

**Vermont Medical Society (VMS) Comments on
Vermont Board of Nursing's
January 11, 2010 Draft
Amended Administrative Rules on APRN Practice & Licensure**

The Vermont Board of Nursing Rules (2004)¹ currently in effect provide that an APRN performs medical acts independently within a collaborative practice with a licensed physician “under practice guidelines which are mutually agreed upon between the APRN and the collaborating physician and which are *jointly acceptable to the medical and nursing professions.*” The Board of Nursing has proposed new APRN rules that remove this collaborative practice requirement and would permit APRNs to practice independently in the fields of both medicine and nursing with full prescribing authority.

The requirement in the 2004 rules that the guidelines be acceptable to both the medical and nursing professions is designed to ensure that patients receive the same standard of medical care whether they receive treatment from an APRN or a physician. Most patients assume that they will receive the same level of care. The requirement also ensures that a system is in place for collaboration of care between the two professions when more complex care or coordination of care is called for. Having a collaborative system has the potential to work more efficiently and reduce the need for direct patient referrals to subspecialists.

The two requirements, for joint guidelines and collaboration between physicians and APRNs, have created a system of care that is working well in Vermont. Physicians who have had the opportunity to work with advanced practice registered nurses believe this collaborative system of care has been helpful to both professions, offering APRNs and physicians an opportunity to learn from each other and improve the care they provide to their patients.

Many new initiatives, such as the Blueprint for Health, focus on improving, coordinating and standardizing high quality care in communities. The requirements for mutually acceptable guidelines and collaboration support the value these initiatives place on a high quality single standard of care and collaboration.

Should the Board of Nursing decide to remove the requirement for a written collaborative agreement between physicians and APRNs -- enabling APRNs to practice medicine independently without any limitation -- VMS believes that regulators and policy makers must take a much more active and ongoing role in addressing patient safety, patient disclosure and transparency and ensure regulation by medical peers performing the same type of work. Allowing professionals with different levels of education and clinical training to perform the same work while operating under different standards and regulatory structures, could lead to patient confusion, undermine collaboration, and would not ensure safe, high quality care.

¹ (2004) Chapter 4, Subchapter 8, http://vtprofessionals.org/opr1/nurses/rules/NU_Rules.pdf

VMS believes strongly that the current system of collaboration between APRNs and physicians is working well in Vermont and should be maintained. Any isolated problems encountered in finding a collaborating physician should be addressed on a case-by-case basis. VMS has repeatedly offered to help with any such concerns.

It was the understanding of the Vermont Medical Society that any draft proposed amendment to the rules regarding APRNs would implement the legislative intent that created a legislative taskforce in 2007 to focus on increasing access to primary care through APRNs. The assignment of that taskforce was to consider:

The advisability of eliminating the requirement for an advance practice nurse to work in a collaborative practice with a licensed physician, with the goal of evaluating *whether advance practice nurses might serve a greater role as primary care providers who provide essential chronic care management.*

While the legislative intent was to focus on nurse practitioners providing primary care, the Draft APRN Rules exceed the legislative intent by including CNMs, CRNAs and clinical nurse specialists in psychiatric and mental health nursing, and other clinical nurse specialists.

The Vermont Board of Medical Practice reviewed the draft Task Force report in January of 2008 and made six recommendations to the Task Force. The six recommendations below have not been fully implemented by the Board of Nursing in the Draft APRN Rule:²

- 1) If APRNs are to be licensed to provide primary care independently, their scope of practice must be limited to primary care and they must have had significant specialized training in this field.
- 2) Before APRNs are licensed to provide primary care independently, they must first practice for a considerable period, perhaps four years, under a formal collaborative agreement that has been reviewed by their licensing Board and found to be likely to maximize their preparation for independent practice. No APRN should be permitted to practice independently without showing evidence of successfully completing this extended period of monitored and supervised clinical experience. In the case of APRNs who have practiced in other states, a demonstration of clinical experience should be required that is deemed equivalent by the licensing Board.
- 3) A formulary should be established by a multidisciplinary group to govern the prescribing authority of independent APRNs.
- 4) Medical professionals who are fully licensed to provide primary medical care without supervision should be regulated by the Medical Practice Board or, in the alternative, by a Board made up primarily of medical professionals with at least

² Attached

the same level of training as the professionals being regulated. All statutory definitions of unprofessional conduct for physicians should apply to APRNs practicing in an independent setting. If APRNs are to be regulated by the Board of Medical Practice, they should be numbered in the Board's membership. If Vermont is going to address the shortage of primary care providers by placing APRNs in the role of independent provider, then it must do so in a manner that does not create a double standard of care and of professional regulation.

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

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

General recommendations of the Vermont Medical Society

- VMS strongly recommends that the proposed amendment for APRNs in Vermont conform fully to the six recommendations of the Vermont Board of Medical Practice to ensure a meaningful standard of training and regulation.
- Consistent with the legislature's directive to the taskforce, VMS recommends that the draft amendment to the Board of Nursing Rules for APRNs be limited to nurse practitioners providing primary care and chronic care. Before recommending elimination of the requirement for collaborative practice for nurse midwives (CNMs), nurse anesthetists (CRNAs) or other clinical nurse specialists (CNS), the VMS recommends that the Board of Nursing, Board of Medical Practice and Board of Pharmacy jointly convene a task force to review the consequences of making this change.
- VMS recommends that the proposed amendment ensure that the standard of regulation, education, training and oversight for APRNs in Vermont should be comparable to the standard for other clinicians performing similar work. VMS recommends that patients receiving care from an APRN practicing independently should receive the same standard of care as patients receiving care from a physician, and that the APRNs should be regulated by the Vermont Board of Medical Practice.
- To ensure comparable legislative oversight to other professions, VMS recommends that a statute be enacted that would include requirements for APRNs' education, training, scope of practice, professional conduct and patient disclosure.

- VMS recommends that the requirements for collaboration with physicians and for guidelines that are acceptable to both physicians and APRNs in the current Board of Nursing rules be maintained in the Draft APRN rules.

Specific VMS Comments on the Board of Nursing’s Draft APRN Rules

Section 31. Education and training

The Draft APRN Rules require an APRN’s graduate nursing education program to include a supervised clinical component of a minimum of 500 hours and at a minimum graduate level courses in advanced pharmacotherapeutics, advanced patient assessment and either advanced pathophysiology or psychopathology. There is no required number of hours for these specific courses.

Medical students at the UVM College of Medicine, in contrast receive about 5000 hours of clinical training and take many hours in each of the specific subjects – over 300 hours in pharmacotherapeutics, over 2000 hours in patient assessment, over 900 hours in pathophysiology and over 80 hours of psychopathology.

- VMS recommends that standards of education comparable to physicians’ education be required for APRNs who are independently practicing medicine.

Sections 46 – 56. Limited License – practice with preceptor/preceptor team

The Draft APRN Rules require a new graduate APRN or an APRN who is changing practice role or population focus to work in a setting with an on-site preceptor who is an APRN or physician (MD or DO). A new graduate with a limited license must complete at least 1000 hours (approximately 6 months at 37.5 hours per week) of clinical practice with a preceptor in the same specialty area.³ APRNs changing roles or population focus also must practice with an on-site preceptor, but the board of Nursing has authority to allow fewer than 1000 hours. APRNs with limited licenses may not engage in solo practice.⁴

In contrast to the minimal preceptorship requirements in the Draft APRN Rules, in Vermont, all physicians are required to complete at least one year of supervised postgraduate training (three years for international medical school graduates) in order to attain initial medical licensing.⁵ In addition, the majority of Vermont physicians are board certified and have completed the three or more years of supervised post-graduate medical training required to obtain certification. Postgraduate training for physicians is subject to intense control and review and generally involves practicing in a hospital

³ Supervised on-site practice with a preceptor prior under a pre-licensure permit may be credited against the 1000-hour period.

⁴ The July 2008 version of the Vermont Draft APRN Rules required APRNs to participate in a two-year mentored practice with an APRN or physician.

⁵ 26 V.S.A. § 1396 (a)(3)

setting where supervision and review of all provided care by an experienced attending physician occurs.

- Consistent with VBMP recommendation #2 above, VMS recommends that the Vermont APRN preceptorship be consistent with the VBMP's prerequisites for independent practice -- four years of practice under a formal collaborative agreement and an extended period of monitored and supervised clinical experience.
- VMS recommends that preceptors should be physicians licensed under 26 V.S.A., Chapter 23 (MDs) or Chapter 33 (DOs). Preceptorship teams could include one or more physicians and APRNs.

Sections 74 – 77. Grandparenting of endorsed APRNs, RNs with lapsed APRN endorsements and APRNs from other jurisdictions

Under the Draft APRN Rules, all APRNs with active APRN endorsements as of the effective date of the Draft APRN Rules, including new graduates, will have their endorsement converted to an APRN license and will be eligible to engage in solo independent practice. New graduate APRNs who receive endorsements immediately before the effective date of the Draft APRN Rules who have not participated in the 6-month preceptorship will be eligible to practice independently.

APRNs from other jurisdictions with licensing requirement substantially similar to Vermont's will have 6 months before they will be required to comply with the requirements in the Draft APRN Rules.

RNs with lapsed APRN endorsements will have 6 months to renew their endorsement under the 2004 rules.

- Consistent with VBMP recommendation # 2, VMS recommends that any exemption from the education or collaboration requirements for APRNs with current or lapsed licenses or APRNs from other jurisdictions only apply to APRNs who demonstrate equivalent educational and clinical experience.

Section III. C. 3. [July 2008draft] Certified Registered Nurse Anesthetists (CRNAs)

Both the Board of Nursing Rules (2004) currently in effect and the Board of Nursing's July 2008 draft of the APRN rules required CRNAs to identify by name "at least one anesthesiologist or surgeon who will be routinely utilized for professional collaboration, consultation and referral." That requirement has been removed from the Board of Nursing's January 2010 Draft APRN Rule.

- Absent a thorough review of the distinct issues related to CRNAs, VMS recommends that the proposed rule should not apply to CRNAs,

- Consistent with VBMP recommendation # 1, VMS recommends that the current rules should remain in effect for CRNAs, including the provision requiring a CRNA to identify an anesthesiologist or surgeon who will be routinely used for collaboration, consultation and referral.

This recommendation is consistent with current Medicare rules which require physician supervision of CRNAs, absent action by a state’s governor,⁶ and with Maine regulations that require nurse anesthetists to be responsible and accountable to a physician or dentist “for aspects of anesthesia practice that require execution of the medical regimen.”⁷

Section 13. Scope of Practice and Professional Standards

The Draft APRN Rules describe an APRN’s scope of practice very generally as including assessing at an advanced level, diagnosing, prescribing, giving **medical** and nursing orders, and evaluating care. The Draft APRN Rules further specify that APRNs may serve as primary care providers of record and states that APRNs may prescribe medications and may initiate written or oral orders to other health care providers.

Despite the fact that the draft APRN rules would authorize APRNs to provide **medical** treatment, they are only required to adhere to the professional standards of the American Nurses Association, including the *Scope and Standards of Practice* and the *Code of Ethics for Nurses*. (Section 21).

- Consistent with VBMP recommendation #4, VMS recommends that practitioners performing the same type of work treating patients should adhere to a single standard of practice, be regulated by the Vermont Board of Medical Practice and abide by the same ethical standards as physician, the *Code of Medical Ethics*, adopted by the Council on Ethical and Judicial Affairs of the American Medical Association.

Section 36 – 40. Practice Guidelines

The 2004 rules require APRNs to practice “under practice guidelines which are mutually agreed upon between the APRN and the collaborating physician and which are *jointly acceptable to the medical and nursing professions*.” The 2004 rules included several requirements for practice guidelines that were removed in the Draft APRN Rules including a requirement that the guidelines include an indexed copy of the standards for clinical practice, method of data collection, assessment, plan of care, and the name of at least one physician who will be routinely utilized for collaboration, consultation and referral.

Instead, the Draft APRN Rules only requires the APRN to identify the specialty standards of practice that the APRN will use and to provide citations of the most frequently and

⁶ A change in the Medicare physician supervision requirement for CRNAs can only be undertaken by the state’s governor, through a process specified in Medicare rules.

⁷ Link to Maine Rules: <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc>

currently applicable published resources and authorities that provide guidelines for the APRN's specialty practice. [Section 39.]

Maine, in its APRN regulations⁸, specifies in detail the components of the scope of practice for certified nurse practitioners, certified nurse-midwives, certified registered nurse anesthetists and certified clinical nurse specialists.

- VMS recommends that the draft proposed amendment include the specific components of the scope of practice for each specialty of APRN, and that consistent with VBMP recommendation #4, a single standard of care be established for professionals treating similar patients and performing similar work.

Section 39 of the Draft APRN Rules also requires APRNs' practice guidelines to include criteria for professional consultation and referral including emergency referral. A requirement that the guidelines include criteria for collaboration has been removed from the rules.

- Consistent with VMS policy, VMS recommends that the rules require APRNs to identify by name one or more physicians who will be used for collaboration, consultation and referral, including emergency referral.

Single Standard of Care

Vermont patients expect and believe that the primary care and specialty care clinicians treating them provide the same standard of care, either independently or under supervision, and are subject to the same oversight and professional regulation.

- Consistent with the VBMP recommendation #4, VMS recommends that patients receiving care from an APRN practicing independently should receive the same standard of care as patients receiving care from a physician, and have the same level of public protection offered by the professional conduct regulation and complaint procedures of the Vermont Board of Medical Practice.

Disclosure to Patients

The draft proposed amendment requires scope of practice guidelines to be approved biennially by the Board of Nursing at the time of license renewal and maintained at the workplace. There is no requirement in the draft proposed amendment that APRNs provide patients or referring or consulting clinicians access to their practice guidelines.

Similarly, patients should have access to information about the education and training of their clinicians. One model for providing this type of information would be to create an

⁸ Link to Maine Rules: <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc>

on-line profile such as the profile created by the VBMP for physicians, physician assistants, anesthesiologist assistants and podiatrists.

Detailed information about physicians' education, training, board certification, practice location, and whether their practices are open to new patients with covered by public and private insurance, is available in the Physician Profiles section of the Department of Health website. The profiles also include information or links to information about hospital and board discipline, criminal convictions and malpractice judgments and settlements.⁹

- Consistent with VMS policy, VMS recommends that APRNs' practice guidelines and information about their education, training, board discipline, malpractice and criminal convictions, if any, should be made available to patients, consulting and referring physicians, and the public through a web-based system similar to the physician profiles.
- Consistent with VBMP recommendation # 6, VMS recommends that APRNs with non-medical doctorates be prohibited from using the title "Doctor" or Dr." in a clinical setting, or in any way that could represent to patients or the public that they are medical doctors.

Section 14 Medications Covered in Practice Guidelines

The Draft APRN Rules permit APRNs to prescribe medications consistent with their scope of practice. The scope of practice for APRNs however, is broadly stated in the Draft APRN Rules and does not include any limitation on prescribing any specific drug, or any class of drug, or controlled substance.

Many states limit or prohibit APRNs' authority to prescribe controlled substances, and almost all require collaboration for APRN prescribing. Some require special licensing endorsements for APRNs who wish to prescribe medications. Many states impose specific educational requirements with respect to prescribing.

The Draft APRN Rules require the Board of Nursing to create a list of APRNs with prescriptive privileges and make the list available to the Board of Pharmacy. There is no requirement in the Draft APRN Rules that this list include information about which drugs may be prescribed by which APRN under the APRN's practice guideline. Pharmacists filling APRN prescriptions will be unable to determine from the list of names whether an APRN's prescription is consistent with his or her practice guideline.

Maine has a number of specific regulations relating to prescriptive and dispensing authority for certified nurse-midwives and certified nurse practitioners. The Maine rules require specific numbers of contact hours in pharmacology and specific requirements for

⁹ <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=023&Section=01368>
http://healthvermont.gov/hc/med_board/profiles.aspx

pharmacology courses. Maine also includes a list of six actions related to abuse of prescriptive authority by an APRN that constitute unprofessional conduct.

- Consistent with VMS policy, VMS recommends that physician collaboration be required for prescribing.
- Consistent with VBMP recommendation #3, VMS recommends that a multi-disciplinary formulary committee be created to develop a formulary for APRNs and that this formulary be distributed to all pharmacies and pharmacists in Vermont.
- Consistent with regulations in Maine, VMS recommends that the Draft APRN Rules include specific educational requirements specifying numbers of contact hours of pharmacology for initial APRN licensure and renewal.

Regulatory Board Expertise

By law, the Vermont Board of Nursing includes 10 members appointed by the governor: five registered nurses, including at least one endorsed as an advanced practice registered nurse, two practical nurses, one nursing assistant and two public members. Currently one APRN serves on the Board of Nursing. If APRNs are permitted to practice medicine independently, they should be held to the same standard of care as comparable physicians. The regulatory board providing oversight for their practice should be the Vermont Board of Medical Practice to assure the clinical expertise needed to review the quality and safety of the care being provided. Having only one clinical peer available to participate in Board decisions concerning licensing, endorsement, discipline and approval of practice guidelines for APRNs in Vermont is insufficient.

- Consistent with VBMP recommendations # 4 and #5, VMS recommends that if APRNs practice independently without collaboration, they should be regulated by the Vermont Board of Medical Practice (VBMP),¹⁰ and that at one or more APRNs should be added to the VBMP. In the alternative, they should be regulated by a board made up primarily of medical professionals with at least the same level of training. Also, as recommended by the VBMP at least one APRN on the licensing board for APRNs should be involved in investigating any complaint of unprofessional conduct involving medical care that is filed against an APRN and at least one other APRN on the board should be involved in adjudicating any resulting charges.

Unprofessional conduct requirements

The draft proposed amendment does not comprehensively address unprofessional conduct standards for APRNs who practice independently. The unprofessional conduct

¹⁰ The VBMP currently consists of 9 physicians, one physician assistant, one podiatrist and 6 public members.

standards for nurses do not include a number of patient protections that are included in the unprofessional conduct standards for physicians.

- Consistent with VBMP recommendation, # 4, VMS recommends that all statutory definitions of unprofessional conduct for physicians should apply to APRNs practicing independently. This will prevent the creation of a double standard for oversight and patient protection based on licensing category.
- VMS also recommends that unprofessional conduct standards for APRNs include actions related to abuse of prescriptive authority similar to those in the Maine regulations.¹¹

In conclusion, it is not VMS members' preference to argue with advanced practice registered nurses who are their valued colleagues. As VMS testified at the hearing in July, VMS believes that it would make sense for APRNs and physician colleagues of affected specialties to discuss how best to serve their patients, and how to remove barriers to access to care. VMS members again offer to meet with specialty colleagues in APRN roles to discuss these issues.

¹¹ Maine includes a list of six actions related to abuse of prescriptive authority by an APRN that constitute unprofessional conduct.