

**Work Group Summary**  
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**Advanced Practice Registered Nurses (APRNs)**  
**as Primary Care Providers (Act 71)**

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**Introduction**

In 2007, The Legislature passed Act 71, An Act Relating to Ensuring Success in Health Care Reform. One section of the Act, relating to “Support for Primary Care Providers,” calls for a study of “the advisability of eliminating the requirement for an advanced practice nurse work in a collaborative practice with a licensed physician, with the goal of evaluating whether advanced practice nurses might serve a greater role as primary care providers who provide essential chronic care management.”

The work group was convened by representatives of the Commissioner of Health, the Director of the Secretary of State’s Office of Professional Regulation, and the Vermont Board of Nursing. The work group met four times over four months and, in addition to representatives of the three agencies listed above, included 10 additional members representing the following groups: the Vermont Legislature, Vermont Consumers, the UVM School of Nursing, the Vermont Medical Practice Board, the Vermont Medical Society, the Vermont Nurse Practitioner Association, and the Vermont State Nurses Association. As agreed by the Work Group at its September meeting, the scope of this report is limited to a discussion of whether to change or eliminate the requirement for physician collaboration for APRNs serving as primary care providers, who provide chronic care management. This report does not address APRNs who are qualified as Certified Registered Nurse Anesthetists, or other APRNs from specialty groups.

**Background on Regulation and Oversight of Advanced Practice Registered Nurses in Vermont (APRNs): Requirement for a Practice Guideline and Collaborating Physician**

APRNs are clinicians who practice in ambulatory, acute and long-term care settings. Consistent with their specialization, they provide nursing and medical services to individuals, families and groups. In addition to diagnosis and management of acute episodic and chronic illness, APRNs in certain specialties emphasize health promotion and disease prevention. Services include but are not limited to ordering and interpreting diagnostic tests, prescribing therapeutic medications and non-medication therapies, and managing uncomplicated labor and delivery. Teaching and counseling are a major part of care provided by APRNs in some specialties.

The current language of the State of Vermont Board of Nursing Administrative Rules (2004) Chapter 4, Subchapter 8,<sup>1</sup> provides that while an APRN performs medical acts independently, the APRN practices 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 requirement that the guidelines be mutually acceptable to the medical and nursing professions is designed to ensure that patients are treated under guidelines that are the same whether they receive treatment from an APRN or a physician and to ensure collaboration of care between the two professions when more complex care is required. This requirement for guidelines is in place in order to help prevent different levels of care or standards of treatment from developing among patients that receive care from APRNs as opposed to physicians. As many new initiatives focus on improving, coordinating and standardizing high quality care, this requirement also helps to coordinate this effort.

As described by the rules, practice guidelines for APRNs must include:

- a. *A description of the clinical practice, including practice site(s), focus of care, and general category of clients;*
- b. *An indexed copy of standards for clinical practice<sup>2</sup> including method of data collection, assessment, plan of care, and criteria for collaboration, consultation and referral, including emergency referral;*
- c. *The name of at least one physician who holds an unencumbered license in Vermont who practices in the same specialty area who will be routinely utilized for collaboration, consultation and referral; and*
- d. *Methods of quality assurance.*<sup>3</sup>

The practice guidelines must also be “*reviewed, mutually agreed upon, and signed annually by the APRN and the collaborating physician and placed on file in the workplace.*” The guidelines must “*be reviewed and approved by the Board of Nursing and kept on file in the workplace and be made available to the Board of Nursing at any time upon request.*”

## **Collaboration, Consultation and Referral**

Collaboration is the preferred model of health care practice and clinical autonomy has been identified as a barrier to improving the quality of medical care.<sup>4</sup>

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<sup>1</sup> The current language of the State of Vermont Board of Nursing Administrative Rules (2004) Chapter 4, Subchapter 8, III C was written 23 years ago in 1984, and updated at least once since then to remove a requirement that APRN guidelines be filed with the Vermont Board of Medical Practice (VBMP).

<sup>2</sup> The nursing board rules require that, national certifying organizations wishing to obtain recognition from the Vermont State Board of Nursing, must “*have developed standards and Scope of Practice statements for the nurse in advanced practice.*” See, <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> , at page 24

<sup>3</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> , at page 25

The State of Vermont Board of Nursing Administrative Rules (2004) define collaboration as “*a process which involves two or more health care professionals working together, though not necessarily in each other’s presence, each contributing one’s respective area of expertise to provide more comprehensive care than one alone can offer.*”<sup>5</sup>

The rules define “Collaboration as it pertains to advanced practice” as, “*The Advanced Practice Registered Nurse acts independently in dealing with the nursing needs of the individual; and independently consistent with practice guidelines with a collaborating physician in the appropriate specialty area for all related medical functions; or by clinical privileges approved by the facility or facilities at which the individual practices.*”<sup>6</sup>

A “Collaborating physician” is defined in the rules as “*a physician who holds an unencumbered license and is actively practicing medicine in the State of Vermont who has formally agreed to be available for collaboration, consultation and referral.*”

*Collaboration between health care providers should be the professional norm, as described in 2007 Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations.*<sup>7</sup> “The expectation is that competent providers will refer to other providers when faced with issues or situations beyond the original provider’s own practice competence, or where greater competence or specialty care is determined as necessary or even helpful to the consumer’s condition.”(p.9). While the Committee heard that the expectation is that APRNs will collaborate with other health care professionals as appropriate, guided by their training, there was no evidence or data found in the literature that defined collaboration or standards for collaboration in order to compare APRN care within or without a collaborative agreement. The literature reviewed comparing care between APRN and physicians, and generally showing no substantive differences, did not make clear whether the APRN care studied was within or without a collaborative care relationship or agreement. In fact, many of these studies were performed in states that require such agreements. Unfortunately, this leaves no direct supporting evidence to conclude that collaboration will take place regardless of the presence of a signed collaborative agreement. In addition, Vermont has no experience upon which to draw from in this regard.

Section 7(e)<sup>8</sup> of Act 71, of the 2007 General Assembly, establishes a medical home project to facilitate the provision of accessible, continuous, and coordinated care to high-need populations. Primary care providers participating in the project would provide ongoing support, oversight, and guidance to implement a plan of care developed in partnership with patients and including all other physicians furnishing care to the patient.

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<sup>4</sup> Almaguer R, Auoy Y, Berwick D, Barach P Five System Barriers to Achieving Ultrasafe Health Care, *Annals of Internal Medicine* 2005 142: 756-764

<sup>5</sup> <http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> (page 3)

<sup>6</sup> Id.

<sup>7</sup> [http://www.fsmb.org/pdf/2005\\_grpol\\_scope\\_of\\_practice.pdf](http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf);  
<http://www.fsbpt.org/standards/ScopeOfPractice/index.asp>

<sup>8</sup> <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT071.HTM>

In the legislation, a primary care provider would provide first contact and continuous care for individuals under his or her care and has the staff and resources sufficient to manage the comprehensive and coordinated health care of each such individual. Thus, under the medical home model, there will be an even greater need for a coordinated team approach within primary care.

#### Physician Requirements for Independent Care

In the state of Vermont, physicians are required by Vermont State law to complete at least one year of supervised postgraduate training (three years for international medical school graduates) in order to attain initial medical licensing. Postgraduate training is well described elsewhere, is subject to intense control and review and is generally a practice in a hospital setting<sup>9</sup> where supervision and review of all provided care by an experienced attending physician occurs. In order to obtain specialty board certification, including primary care specialties, physicians need complete three or more years of supervised residency training. It needs to be recognized that, should the collaborative agreement be eliminated, an APRN would have the ability to immediately enter independent practice without ongoing training or oversight.

#### **Impact of Existing Law Requiring a Written Collaborative Agreement: Barriers to Access to Patient Care**

There were several presented anecdotal examples where the requirement for a collaborative agreement was a barrier to practice by a Vermont APRN. It is important to note that these instances were not clearly documented and the full reasons behind them not well explored. However, these possible identified barriers may be addressed in a variety of ways.

- APRNs in teaching environments are required to have a license and thus a collaborative agreement and need to work a second clinical job in order to be on the teaching faculty: It is suggested that an exception be explored allowing APRNs with national certification who work in academic settings and who do not engage in clinical practice be licensed without a collaborative agreement.
- APRN inability to identify a collaborative physician: Organizations such as VMS, state specialty societies, the Vermont Association of Hospitals and Health Systems (VAHHS) and BiState Primary Care Association could be approached for assistance with locating collaborating physicians.
- Fees, some reportedly excessive, charged for a collaborative agreement in the understanding that such an agreement increased liability exposure: The fees charged by collaborating physicians could be limited by rule or policy after careful study, and a showing of reasonable nexus to increased cost for the physician, if any, such as increased malpractice insurance expense, or time spent in reviewing charts could be required. A position paper could be developed addressing the liability of collaborative physicians or in the alternative, state law could provide immunity for collaborating physicians.

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<sup>9</sup> 26 V.S.A. § 1396 (a)(3)

- Concern that guidelines are not updated in a timely fashion: National certifying organizations are required by the nursing rules to have “standards and scope of practice statements for the nurse in advanced practice.” Presumably these national organizations regularly update their guidelines and standards. APRNs could forward these amendments to their collaborating physician as well as to the State. The use of technology should make this a rapid and minimally time-consuming event.
- The cost in time and dollars on hospital credentialing committees who must ensure the presence of current practice guidelines when they initially credential and then re-credential APRNs: There is no direct evidence that this is over burdensome at this time. One physician (PHC) currently chairs the credentialing committee for his Health Care Service and does not identify this as a concern for his committee at this time.

### **Other States’ Experiences**

The Committee discussed nine states that have legislated autonomous practice for APRNs with no requirement for a collaborative or supervisory relationship with physicians. More specifics are described below.

#### **New Hampshire**

New Hampshire does not require a written collaboration agreement with a physician, however New Hampshire has established a Joint Health Council<sup>10</sup> made up of three APRNs, three physicians and three pharmacists,<sup>11</sup> which has established the “Exclusionary Formulary”<sup>12</sup> for APRNs who prescribe medication. The formulary identifies individual drugs and classes of drugs that are restricted or approved for use with specific types of collaboration or consultation. For example abacavir is approved for use with an infectious disease consultation and requires collaboration for APRNs working in a HIV clinic. Some drugs are approved for use by APRNs with certain specialties such as Psych/Mental Health or are approved for renewal of a physician-initiated prescription. Some drugs may be prescribed in consultation in certain settings such as institutional or in a Hematology/Oncology setting. Some drugs may be prescribed for treatment of a diagnosis made according to guidelines published by physician specialty organizations. Specific definitions of “consultation” and “collaboration” are included in the definition section of the formulary. APRNs may submit requests to the Joint Council asking that drugs be added to the formulary or taken

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<sup>10</sup> New Hampshire Joint Council law:  
<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-10.htm>

<sup>11</sup> New Hampshire Joint Council Members:  
<http://www.nh.gov/nursing/jhc/JointHealthCouncilMembers.htm>

<sup>12</sup> New Hampshire Joint Council Formulary:  
<http://www.nh.gov/nursing/jhc/documents/JHCFormulary8.07.doc>

off the formulary.<sup>13</sup> New Hampshire also has specific minimum requirements for continuing education for APRNs who prescribe medication.<sup>14</sup>

## Maine

While nurse practitioners in Maine can practice independently, prior to practicing independently, the Maine Regulations Relating to Advanced Practice Registered Nursing require nurse practitioners to practice for a minimum of 24 months under the supervision of a licensed physician, or be employed by a clinic or hospital that has a medical director who is a licensed physician.<sup>15</sup> The APRN applicant must identify and provide a statement of agreement from a licensed physician practicing in the same practice category as the APRN who agrees to provide oversight to the APRN. This requirement is somewhat comparable to the internship and residency training that physicians participate in prior to practicing independently, although it is not required to be in a hospital setting.

In Maine, as described above, nurse practitioners may work as licensed independent practitioners. If, however, they choose to perform medical diagnosis or prescribe therapeutic or corrective measures delegated by a licensed physician, the physician/APRN relationship must be registered with the Board of Licensure in Medicine.<sup>16</sup>

Maine also has specific education and experience requirement with respect to prescribing and dispensing authority for nurse practitioners and formulary regulations.<sup>17</sup>

Many other states limit prescription of controlled substances and other drugs by APRNs. Some methods of regulation of APRN prescribing used in other states follow:

- Schedule II through IV drugs not permitted; collaboration required for other legend drugs (Alabama, Florida, Hawaii, Missouri)
- No Schedule II (Georgia, Illinois, Oklahoma, West Virginia)
- Schedule II only in a hospital, surgical-center or hospice and limited to 7-day post discharge supply
- Schedule II only if approved by Board on an individual basis (LA) spell out states
- Schedule II only if specified in collaborative practice agreement (CT)
- Special mid-level prescribing license required for schedules III, IV or V (Illinois)

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<sup>13</sup>New Hampshire Joint Council Drug request form:  
<http://www.nh.gov/nursing/jhc/documents/JHCRequestforChangeinDrugFormulary9.07.doc>

<sup>14</sup> New Hampshire statutory requirements for continuing education:  
<http://www.gencourt.state.nh.us/rsa/html/XXX/326-B/326-B-31.htm>

<sup>15</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc>

<sup>16</sup> <http://www.maine.gov/sos/cec/rules/02/373/373c003.doc>

<sup>17</sup> <http://www.maine.gov/sos/cec/rules/02/380/380c008.doc> (section 6 & 7)

In addition to limitations on prescribing controlled substances, all but a handful of states require collaboration for APRN prescribing. Some require special licensing endorsements for APRNs who wish to prescribe medications. And many states impose specific educational requirements with respect to prescribing.

### **APRN Workforce/ Access to Care**

While there is evidence documenting improved outcomes and lower costs in situations where patients have a primary physician<sup>18</sup>, the Work Group was not presented with any supportive evidence that indicated access to care would improve if APRNs were decoupled from physician collaborative guidelines.

The Office of Professional Regulation (OPR) publishes an Annual Report on Professional Licensing that tracks the numbers of the professional groups licensed by OPR.<sup>19</sup> These reports indicate that the number of APRNs licensed in Vermont has increased from 346 to 521 between 1996 and 2006. In 2006 about 1/5 of those were not residents. Under the current requirements, over the last 10 years, the number of APRNs in Vermont has increased considerably, by approximately 50%.

The Department of Health collects detailed demographic workforce information about physicians, physician assistants, podiatrists and dentists, including information on whether their practices are open to patients, and open to Medicaid and Medicare patients. This information is compiled into statistical reports and summary reports, based on licensing renewal information, that are then posted on the publications section of the Department of Health website,<sup>20</sup> and updated every two years.

In 2002, the Department of Health surveyed APRNs, but since that time due to loss of funding, has been unable to update the APRN workforce survey.<sup>21</sup> According to the Department of Health's 2002 APRN statistical report, with respect to access to primary care provided by APRNs in office settings and community health centers, 88% of adult APRNs, 86% of family APRNs and 95% of pediatric APRNs and 76% of mental health APRN practices were accepting new Medicaid patients. With respect to access for Medicare patients, 92% of adult APRNs had open practices, 84% of family APRNs and 65% of mental health APRNs.<sup>22</sup>

In 2002 the distribution of access for Medicaid patients to primary care APRN practices by county varied from 80% in Bennington County to 100% in several counties. Access for Medicare patients ranged from 71% in Addison County to 100% in several counties.<sup>23</sup>

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<sup>18</sup> Starfield B, Contributions of Primary Care to Health Systems and Health, *Milbank Quarterly*, 2005 83-3: 457-502

<sup>19</sup> <http://vtprofessionals.org/opr1/opr/pubs/rpttxt.html>

<sup>20</sup> <http://healthvermont.gov/pubs/Publications.aspx>

<sup>21</sup> <http://healthvermont.gov/pubs/apn/APRN02BK.PDF>

<sup>22</sup> Id at page 44 of PDF, page 38 printed

<sup>23</sup> Id. at page 45 of PDF, page 39 printed

In some of the most rural areas of the state, like the Northeast Kingdom, in the 2002 report, 100% of APRN practices were open to new patients, including new Medicaid and Medicare patients, perhaps reflecting the prevalence of primary care delivered through Federally Qualified Health Centers (FQHCs) in those areas. FQHCs and Rural Health Clinic (RHCs) are eligible for cost-based Medicaid and Medicare reimbursement, reducing the financial stress on primary care practices.

According to the 2007 Re-licensure Survey and the 2007 Health Workforce Assessment Pilot Survey data, presented to the Work Group at its October meeting, these numbers have changed somewhat, with 88% of APRNs participating in Medicaid in 2007, but only 80% accepting new Medicaid patients and 78 % participating in Medicare but only 71% accepting new Medicare patients. No specialty or geographic analysis of this updated access information was presented to the group.

It appears that, despite the significant increase in the numbers of APRNs licensed in Vermont over the past 10 years, approximately 50%, the percentage of APRNs whose practices are accepting new Medicare and Medicaid patients has declined.

No information was presented to the group as to whether APRNs in independent practice are more or less likely to accept Medicaid and Medicare patients than their colleagues who work for FQHCs, RHCs or in physician practices. Presumably, APRNs in private practice would be subject to more financial pressure than those working for clinics receiving higher reimbursement rates and may be less likely to have open practices to low-income patients.

### **Existing and Continued Regulatory Environment**

The Vermont Board of Nursing will continue to endorse APRNs with a license to practice in Vermont who demonstrate professional accountability and have met and maintained national credentialing requirements for APRNs in their specific specialty. This will address the expectation of continuing education and quality monitoring of care provided. Public protection will be a priority for the Board of Nursing and will guide their work such that the public will have access to APRNs who practice safely and competently.

### **Structural Considerations for Regulatory Board Oversight**

- **Regulatory board expertise**

By statute, the Vermont Board of Nursing includes ten members appointed by the governor, five registered nurses, two practical nurses, one nursing assistant and two public members. One APRN currently serves on the Board; however, there is no statutory requirement that the board membership include any APRNs. There is a provision in the Nursing Board rules that authorizes the Board to establish an advisory committee of APRNs to assist the Board in the implementation of the Nursing Board rules. Oversight of the Nursing Board is provided by the Office of Professional Regulation (OPR), a division of the Office of the Secretary of State.

If APRNs are held to the same standard of care as primary care physicians, the Board must have sufficient clinical expertise to review the care they provide when necessary. Without this type of expertise patients who see APRNs will be at risk of receiving a different level of care from patients who see MDs or DOs. Other states, such as Delaware and New Hampshire, have used multidisciplinary models, involving physicians and pharmacists, in oversight and regulation of APRNs particularly with respect to prescribing.

For efficiency of administration and expertise, the Work Group should explore whether APRN oversight should be transferred to the VBMP. One or more APRNs could be added by law to the VBMP, which includes 9 physicians, one podiatrist, one physician assistant and 6 public members. Oversight of the VBMP is performed by the Department of Health. Location of the Board in the Department of Health allows for coordination and collaboration between the licensing entity and other important health initiatives such as Emergency Preparedness, the chronic care initiative the Office of Alcohol and Drug Abuse Programs (ADAP), and the Vermont Advanced Directive Registry (VADR).

- **Unprofessional conduct requirements**

If laws and regulations are changed to permit independent practice, the unprofessional conduct standards for APRNs in the current Vermont rules and laws should be reviewed to determine that they afford appropriate public protection, particularly in the areas of standard of care and prescribing,<sup>24</sup> and appropriately address situations that might arise when APRNs are practicing independently as primary care clinicians. The workgroup could consider whether the unprofessional conduct requirements for physicians should apply to APRNs who serve as primary care providers, to prevent creation of a double standard.

- **Patient disclosure requirements**

It is in the public interest to ensure that patients are informed of the level of education and credentials of the professionals treating them and the process for making complaints to the appropriate regulatory board. APRNs in private practice should provide this of information to their patients in a manner similar to the disclosure required in Vermont for psychologists and other mental health practitioners.<sup>25</sup> 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 about all MDs licensed in Vermont in the Physician Profiles section of the Department of Health website. The profiles also include information or links to information about

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<sup>24</sup> <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=028&Section=01584>  
<http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=028&Section=01595>  
<http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=03&Chapter=005&Section=00129a>  
<http://vtprofessionals.org/opr1/nurses/forms/nursingrules.pdf> Rules: See, Subchapter 4. Discipline II Definitions, D. "Conduct likely to deceive, defraud, or harm the public"

<sup>25</sup> <http://vtprofessionals.org/opr1/psychologists/psychrules.pdf> Psychologist rules at Page 15. See also, rules for other allied mental health professionals.

hospital and board discipline and malpractice judgments and settlements.<sup>26</sup> Should oversight of APRNs be transferred to the VBMP, similar profiles could be created for APRNs.

## CONCLUSION

This Committee was charged with evaluating “the advisability of eliminating the requirement for an advanced practice nurse work in a collaborative practice with a licensed physician, with the goal of evaluating whether advanced practice nurses might serve a greater role as primary care providers who provide essential chronic care management.”

- 1) There is currently no supportive evidence that the elimination of the requirement for a collaborative agreement will change access to chronic care in the State.
- 2) While there is anecdotal evidence that the requirement for a collaborative agreement is limiting APRN practice in the State, specific solutions to these issues can be provided without the elimination of the requirement.
- 3) Physicians are currently required to have a minimum of one year of postgraduate medical training for State licensing, and thus independent practice with most physicians providing primary care completing at least three postgraduate training years.

Therefore,

- A) Without evidence of a positive impact on primary care access for the provision of essential chronic care management and;
- B) Without data supporting equitable quality of APRN provided care in a non-collaborative model and;
- C) Given the current licensing requirement for physicians of a minimum of one year postgraduate medical training (three years for international medical graduates) and the necessity of at least three years of specialty training for primary care physician providers and;
- D) Given that the anecdotal hardships regarding the requirement for a collaborative agreement for APRN practice can be separately addressed;

Eliminating the requirement for APRNs to work within a collaborative agreement with a licensed physician with the stated goal of APRNs serving a greater role as primary care providers who provide essential chronic care management does not appear to be supported by the information and data reviewed to date.

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<sup>26</sup> <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=26&Chapter=023&Section=01368>  
[http://healthvermont.gov/hc/med\\_board/profiles.aspx](http://healthvermont.gov/hc/med_board/profiles.aspx)