentation that was provided in support of their request to eliminate the mandatory collaborative agreement substantiates that in other states where there is no mandatory collaborative agreement there have been cost savings including lower drug costs, lower per-patient costs, lower visit costs and lower costs associated with lower rates of emergency department referrals. No specific data relative to costs in Connecticut is available. It was suggested that if a proposal to eliminate the requirement for a collaborative agreement move forward, data regarding any costs savings should be tracked.

Limitations associated with the APRN scope of practice and the requirement for a collaborative agreement are not the only barriers that impact an APRN’s ability to practice to the full extent of his or her education and training. Other Federal and state laws and regulations and/or accreditation standards or other rules governing areas including, but not limited to, reimbursement, admitting privileges, ordering and evaluating tests, and frequency of APRN and physician visits, also restrict APRNs from practicing to the full extent of their education and training. The scope of practice committee

acknowledged the existence of these additional barriers however, they are outside the purview of this scope of practice review process. Although eliminating the mandatory collaborative agreement would enhance an APRN's ability to practice to the full extent of his or her education and training, it would not remove these additional barriers.

Background

Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions, established a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of Sections 19a-16d through 19a-16f, inclusive, of the Connecticut General Statutes, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;
2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member and chairperson of the committee.

The Commissioner of Public Health was also authorized to expand the membership of the committee to include other representatives from other related fields if it was deemed beneficial to a resolution of the issues presented.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) submitted a scope of practice request to eliminate the requirement for the mandatory collaborative practice agreement with a physician. In doing so, their goals include allowing licensed Advanced Practice Registered Nurses the flexibility to establish independent practices while continuing to collaborate with a variety of health care providers, including physicians. CTAPRNS anticipates that eliminating the requirement for the collaborative agreement will have no impact on collegial consultation and collaboration among health care providers, specialty referrals and other expected professional practices, and that patient care would continue without interruption or change.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by CTAPRNS were received from several individuals and organizations:

- AARP
- American Psychiatric Nurses Association CT Region
- Community Health Center, Inc.
- Connecticut Academy of Family Practitioners
- Connecticut Academy of Physician Assistants
- Connecticut Association of Nurse Anesthetists
- Connecticut Chapter of the National Association of Pediatric Nurses and Practitioners
- Connecticut Coalition of Advanced Practice Nurses
- Connecticut ENT Society
- Connecticut Dermatology & Dermatologic Surgery Society
- Connecticut Urology Society
- Connecticut Hospital Association
- Connecticut Nurses Association
- Connecticut Psychiatric Society
- Connecticut Society of Eye Physicians
- Connecticut Society of Radiologic Technologists
- Connecticut State Medical Society
- Erin McCarthy

- Danielle Morgan, APRN
- Henry Schneiderman, M.D.
- Edward Volpintesta, MD

Several of these individuals and organizations are supportive of eliminating the requirement for the mandatory collaborative practice agreement. While the other organizations indicated a willingness to discuss how barriers to obtaining and maintaining the collaborative agreement can be addressed, they are not supportive of an independent practice model. All of the impact statements that were received by the Department of Public Health in accordance with the statutorily mandated submission date are included in the Appendix. CTAPRNS submitted written responses to the impact statements, which were reviewed by the scope of practice review committee and are also included in the Appendix.

Scope of Practice Review Committee Membership

In accordance with the provisions of Connecticut General Statutes, Section 19a-16e, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the CTAPRNS. The committee established for this scope of practice request included representation from:

1. AARP
2. American Psychiatric Nurses Association CT Region
3. Community Health Center, Inc.
4. Connecticut Academy of Family Practitioners
5. Connecticut Academy of Physician Assistants
6. Connecticut Advanced Practice Registered Nurse Society
7. Connecticut Association of Nurse Anesthetists
8. Connecticut Chapter of the National Association of Pediatric Nurses and Practitioners
9. Connecticut Coalition of Advanced Practice Nurses
10. Connecticut ENT Society
11. Connecticut Dermatology & Dermatologic Surgery Society
12. Connecticut Urology Society
13. Connecticut Hospital Association
14. Connecticut Nurses Association
15. Connecticut Psychiatric Society
16. Connecticut Society of Eye Physicians
17. Connecticut Society of Radiologic Technologists
18. Connecticut State Medical Society

19. Erin McCarthy
20. Danielle Morgan, APRN
21. Henry Schneiderman, M.D.
22. Edward Volpintesta, MD; and
23. The Commissioner of Public Health's designee (chairperson and ex-officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

CTAPRNS's scope of practice request included all of the required elements identified in Connecticut General Statutes Section 19a-16d. Relevant information is outlined below.

Health & Safety Benefits

The Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) provided documentation from numerous studies demonstrating that advanced practice registered nurses provide safe, high-quality care. These studies found that APRNs produce patient outcomes that are comparable to, or in some instances exceed, those of physicians in relation to patient health status and functional status, use of emergency departments and patient satisfaction. This evidence provided by CTAPRNS in support of their request concluded that APRN care is equivalent to physicians in the following areas:

- 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; and
- Mortality.

CTAPRNS and other committee members also identified multiple potential benefits of allowing APRNs to practice to the full extent of their education and training without requiring a physician collaborative agreement. APRNs are known for their emphasis on holistic patient care, prevention, health promotion and living well with chronic conditions. Evidence provided from practice experience in other states where there is no requirement for a physician collaborative agreement demonstrates that removal of the agreement creates an environment in which APRNs are able to expand current practice and explore

other options for delivering primary care services. Additional benefits in these other states have included:

- Increased access to health care which will become increasingly important as the number of insured individuals and families is expected to increase with further implementation of the Affordable Care Act;
- Increased choice for patients concerning health care providers;
- Ability for APRNs to spend additional time with patients;
- Decreased costs over time related to increased disease prevention and health promotion activities; and
- Reduction in duplication of services.

Although many of the representatives from the physician organizations participating on the scope of practice review committee indicated that they are extremely uncomfortable with the proposal to remove the mandatory collaborative agreement and have identified strong concerns regarding public health and safety, there was no substantive evidence or data provided to demonstrate that patient care would be at risk if the collaborative agreement was removed for APRNs who have received adequate education and training as well as mentoring in the practice environment. They caution that without carefully evaluating each of the studies provided in support of the CTAPRNS' request as well as any studies to the contrary, conclusions regarding health safety and benefits should not be drawn. It should be noted that there were no contrary studies provided to the committee for review.

In The Physicians Foundation November 2012 report titled *“Accept No Substitute: A Report on Scope of Practice,”* the authors specifically note that there is a lack of evidence and few, if any, studies available to “refute the growing body of research presented by non-physicians and their advocates that tends to show that their clinical outcomes are at least as good as those of physicians.” The report also recognizes that despite methodological flaws and limitations identified by physicians in reviewing the many studies regarding the safe practice of APRNs, conclusions have been drawn that nurse practitioners can provide primary care as well as physicians. The report indicates that it is possible that these conclusions may have been based on the cumulative weight of a substantial number of studies however one study cited in this report does state that “the findings suggest that nurses and doctors generate similar health outcomes for patients, at least in the short-term, over the range of care investigated.” *Note:* The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and help facilitate the delivery of health care to patients.

Access to Health care

In their November 2012 report titled *“Accept No Substitute: A Report on Scope of Practice,”* The Physicians Foundation found that along with cost-savings, the argument most frequently used in

support of expanding the scope of practice of non-physicians is that it will increase the public's access to care. They cite, for example, the Institute of Medicine's report on the future of nursing which highlights the issue of access calling for expanded scope of practice: "To ensure that all Americans have access to needed health care services and that nurses' unique contributions to the health care team are maximized, federal and state actions are required to update and standardize scope-of-practice regulations to take full advantage of the full capacity and education of APRNs [Advanced Practice Registered Nurses]." The authors draw additional attention to the fact that supporters have used the projected increase in the number of insured Americans under the federal Affordable Care Act as another compelling reason for states to expand the scope of practice of non-physician providers. The medical community has also acknowledged that enactment and implementation of the Affordable Care Act would result in increased pressure on state legislatures to loosen existing restrictions on scope of practice because of the current shortage in the number of primary care providers. It is anticipated that removing barriers that negatively impact an APRN's ability to practice to the full extent of his or her education and training will enhance access to quality and affordable health care.

Barriers associated with the mandatory collaborative practice agreement

APRNs practice in a variety of settings and in accordance with current law they may legally open private practices provided they have a collaborating physician and a written collaborative agreement if exercising prescriptive authority. APRN practices in which prescriptive authority is not exercised are virtually non-existent. The evidence provided by CTAPRNs in support of their scope of practice request demonstrated that there can be substantial risks for the APRN as well as his or her patients associated with establishing a private practice, with the current requirement for maintaining a written collaborative practice agreement. If the collaborating physician abruptly terminates the collaborative agreement for any reason (e.g., retirement, relocation or death), the APRN is placed in an untenable dilemma of practicing without legal authority despite the professional ethical requirement not to abandon patients. Hundreds of patients can be left, suddenly and unexpectedly, without a health care provider until the APRN is able to secure another collaborating physician. Additionally, when an APRN practice is forced to close, the APRN must come off insurance panels and reapply after finding another collaborating physician. This process can take up to six months, often leaving patients without care and often no choice but to find another provider. Under these circumstances, the suspension of the APRN's ability to practice is not directly related to his or her skill or fitness for practice, but hinges solely on his or her ability to enter into a new collaborative agreement.

However, these barriers have been mitigated and APRNs are able to practice to the full extent of their education and training in many settings such as group practices, hospitals or other large health systems. Physicians who practice in settings such as group practices, hospitals or other large health systems where physicians, APRNs, physician assistants and others work together as a team, indicated that it is not the mandatory collaborative agreement or "piece of paper" that drives their collaborative practice with APRNs but rather the mutually respectful, educational and responsible team relationship that develops over time working together and the need for collegial interactions to ensure patients' health

care needs are being met. While this type of relationship can develop when an APRN establishes his or her own private practice, the challenges of establishing the same type of collaborative practice arrangement and relationship in an independent practice setting are of concern to many physicians. This setting is where these practice barriers are most significant and raise the most concern for these physicians. The committee discussed the importance of mentoring newly licensed and certified health care providers, whether they are APRNs, physicians or other practitioners, to the practice environment and requiring some type of residency or other “transition-to-practice” program to provide a mechanism for the practitioner to optimize clinical competency in the practice environment before they practice independently. Working toward establishing residency or “transition-to-practice” programs for nurses, after they have completed advanced practice degree programs or when they are transitioning into new clinical practice areas, aligns with the recommendations included in the 2010 Institute of Medicine report on the future of nursing. In states where the requirement for the mandatory collaborative agreement has already been eliminated and where there is documentation demonstrating that patient outcomes have been favorable, residency programs have not been established.

Restrictions outlined in employment agreements in any setting will always exist. Regardless of the health care profession, employer constraints concerning practice parameters can be and are often more stringent than what a scope of practice law may allow. Entering into an employment agreement with added restrictions is a personal choice for a practitioner that cannot be regulated through scope of practice provisions.

2012 National Governors Association Paper entitled “The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care

In 2012, the National Governors Association (NGA) issued a paper entitled “*The Role of Nurse Practitioners in Meeting increasing Demands for Primary Care.*” The paper summarizes the NGA’s review of literature and state rules governing nurse practitioner scope of practice to answer three questions pertaining to the role of nurse practitioners in meeting the increasing demand for primary care:

- 1) To what extent do scope of practice rules for NPs, as well as licensure and other conditional requirements, vary across states?
- 2) To what extent do states’ rules and requirements for NPs deviate from evidence-based research of appropriate activities for NPs?
- 3) Given current evidence, what would be the effect of changes to state scope of practice laws and regulations on health care access and quality?

The NGA’s review of the written laws and regulations governing nurse practitioners revealed wide variation among the states. Most notably, there is great variance related to rules governing scope of practice including prescriptive authority and level of physician oversight. The report indicates that none of the studies included in the NGA’s literature review raised concerns about the quality of care offered by nurse practitioners and that most of the studies that were evaluated showed that care provided by

nurse practitioners is comparable to physician-provided care on several process and outcome measures. The report also indicated that the evaluated studies suggest that nurse practitioners may provide improved access to care.

The NGA did however also recognize limitations associated with their review. “Although there is a growing body of evidence from health services research that suggests that NPs can deliver certain elements of primary care as well as physicians, there is a dearth of rigorous research that isolates the effect of NP scope of practice rules on health care quality, cost, and access at the state level. No studies included in this review were designed to measure differences in health care quality, access, or costs between states with more and less restrictive scope of practice laws.”

The NGA review maintains that “the demand for primary care services in the United States is expanding as a result of the growth and aging of the U.S. population and the passage of the 2010 Affordable Care Act, and this trend is expected to continue over the next several years.” The report concludes that:

- Nurse practitioners may be able to mitigate projected shortages of primary care services.
- Existing research suggests that nurse practitioners can perform a subset of primary care services as well as or better than physicians.
- Expanded utilization of nurse practitioners has the potential to increase access to health care, particularly in historically underserved areas.

The NGA’s literature review suggests that nurse practitioners are “well qualified to deliver certain elements of primary care.” As such, the NGA recommended that “states might consider changing scope of practice restrictions and assuring adequate reimbursement for services as a way of encouraging and incentivizing greater nurse practitioner involvement in the provision of primary health care.”

The Federal Trade Commission

More recently, the Federal Trade Commission (FTC) has also begun to weigh in on scope of practice legislation. In 2013, FTC staff commented on a pending bill in CT and stated that eliminating the requirement for the mandatory requirement for a collaborative agreement could benefit Connecticut health care consumers by expanding choices for patients, containing costs and improving access to primary health care services. The FTC staff recognized that collaboration between APRNs and other health care providers is beneficial but such collaboration doesn’t require direct supervision of one licensed health care provider by another. FTC staff specifically stated in the letter: “Given the potential benefits of eliminating unwarranted impediments to APRN practice we recommend that the Connecticut Legislature seek to ensure that statutory limits on APRNs are no stricter than patient protection requires. We encourage the Legislature to carefully consider available safety evidence on APRN practice in Connecticut and elsewhere. Absent a finding that there are countervailing safety concerns, the FTC supports that legislation to remove the mandatory collaborative agreement appears to be a pro-competitive improvement in the law that would benefit Connecticut health care consumers.”

A press release regarding this letter indicates that the FTC's comments are part of their efforts to promote competition in the health care sector, which benefits consumers through lower costs, better care and more innovation. In 2012, the FTC also commented on similar legislation that was proposed in Louisiana which would have removed the requirement for a physician collaborative agreement for APRNs who practice in medically underserved areas or who treat medically underserved populations. In reviewing the pending legislation in Louisiana, the FTC specifically noted that Federal and state reports on the topic of primary care provider shortages, as well as the Institute of Medicine's report on the future of nursing, stressed that excessive regulation restricts and impedes an APRN's ability to help alleviate shortages.

It is important to note that there is disagreement among members of Congress and others as to whether or not the FTC should comment on or be involved in scope of practice disputes and whether their actions conflict with the legislatively mandated responsibility of state health regulatory boards to make policy determinations to protect the public. Nursing organizations from around the country as well as the AARP have expressed their support for the FTC's involvement in scope of practice issues such as this.

Evidence provided in support of the CTAPRNS' scope of practice request demonstrates some improvements in access to care in states where there is no requirement for a physician collaborative agreement. CTAPRNS contends that access for medical underserved populations will improve as practice restrictions are lifted. The evidence that was reviewed does not differentiate between care provided in medically underserved and other areas. Representatives from the physician organizations participating on the scope of practice review committee expressed concern that independent APRN practices would overlap areas that are already being served instead of improving access to those in need of care.

Primary Care Provider Shortage

Another important argument related to access is the growing shortage of primary care physicians, which is leaving a gap that APRNs and others want to fill. In reviewing research related to primary care shortages, projections indicate that the nation will be short approximately 45,000 primary care physicians by the year 2020 and up to 65,000 by the year 2025. Only fifteen to twenty-five percent of medical students end up practicing primary care. The Connecticut Health care Innovation Plan which was submitted to the Center for Medicare and Medicaid Services (CMS) in December 2013 identified that 65,000 Connecticut residents have enrolled in the Access Health CT program with an anticipated 300,000 more to enroll, and that thirty-six percent of CT residents have Medicare (470,000), Medicaid (630,000) or are uninsured. The report also cites that Connecticut has high emergency room utilization especially for non-urgent care, relatively high hospital readmission rates, and health care spending per capita that is the third highest amongst the states, and that health care consumers report the following:

- long wait times to get appointments (especially with specialists);
- limited hours of provider offices;

- inability to find an available provider (including specialists);
- distant locations to access providers; and
- a sense, especially among Medicaid recipients, that they are not welcome.

Consumers want same day appointments and convenient, direct access, especially for non-urgent care and are seeking out more preventive care. The report states APRNs are poised to play a greater role in providing primary care, and in turn addressing many of these issues.

According to Traczynski, et al, “NP Independence, Health Care Utilization and Health Outcomes” which was published March 2013, the number of nurse practitioners practicing in primary care has grown nationally by approximately 9.4% since the mid 1990’s while MDs in primary care grew 1.1%. In addition, the American Association of Nurse Practitioners cites that based on a review of their national nurse practitioner database for the period of 2010 – 2011 68% of APRNs provide primary care. With the number of primary care physicians in Connecticut not improving, increasing demands that are not being met, CTAPRNS believes that meeting these demands will require access to all qualified and available personnel and that APRNs can play a significant role.

Relevant Laws Governing the Profession

Chapter 378 of the Connecticut General Statutes defines “advanced practice nursing” as the performance of advanced level nursing 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 current scope of practice allows advanced practice registered nurses to perform acts of diagnosis and treatment of alterations in health status and requires that the advanced practice registered nurse shall collaborate with a physician licensed to practice medicine in Connecticut. By virtue of this collaborative agreement, the advanced practice registered nurse may prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples. “Collaboration” is defined as 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 the 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. The collaborative agreement shall be in writing relative to the exercise of prescriptive authority and shall address the level of schedule II and III controlled substances that the advanced practice registered nurse may prescribe.

As a condition of renewing their licenses, APRNs are required to hold and maintain professional liability insurance or other indemnity against liability for professional malpractice at the same level required for physicians.

Education, Training and Applicable Certification Requirements

In order to qualify for licensure as an advanced practice registered nurse in Connecticut, an applicant must hold and maintain licensure as a registered nurse (which requires completion of an approved registered nurse education program and successful completion of the national licensure examination for registered nurses); have earned a graduate degree (master's or doctoral program) in nursing or a related field that qualifies an applicant to become certified; document successful completion of a minimum of thirty (30) hours of coursework in pharmacology; and hold and maintain a national board certification by one of the certifying bodies recognized by the Board of Examiners for Nursing and the Department of Public Health. Prior to entering a master's or doctoral program to become an APRN, the individual must have earned a baccalaureate degree in nursing.

Master's and doctoral nurse practitioner programs typically consist of approximately forty-five (45) to fifty-five (55) credits (two years of full-time study) and sixty-five (65) to seventy-five (75) credits (three years of full-time study) respectively. In order to successfully complete a master's degree, a minimum of five hundred (500) hours of supervised clinical experience must be completed and for a doctoral degree, a minimum of one thousand (1,000) hours of supervised clinical experience must be completed. Coursework includes but is not necessarily limited to: advanced health assessment, advanced pharmacology, advanced pathophysiology, acute and chronic disease assessment and treatment, professional ethics and standards, biostatistics, quantitative and qualitative research, and health policy. Doctoral students have additional coursework in quality improvement, health informatics and epidemiology.

Comparison of Education and Training Requirements for Physicians and Physician Assistants to Education and Training Requirements for APRNs

For purposes of discussions relevant to patient safety and public protection, committee members carefully reviewed the education and training requirements for physicians and physician assistants and compared them to the education and training requirements for APRNs as outlined above. Upon reviewing the APRN education and training requirement, representatives from the physician organizations who participated on the committee as well as representatives from the Connecticut Academy of Physician Assistants (ConnAPA) indicated that they do not believe APRNs receive equivalent education and training and as such should not be granted authority to practice independent of physician collaborative agreement. More specifically, they identified less rigorous objective requirements for initial education and training as well as re-certification requirements as follows:

- Fewer hours of post-graduate clinical practice experience;
- Fewer hours of post-graduate pharmacology;
- Fewer hours of mandatory continuing medical education; and
- Lack of a national, standardized board re-certification examination.

Physicians are required to complete a minimum of two to three years in an accredited post-graduate residency training program prior to being able to practice independently. The lack of a similar

requirement for a period of post-graduate residency training prior to independent practice for APRNs was also raised as a significant concern, although physicians and physician assistants are less concerned about APRNs who have been in practice for a number of years than they are about new graduates who may be looking to establish a private practice right after graduation. They contend that APRNs should be required to meet equivalent standards for post-graduate residency training if they want to practice independently.

APRNs and others who support removal of the mandatory physician collaborative agreement disagree with these conclusions. APRNs do not intend to replace physicians or physician assistants and are not asking to extend their practice authority. They intend to practice within their existing scope of practice and to practice within the parameters of their education and training as they always have. CTAPRNs and others who support removal of the mandatory physician collaborative agreement continue to strongly assert that the studies submitted in support of this scope request clearly demonstrate that APRNs in other states with comparable education and training requirements provide safe, high-quality care with patient outcomes that are comparable to or in some instances exceed those of physicians in several areas.

Specific education and training requirements for APRNs, physicians and physician assistants are included in the Appendix.

APRN Consensus Model

The APRN Consensus model recognizes that APRNs have become an integral part of the health care system and because of the importance of APRNs in caring for current and future health care needs of patients, education, accreditation, certification and licensure of APRNs needs to be effectively aligned in order to ensure patient safety while expanding access to providers. In 2010, more than 40 nursing organizations, including the National Council for State Boards of Nursing agreed to support the Consensus Model for APRN Regulation which was developed in 2008. These regulations, involving licensure, education program accreditation, certification and education, outline uniform requirements for all four roles of APRNs.

The four roles recognized in the APRN consensus model for regulation include: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). For purposes of this report, CNM's will not be addressed as they hold a separate license in CT and are not included in this scope of practice request. In Connecticut, each of these roles holds the title of APRN. APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psychiatric/mental health. APRN education programs, including degree-granting and post-graduate education programs are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as discrete courses in

specialty and primary care related to pathophysiology, mental health pediatric health, women's health, assessment, and specialty pharmacology, and appropriate clinical experiences.

Individuals who have completed the required education and training sit for a certification examination to assess national competencies of the APRN core role and at least one population focus area of practice. APRN certification programs are accredited by a national certification accrediting body. APRN certification programs require demonstration of continued competence.

The Consensus Model defines an Advanced Practice Registered Nurse (APRN) as a nurse:

- who has completed an accredited graduate-level education program preparing him/her for one of the recognized APRN roles;
- who has passed a national certification examination that measures APRN role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
- who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;
- whose practice builds on the competencies of first being registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
- who has clinical experience of sufficient depth and breadth to reflect the intended license; and
- who has obtained a license to practice as an APRN.

APRNs are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act, and for the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate. All APRNs are educationally prepared to provide a scope of services across the wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies. The emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs. Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

APRN Roles

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist (CRNA) is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetric delivery rooms; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. CRNAs do not practice independently of physicians.

The Clinical Nurse Specialist

The Clinical Nurse Specialist (CNS) has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

The Certified Nurse Practitioner

Certified Nurse Practitioners is the group to which the largest number of APRNs belong and is generally the group referred to when APRNs are referenced in general. For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, psychiatry and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing and comprehensive care includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

APRN Specialties

Preparation in a specialty area of practice is optional. Specialty practice represents a much more focused area of preparation. Specialty practice may focus on specific patient populations beyond those

identified above, or on specific health care needs such as oncology, palliative care, substance abuse, or nephrology. APRN specialty education and practice is above and beyond the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an adult-gerontology CNS could specialize in palliative care; or a CRNA could specialize in pain management.

APRN specialties provide flexibility within the profession to meet the emerging needs of patients. Specialties also may cross several or all APRN roles and indicate that an APRN has additional knowledge and expertise in a more discrete area of practice. Competency in the specialty area could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations). Specialty competencies must be assessed separately from APRN role competencies. APRNs are not licensed at the specialty level.

Summary of Known Scope of Practice Changes

Requested but did not pass

- 2007 – An Act Revising the Definition of Advanced Nursing Practice (Raised Bill 7161)
- 2009 – An act Concerning Workforce Development and Improved Access to Health Care Services (Raised Bill 6674)
- 2010 – An Act Concerning the Listing of Advanced Practice Registered Nurses in Managed Care Organization Provider Listings and Primary Care Provider Designations (Substitute Bill 192)
- 2013 – An Act Concerning the Practice of Advanced Practice Registered Nurses (House Bill 6391)
- 2013 – An Act Concerning Targeted Health Areas (House Bill 5568)

Enacted

- 2011 – An Act Concerning the Listing of Advanced Practice Registered Nurses in Managed Care Organization Provider Listings and Primary Care Provider Designations (P.A. 11-199)
-APRNs are listed as primary care providers
- 2012 – An Act Concerning Various Revisions to the Public Health Statutes (P.A. 12-197)
-Amends 20 sections of the statutes to allow APRNs to sign various certification forms

Impact on Existing Relationships within the Health Care Delivery System

CTAPRNS indicated in its request that eliminating the requirement for the collaborative agreement will have no impact on patient care, collegial consultation and collaboration among health care providers, specialty referrals and other expected professional practices and that patient care would continue without interruption or change.

Advanced practice registered nurses already work collaboratively with a variety of health care providers in an integrated care model and refer patients with needs outside of the advanced practice registered nurse's scope of practice, including the coordination of such referrals for treatment with a licensed physician or other health care providers as appropriate. CTAPRNS maintains that the proposed elimination of the collaborative agreement with a physician in the same practice area would not impact the advanced practice registered nurse's existing relationships for referral and consultation so that patients in need of services outside of the APRN scope will continue to be able to access comprehensive care. The elimination of the collaborative agreement is not intended to allow an APRN to replace any member of the health care team, and it is anticipated that it would supplement and increase the ability of the existing primary care workforce to reach patients who are unable to obtain needed services from the current health care system.

Opponents of the proposal are concerned that eliminating the mandatory collaborative agreement has the potential to negatively impact patients as well as the working relationship of the health care team. They believe that APRNs who practice independently would be competing for patients without being able to provide the full range of care and services that are typically provided by a physician, and that individuals who utilize APRNs as their primary care provider might find themselves with compromised access to physicians if they are allowed to practice without the benefit of a collaborating physician. There was no evidence provided to substantiate that this has occurred in states where there is no requirement for a collaborative agreement. CTAPRNS has been clear that they are not looking to eliminate collaboration, and that the proposed scope of practice change is only intended to eliminate the requirement for a written collaborative agreement.

Of note, APRNs who must currently compensate a physician in order to obtain the required collaborative agreement would no longer need to do so and the fiscal relationship between them and collaborating physician would end.

Certified Registered Nurse Anesthetists (CRNAs), who are also categorized as APRNs, are supportive of the request to remove the requirement for the physician collaborative agreement. It is not anticipated that this change would impact how a CRNA practices however as existing language in Connecticut General Statutes, Section 20-87a(b) which states in part "...except that an advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administering medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed" would not be repealed or revised.

Economic Impact

The CTAPRNS asserts that removing the barriers for APRN practice would have positive impact on state and federal health care costs for several reasons. Documentation provided in support of their request to eliminate the mandatory collaborative agreement substantiates that in other states where there is no

mandatory collaborative agreement there have been cost savings including lower drug costs, lower per-patient costs, lower visit costs and lower costs associated with lower rates of emergency department referrals. A 2009 RAND study that evaluated the Massachusetts health infrastructure reforms that were adopted in 2008 estimates cumulative state savings of 0.6 to 1.3 percent for the period 2010 to 2020 by allowing nurse practitioners and other “non-physician providers” to practice without mandated physician involvement equating to projected cumulative savings of \$4.2 to \$8.4 billion by 2020.

In a 2013 Mayo Clinic article entitled “*Comparison of the Quality of Patient Referrals From Physicians, Physician Assistants, and Nurse Practitioners*,” findings from a study comparing the quality of referrals of patients with complex medical problems from nurse practitioners (NPs), physician assistants (PAs), and physicians to general internists were reviewed. The study recognized that allowing NPs to practice independently in all states has been identified as a potential solution to the primary care workforce shortage and that controversy exists regarding the roles of physicians and NPs within health care teams and levels of supervision. The study found that the quality of pre-visit care and patient referrals to general internists at a tertiary medical center was higher for physicians than for NPs and PAs. The findings indicate the need for future studies to compare patient referrals by physicians, NPs, and PAs with respect to higher-level outcomes such as patient satisfaction and quality of care metrics, as well as research into optimal interdisciplinary models for teams involving physicians, NPs, and PAs. In evaluating quality of care provided by advanced practice registered nurses and the impact it has on cost, this study was reviewed as several committee members inferred that the results support the concept that costs may be higher related to referrals made by nurse practitioners. Although there was disagreement among scope of practice committee members regarding their own interpretations of the study’s findings, information from the article is being included in this section as it is relevant to the scope discussion. The finding of the study did not specifically address any issues related to cost.

Physician utilization of midlevel providers

The cost-saving argument was also highlighted in The Physicians Foundation’s November 2012 report “*Accept No Substitute: A Report on Scope of Practice*”, which indicated that the argument has also been persuasive to large numbers of practicing physicians. The report indicates that an increasing number of physicians now employ non-physician providers including APRNs in their practices partially in response to declining reimbursement rates and the need to increase patient volume in order to keep their practices afloat. The report cites results from the 2009 National Ambulatory Medical Care Survey, conducted by the National Center for Health Statistics, which indicated that at that time almost half of all office-based physicians (49.1 percent) were in practices that used nurse practitioners, certified nurse midwives or physician assistants, and concludes that “it appears that physicians themselves have been an important source of demand for at least some of the non-physician professions—largely because these non-physician providers offer a way for physician practices to increase patient volume (and revenues) at considerably lower cost than they could by bringing on additional physicians.”

Regional and National Trends

Twenty jurisdictions allow APRNs to practice autonomously to the full extent of their education and training with no requirement for a collaborating physician. 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 Massachusetts and Connecticut have not yet removed the requirement for a collaborating physician. In the New England region, Vermont was the most recent state to eliminate the requirement for a collaborating physician through regulatory reform in 2011.

During the 2013 state legislative sessions, legislation to remove physician involvement from APRN practice was considered in twelve states (California, Connecticut, Illinois, Kentucky, Kansas, Massachusetts, Michigan, Minnesota, North Carolina, New Jersey, Nevada, New York and Pennsylvania). Legislation successfully passed in Nevada. It is anticipated that during the 2014 state legislative sessions, legislation to eliminate the collaborative practice agreement will be proposed in all of these states and possibly more.

As previously referenced, the APRN Consensus model recognizes that APRNs have become an integral part of the health care system and because of the importance of APRNs in caring for current and future health care needs of patients, education, accreditation, certification and licensure of APRNs needs to be effectively aligned in order to ensure patient safety while expanding access to providers. In 2010, more than 40 nursing organizations, including the National Council for State Boards of Nursing agreed to support the Consensus Model for APRN Regulation which was developed in 2008. These model regulations, involving licensure, education program accreditation, certification and education, outline uniform requirements for all four roles of APRNs. It is anticipated that the majority of these regulations will be adopted in most if not all states by 2015.

Other Health Care Professions that may be Impacted by the Scope of Practice Request as Identified by the Requestor

CTAPRNS indicated in their scope request that standards of professional practice require APRNs to collaborate with physicians and other health care providers. As such, it is anticipated that the removal of the mandated collaborative agreement would have no direct impact on any other health care profession. There was no evidence provided as part of the scope of practice review process to support that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk or that this has been an issue in states where there is no required collaborative practice agreement.

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

Although the mandatory physician collaborative agreement does not in and of itself necessarily limit an APRN's ability to practice to the full extent of his or her education and training, evidence was provided during the scope of practice review process to demonstrate that the required collaborative agreement has become a barrier for many APRNs to practice at that level.

The evidence provided by CTAPRNS regarding other states that have no requirement for a collaborative practice agreement suggests that an APRN's ability to practice independently should be directly linked to the APRN's education, training and maintenance of competency through national board certification rather than to inconsistent interpretations of what a collaborative agreement should be. As identified above, evidence provided in support of this request demonstrated that there can be substantial risks for the APRN in Connecticut as well as his or her patients associated with independent practice that are not directly related to his or her skill or fitness for practice but upon on his or her ability to find and enter into a collaborative agreement. Physicians who practice in settings such as group practices, hospitals or other large health systems where physicians, APRNs, physician assistants and others work together as a team, indicated that it is not the mandatory collaborative agreement or "piece of paper" that drives their collaborative practice with APRNs but rather the mutually respectful, educational and responsible team relationship that develops over time working together and the need for collegial interactions to ensure patients' health care needs are being met.

The APRN scope of practice and the requirement for a collaborative agreement are not the only barriers that impact an APRN's ability to practice to the full extent of his or her education and training. Other Federal and state laws and regulations and/or accreditation or other rules governing areas including, but not limited to, reimbursement, admitting privileges, ordering and evaluating tests, and frequency of APRN and physician visits also restrict APRNs from practicing to the full extent of their education and training. Although the scope of practice committee acknowledged the existence of these additional barriers, they are outside the purview of this scope of practice review process. Eliminating the requirement for a physician collaborative agreement would not remove these additional barriers.

Findings and Conclusions

The scope of practice review committee reviewed and evaluated all of the information provided in CTAPRNS' scope of practice request as well as additional information that was requested and provided as a result of committee discussions. In reviewing and evaluating the information presented, the scope of practice committee focused on assessing any public health and safety risks associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

The Connecticut Advanced Practice Registered Nurse Society (CTAPRNS) provided documentation from numerous studies demonstrating that advanced practice registered nurses provide safe, high-quality care. These studies found that APRNs produce patient outcomes that are comparable to, or in some instances exceed, those of physicians in areas such as patient health status and functional status, use of emergency departments and patient satisfaction. Additionally, evidence provided from practice experience in other states where there is no requirement for a physician collaborative agreement

demonstrates that removal of the agreement creates an environment in which APRNs are able to expand current practice and explore other options for delivering primary care services.

The documentation reviewed by the committee supports that an APRN's ability to practice independently should be directly linked to the APRN's education, training and maintenance of competency through national board certification. Several committee members expressed significant concerns with the proposal to remove the mandatory collaborative agreement, including, but not limited to, issues related to what they believe to be deficiencies in the education, training and certification requirements for APRNs when compared to those required for physicians and physician assistants. There was however no evidence or data provided as part of the scope of practice review process to validate that removing the mandatory collaborative agreement would alter APRN patient care or place patients at risk, or that that patients are at risk or care has deteriorated in other states where there is no required collaborative practice agreement. The committee also discussed the importance of mentoring newly licensed and certified health care providers, whether they are APRNs, physicians or other practitioners, to the practice environment and requiring some type of residency or other "transition-to-practice" program to provide a mechanism for the practitioner to demonstrate clinical competency in the practice environment before they practice independently. Working toward establishing residency or "transition-to-practice" programs for nurses, after they have completed advanced practice degree programs or when they are transitioning into new clinical practice areas, aligns with the recommendations included in the 2010 Institute of Medicine report on the future of nursing. In states where the requirement for the mandatory collaborative agreement has already been eliminated and where there is documentation demonstrating that patient outcomes have been favorable, residency programs have not been established.

Documentation of practice experience in other states where there is no requirement for a physician collaborative agreement supports removing barriers that negatively impact an APRN's ability to practice to the full extent of her or her education and training, and enhances access to quality and affordable health care. The evidence provided by CTAPRNS in support of their scope of practice request also revealed that there can be substantial risks for the APRN as well as his or her patients associated with establishing a private practice with the current requirement for maintaining a written collaborative practice agreement. For example, if the collaborating physician abruptly terminates the collaborative agreement for any reason, such as death or retirement, the APRN is placed in an untenable dilemma of practicing without legal authority despite the professional ethical requirement not to abandon patients. Some of these barriers have been mitigated in settings such as group practices, hospitals or other large health systems. Physicians who practice in settings such as group practices, hospitals or other large health systems where physicians, APRNs, physician assistants and others work together as a team, indicated that it is not the mandatory collaborative agreement or "piece of paper" that drives their collaborative practice with APRNs but rather the mutually respectful, educational and responsible team relationship that develops over time working together and the need for collegial interactions to ensure patients' health care needs are being met. Committee members agree that a team approach to providing care that includes multidisciplinary collaboration is critical. Although the mandatory physician

collaborative agreement does not in and of itself necessarily limit an APRN's ability to practice to the full extent of his or her education and training, evidence was provided during the scope of practice review process to demonstrate that the required collaborative agreement has become a barrier to practice for many APRNs and that eliminating barriers enhances access to quality and affordable health care.

In 2012 the National Governors Association (NGA) issued a paper titled "*The Role of Nurse Practitioners in Meeting increasing Demands for Primary Care.*" Findings from this report include:

- Nurse practitioners may be able to mitigate current and projected shortages of primary care services.
- Existing research suggests that nurse practitioners can perform a subset of primary care services as well as or better than physicians.
- Expanded utilization of nurse practitioners has the potential to increase access to health care, particularly in historically underserved areas.

The NGA report also indicates that none of the studies included in their literature review raised concerns about the quality of care offered by nurse practitioners and that most of the studies they evaluated showed that care provided by nurse practitioners is comparable to physician-provided care on several process and outcome measures. The report indicated that the evaluated studies suggest that nurse practitioners may provide improved access to care. Evidence provided in support of the CTAPRNS' scope of practice request also demonstrates improvements in access to care in states where there is no requirement for a physician collaborative agreement. There was no documentation or evidence provided to refute these findings.

Documentation that was provided in support of their request to eliminate the mandatory collaborative agreement substantiates that in other states where there is no mandatory collaborative agreement there have been cost savings including lower drug costs, lower per-patient costs, lower visit costs and lower costs associated with lower rates of emergency department referrals. No specific data relative to costs in Connecticut is available. It was suggested that if a proposal to eliminate the requirement for a collaborative agreement move forward, data regarding any costs savings should be tracked.

Limitations associated with the APRN scope of practice and the requirement for a collaborative agreement are not the only barriers that impact an APRN's ability to practice to the full extent of his or her education and training. Other Federal and state laws and regulations and/or accreditation standards or other rules governing areas including, but not limited to, reimbursement, admitting privileges, ordering and evaluating tests, and frequency of APRN and physician visits, also restrict APRNs from practicing to the full extent of their education and training. The scope of practice committee acknowledged the existence of these additional barriers however, they are outside the purview of this scope of practice review process. Although eliminating the mandatory collaborative agreement would enhance an APRN's ability to practice to the full extent of his or her education and training, it would not remove these additional barriers.

The committee did not review draft statutory revisions. Should the Public Health Committee decide to raise a bill related to the CTAPRNS' scope of practice request, the Department of Public Health, along with the pertinent organizations that were represented on the scope of practice review committee, respectfully request the opportunity to work with the Public Health Committee on such a proposal.