

Request for Consideration of APRN Scope of Practice Change

Submitted to the Connecticut Department of Public Health
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Per P.A. 11-209, I submit the following written scope of practice request to the Department of Public Health to change regulatory language affecting the practice of Advanced Practice Registered Nurses (APRNs) practicing in the State of Connecticut.

1. Plain Language Description of the Request

As an APRN practicing in the State of Connecticut, I respectfully request that “APRNs” be included in the regulatory language of the Regulations of Connecticut State Agencies § 19a-580d along with “physician”, thereby allowing APRNs practicing in the State of Connecticut to write Do Not Resuscitate (DNR) orders for patients for whom they are medically responsible.

According to current Connecticut regulations, a DNR order is defined as “an order written by a Connecticut licensed physician to withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient”.¹

In April 2014, Connecticut permitted APRNs to practice independently, and codified this decision in Connecticut General Statutes Section 20-87a, commonly referred to as “The Nurse Practice Act”.² Yet through the omission of the term “APRN” from Section 19a-580d restrictive, archaic language permeates the associated regulations and prevents APRNs from practicing independently and from honoring their patients’ wishes to receive the end of life care they desire. This result is in direct conflict with the intent of the Nurse Practice Act.

States such as New Hampshire³ and Maine⁴ that allow independent practice of APRNs similar to Connecticut, allow APRNs to write DNR orders. Furthermore, multiple states that are more restrictive of APRN practice than Connecticut, such as Massachusetts, Virginia and North Carolina, which still require APRNs to work under physician supervision⁵, permit APRNs to write DNR orders for their patients.⁶ This reality highlights the disconnect between Connecticut allowing independent practice of APRNs but restricting them from writing DNR orders.

As this restrictive language conflicts with the spirit of the legislation, it seems that the exclusion of APRNs in the current Regulations is outdated and an unintentional

¹ Regs., Conn. State Agencies § 19a-580d-1.

² Conn. Gen. Stat. § 20-87a.

³ See N.H. Rev. Stat. Ann. § 137-J:33 (2012).

⁴ See Facts About Health Care Advance Directives, Revised February 2008, http://www.maine.gov/dhhs/oads/aging/resource/Facts_About_Health_Care_Advance_Directives.pdf.

⁵ See State Practice Environment, <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment> (last visited Aug. 1, 2014).

⁶ See DNR or “Do Not Resuscitate” Information, <http://www.americanmedical-id.com/extras/dnr.php> (last visited Aug. 1, 2014).

oversight. When Section 19a-580d is amended to include language that states “physician or APRN” wherever “physician” is used in regards to DNR orders, it would correct this apparent oversight and allow APRNs to better serve their patients’ needs as the enabling legislation intended.

2. Public Health and Safety Benefits and Concerns

The Patient Self-Determination Act was signed into Federal Law in 1991 with a goal to encourage patients to have advance directives.⁷ The Act requires institutions to document advance directives in a patient’s medical record. APRNs are often on the front line giving direct patient care, particularly to older adults. Furthermore, APRNs often are allowed more time in their schedule to spend discussing non-billable issues, such as end of life. In long term care facilities, APRNs are often the only providers with a daily presence, and in many facilities, physicians are only physically present every few days or less. An optimal time to discuss end of life care is when older adults are admitted to a facility or when they have a change or decline in their medical condition. APRNs are often the most accessible advanced medical staff for patients and families. Allowing APRNs to write DNR orders would help assure accurate and timely documentation of a patient’s wishes, which in turn assures patients’ receive care they desire, or do not receive interventions they wish to avoid.

Unfortunately, as the current iteration of the Regulations now dictate, if a patient wishes to change their code status to DNR they have to wait until a physician is available to discuss this change with them. If a patient is rapidly declining and expresses a wish not to be resuscitated to the APRN managing their care and at their bedside, that change often cannot be made immediately, and may not be made for several days until a physician is accessible. If a patient goes into cardiac arrest after deciding they do not want to be resuscitated, but before a physician is available to change their care order, they could be resuscitated against their wishes and receive unwanted care that results in harm. Resuscitation is not only a traumatic experience, but is also costly.⁸ If APRNs were permitted to document DNR orders as a patient desires, unwanted medical intervention when a patient has opted to allow natural death may be avoided.

3. Impact on Public Access to Health Care

Connecticut recently granted APRNs the ability to practice independently⁹, however the omission of APRNs from § 19a-580d does not allow APRNs to practice to their full potential under the existing law. The current Regulations impede APRNs from effectively serving their patients, especially geriatric patients and other patients at the end of their life. As the population continues to grow older end of life discussions and decisions, as well as the need for DNR orders, will become more prevalent. There is currently a

⁷ See Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508 (1991).

⁸ See A. Maksoud, *Do Not Resuscitate Orders and the Cost of Death*, Archives of Internal Medicine, May 25, 1993.

⁹ Conn. Gen. Stat. § 20-87a.

shortage of physicians interested in and educated in geriatric care, and this shortage is only expected to become more severe.¹⁰ APRNs are part of the solution of filling this void in medical care to the elderly. Restricting APRNs from documenting a patient's desired plan of care at the end of life necessarily reduces access and quality of care to the most vulnerable of patients. APRNs are competent health care providers qualified to discuss and to document end of life decisions and an already present and viable solution to improving timely health care.

4. Summary of State and Federal Laws Governing APRN practice

The Connecticut General Statutes Chapter 378 Nursing or Nurse Practice Act defines an APRN and governs education, certification requirements, licensure, and prescriptive authority for the State of Connecticut.¹¹

§ 20-87a (3) allows APRNs who are licensed and practicing in collaboration with a physician for at least 3 years to then practice alone without the requirement of a collaborative agreement.

§ 20-87a (4) allows APRNs to pronounce the death of a patient and to sign the death certificate.

§ 20-94a requires APRNs to maintain a RN license in Connecticut, to hold a masters' degree, to complete thirty hours of pharmacology education, and to maintain certification as a nurse practitioner, clinical nurse specialist or nurse anesthetist.

§ 20-94c requires that APRNs maintain malpractice insurance.

5. Current State Regulatory Oversight of the Profession

APRN practice in Connecticut is regulated by the Board of Examiners for Nursing, the Department of Public Health, as well as the Nurse Practice Act.¹²

The State of Connecticut Department of Consumer Protection requires all practitioners, including APRNs, to maintain controlled substance registration.¹³

¹⁰ See Chris Lund, United States Facing Major Shortage of Geriatricians, July 11, 2013, <http://www.elderbranch.com/blog/shortage-of-geriatricians/> (last visited Aug. 1, 2014). See Also, The American Geriatrics Society, *The Demand for Geriatric Care and the Evident Shortage of Geriatrics Healthcare Providers*, http://www.americangeriatrics.org/files/documents/Adv_Resources/demand_for_geriatric_care.pdf, March 2013 (last visited Aug. 1, 2014).

¹¹ Conn. Gen. Stat. Title 20, Ch. 378 (2014)

¹² See State Practice Environment, <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment> (last visited Aug. 1, 2014).

¹³ See Connecticut Department of Consumer Protection, *Controlled Substance Registration for Practitioner Frequently Asked Questions*, <http://www.ct.gov/dcp/cwp/view.asp?q=511652> (last visited Aug. 1, 2014).

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

Connecticut General Statutes § 20-94a outlines necessities for licensure and states:

“The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, as amended, upon receipt of a fee of two hundred dollars, to an applicant who: (1) Maintains a license as a registered nurse in this state, as provided by section 20-93 or 20-94, as amended by Public Act 04-221; (2) holds and maintains current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists, their successors or other appropriate national certifying bodies approved by the board of examiners for nursing; (3) has completed thirty hours of education in pharmacology for advanced nursing practice; and (4) if first certified by one of the foregoing certifying bodies after December 31, 1994, holds a masters' degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.”¹⁴

The Consensus Model for APRN Regulation is a National Model for APRN practice that will be fully implemented in 2015. This Model recommends foundational requirements for licensure, accreditation of educational programs, certification, and education within the APRN profession.¹⁵ The goal of the Model is to create more uniform practice of APRNs across the country, to ensure high standards, and to promote independent practice.¹⁶ The restrictive and outdated language of the current Section 19a-580d is in direct conflict with these goals.

¹⁴ Conn. Gen. Stat. § 20-94a.

¹⁵ See APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, July 7, 2008, <http://www.nursecredentialing.org/Certification/APRNCorner/APRN-ConsensusModelReport> (last visited Aug. 1, 2014).

¹⁶ See *Consensus Model for APRN Regulation Frequently Asked Questions*, p. 1 Which states: “The APRN Consensus Model is designed to elevate the role of APRNs and increase job satisfaction through opportunities to practice more independently.” <http://www.nursecredentialing.org/APRNRegulation-Consensus.pdf> (last visited Aug. 1, 2014).

7. Summary of Known Scope of Practice Changes and Requests Concerning the Profession in the Preceding Five Years

2012 and 2013 Requests made to remove the mandatory collaborative agreement requirement for APRNs practicing as nurse practitioners or clinical nurse specialists.¹⁷

2014 Connecticut General Statutes Chapter 378 Nursing or Nurse Practice Act was amended to allow APRNs who have maintained a license for at least 3 years while collaborating with a physician to practice without a mandatory collaborative agreement.¹⁸

Substitute Senate Bill No. 413, Special Act No. 14-5, To authorize the Department of Public Health to undertake a pilot program using Medical Orders for Life-Sustaining Treatment (MOLST) to document end of life health care treatment options. The pilot program and the MOLST model include APRNs as health care providers to help guide people in making end of life decisions and to document such orders.¹⁹

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

Clear documentation of DNR orders is imperative to assuring that patients receive the medical care they desire, to preserving dignity at end of life, and to preventing harm to the patient. Patients may not be ready to make the decision about DNR when initially asked, or may not be cognitively capable of making that decision. Allowing APRNs to conduct discussions with patients and to document DNR orders would allow physicians and APRNs to work together to improve patient care. For example, if a physician discussed DNR status with an elderly woman on admission to a skilled nursing facility, but the patient wanted to wait to discuss the topic with her daughter when she came to visit the following day, an APRN present in the facility the following day could continue the discussion with the patient and the family instead of waiting until the physician is able to return to the facility to complete the decision making process. With multiple qualified providers able to document DNR status, a partnership approach amongst the various practitioners can assure more timely and accurate patient care.

Permitting APRNs to document a patient's decision to not be resuscitated allows patients of APRNs to have a more cohesive experience. Patients of APRNs would be able to discuss the personal and often sensitive and difficult topic of end of life with a provider they were familiar with rather than potentially having to discuss end of life with a physician they may not have previously met just so that their wishes could be legally documented.

¹⁷ Connecticut Department of Public Health, *Scope of Practice Determinations for Health Professions*, <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=486562&dphNav=#2013> (last visited Aug. 1, 2014).

¹⁸ Conn. Gen. Stat. § 20-87a.

¹⁹ Substitute Senate Bill No. 413, Special Act No. 14-5, Approved May 28, 2014.

<http://www.cga.ct.gov/2014/TOB/S/2014SB-00413-R00-SB.htm> (last visited Aug. 1, 2014).

Physicians would still be able to have end of life discussions with their own patients or, when they are available, with a new patient or with a patient who had a change in medical status when the primary provider may not be present. The difference would be that a physician would not have to be brought into a facility or into an exam room with an unfamiliar patient who had requested a DNR status to an APRN.

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

With improved access to health care providers capable of writing DNR orders, more DNR orders will be documented. It is known that hospital and medical charges are less when a patient has a DNR order established compared with patients who do not.²⁰ The personnel, equipment, and medications required for cardiopulmonary resuscitation, as well as the necessary post event hospitalization are significant and costly.²¹ While these costs are unavoidable in a cardiac arrest patient wishing for aggressive intervention, they are avoidable in a cardiac arrest patient who wanted to allow natural death but had not yet had that discussion with a physician so that their wishes could be documented. The cumulative marginal costs associated with the provisioning of such unwanted and unnecessary care is a substantial burden on a health care delivery system currently experiencing scarcity of resources.

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

As of May 2014, 19 states, including Connecticut allow APRNs to practice independently without a collaborative agreement with a physician.²² Multiple other states are pursuing legislative changes to remove physician involvement for APRN practice, and the expectation is that the national trend will be for more and more states to allow APRNs to practice to their full potential.

Multiple states currently permit APRNs to practice as their education and certification has prepared them by allowing them to document DNR code status for patients who desire to allow natural death at the end of their lives. It is intuitive to realize that many states, such as Minnesota, Montana, and Washington, and New England States of Maine, New Hampshire, and Vermont that allow independent practice of APRNs²³ also allow

²⁰ See A. Maksoud, *Do Not Resuscitate Orders and the Cost of Death*, Archives of Internal Medicine, Volume 153, Number 10 (1993).

²¹ Mark E. Ebell and James A. Kruse, *A Proposed Model for the Cost of Cardiopulmonary Resuscitation*, Medical Care, Volume 32, Number 6, pp 640-649 (1994).

²² State Practice Environment, <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment> (last visited Aug. 1, 2014).

²³ See State Practice Environment, <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment> (last visited Aug. 1, 2014).

APRNs to document DNR orders.²⁴ Less intuitively however, is that many states, such as North Carolina, Ohio, Utah, and Virginia and the New England state of Massachusetts, that are still quite restrictive of APRN practice,²⁵ allow APRNs to practice in a way Connecticut does not by documenting DNR orders.²⁶

Connecticut should be more in line with the majority of the other New England states, including the more restrictive Massachusetts, and allow APRNs to document DNR orders. This reality leads the rational citizen to conclude that this is an error of omission.

11. Identification of any Health Care Professionals 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

Physicians, who are currently the only providers in the state of Connecticut able to document DNR orders, would be relieved of struggling to conduct lengthy discussions with patients or with attempting to track down families or representatives for patients who are not cognitively intact and able to make the decision of DNR because physicians would be able to share these duties with other competent health care professionals. Physicians would still have the relationships they have with their patients today and the ability to discuss end of life and other health care issues with their patients as they do now. APRNs would be allowed to practice as their education and certification prepares them and to discuss end of life issues with their patients and to follow through to assure their patients wishes are respected and that they are treated with the care and dignity they deserve at the end of their lives.

Informal discussions with physician's, APRN colleagues, and other members of the interdisciplinary team employed by Hebrew Health Care in West Hartford, Connecticut confirm the benefits of shared responsibility in regards to DNR orders to better serve patients.

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

Nurses have always played a vital role in end of life care, especially in Connecticut. Nursing is well known for time spent at the bedside and for communication; all fundamentals in end of life care. The nursing model has always focused on a holistic approach to patient care that includes the family, which is essential in end of life care. Nurse Florence Wald established hospice in Connecticut in 1974. This was the first hospice care provided in the United States. Nursing continues to be dedicated to

²⁴ See DNR or "Do Not Resuscitate" Information, <http://www.americanmedical-id.com/extras/dnr.php> (last visited Aug. 1, 2014).

²⁵ See State Practice Environment, <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment> (last visited Aug. 1, 2014).

²⁶ See DNR or "Do Not Resuscitate" Information, <http://www.americanmedical-id.com/extras/dnr.php> (last visited Aug. 1, 2014).

improving end of life care and the crucial components for end of life care are innate to the nursing profession.

Not only does the nursing model encompass an understanding of end of life care but APRN education and certification support this. Many undergraduate and graduate nursing programs expose nursing students to palliative care. In 2000, the End of Life Nursing Education Consortium (ELNEC) was established to develop curriculum to improve education and end of life care delivered by nurses.²⁷ Furthermore, APRN certification examinations require testing on knowledge of end of life and palliative care.²⁸

APRNs are educated on and committed to end of life care. APRNs can practice alone in Connecticut, however, the inability to write DNR orders prevents them from truly practicing “alone” as the legislation outlines. To truly exercise the spirit of the legislation as envisioned, APRNs need to be able to assure that the patients they are responsible for are treated in the manner they desire at the end of their lives. APRNs have the education and training to have end of life discussions with patients, they simply need the support of the state to allow them to practice to their full potential under the existing law. The fact that multiple other states allow APRNs to write DNR orders today while Connecticut leaves these archaic restrictions in force is a blemish on Connecticut’s health care delivery system that could easily be corrected by making the changes requested here.

²⁷ See End-of-Life Nursing Education Consortium, *History, Statewide Effort and Recommendations for the Future: Advancing Palliative Nursing Care*, Spring, 2012, <http://www.aacn.nche.edu/elneec/publications/ELNEC-Monograph.pdf> (last visited Aug. 1, 2014).

²⁸ American Nurses Credentialing Center, *Test Content Outline Effective January 29, 2013*, <http://www.nursecredentialing.org/Documents/Certification/TestContentOutlines/AdultGeroPCNP-TCO.pdf> (last visited August 1, 2014).