LEGISLATIVE QUESTIONNAIRE FOR NEW OR EXPANDED REGULATION OF HEALTH OCCUPATIONS

Submitted to the Minnesota Legislature
by the Minnesota Advanced Practice Registered Nurse (APRN) in collaboration with the Minnesota Board of Nursing

January 29, 2014

HF435: A bill for an act relating to health; improving access to health care delivered by advanced practice registered nurses

Responses to Legislative Questionnaire Items #1-9

1. **How is this profession's scope of practice in the area of proposed change currently defined and what failings or shortcomings are being addressed by the proposed changes to the profession's scope?**

   This bill refers to scope of practice of the four categories of advanced practice registered nurses (APRNs): certified clinical nurse specialist (CNS), certified nurse midwife (CNM), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA).

   No expansion of APRN scope. **The bill does not expand the scope of practice of what each APRN role may perform and allows APRNs to practice to the full extent of their education and training.** All four categories of APRNs are currently authorized to practice nursing care, diagnose, treat, manage patient care, order necessary diagnostic tests and procedures, prescribe pharmacological and non-pharmacological agents, and consult and collaborate with, and refer patients to other health professionals as appropriate to their role (e.g. CNS, CNM, CNP, CRNA) and their specific focus population (e.g. Pediatric NP or Adult/Geriatric NP).

   Physician oversight is barrier to practice. Under current law, APRNs must practice this advanced practice nursing scope in settings where a specific physician or group of physicians) has agreed to work with the APRN to manage the care of patient. Current law also requires an APRN to have a signed written prescribing agreement that lists a broad group of drug categories (not specific drugs) that may be prescribed by the APRN. (CNMs are an exception to the second requirement. CNMs may prescribe all drug categories without a written prescribing agreement.)

   These two oversight requirements create barriers for APRN practice and patient access to care. Some APRNs in Minnesota are not able to practice at all because they cannot find a physician willing to provide this oversight. Current law does not protect APRNs from restraint of trade. Some APRNs are required to pay physicians significant amounts of money (e.g. $5,000, $10,000, etc.) in order to meet these requirements. This bill removes these barriers, and eliminates a misperception of physician liability.

2. **Does specialized skill or training support the expansion of this occupation into the proposed areas of practice? If so, what skills or training?**
   This bill does not expand the scope of practice for APRNs. It removes the requirement for physician oversight. **All four categories of APRNs have a nationally standardized, limited, less expansive scope of practice than physicians.** For example, APRNS cannot perform surgery, insert cardiac stents, or deliver babies by Caesarean section. A primary care pediatric nurse

practitioner's scope of practice does NOT include pediatric intensive care provider skills such as inserting a chest tube, or placing a centralized IV catheter. **Physicians have a broader, more expansive scope of practice than APRNs. This bill will not expand APRN scope or contract physician scope of practice.**

Current APRN education requirements include the following:

a. Persons admitted to APRN programs must have a bachelor's degree (or equivalent) in nursing; admitted students are already practicing registered nurses in good standing.
b. All four APRN roles require completion of a graduate degree (either Master's or Doctorate).
c. All APRN programs require completion of courses in advanced pathophysiology, pharmacology, and physical assessment in addition to numerous, specific CNS, CNM, CNP, or CRNA course requirements, competencies and preceptor-supervised clinical hours.

This bill enhances public protection by requiring APRNs to obtain a second APRN license (in addition to the RN license). The bill introduces new license requirements including that the APRN has graduated from an accredited APRN program that includes standardized educational requirements and also mandates that the APRN be certified for competence by an approved national certifying body.

3. **How would the public benefit by the occupation's ability to practice in the new proposed areas of practice? Is there any potential detriment to the public? Who would monitor practitioners to insure high quality service?**

Increase access to care for Minnesota citizens. Removing barriers to APRN practice will benefit the public. First, it allows all licensed APRNs who are educated and trained to deliver health care, without restraint of trade by another profession. This increases consumer access to care and choice of provider. Minnesota has 106 primary care health provider shortage areas (HPSAs) and 53 mental health HPSAs (MDH, June 2012). APRNs have the requisite education and training to meet specific health care needs of citizens in these HPSAs.

Decrease health care costs. Removing barriers to APRN practice has the potential to control or decrease health care costs by increasing competition in the health care market place and allowing for full utilization of APRNs who deliver care at a lower cost to the system. Not all patient health care needs to be delivered by a physician. In fact, often times patients need health care that requires nursing intervention or expertise in procedures that can very safely be performed by APRNs (e.g. routine physician exams, health promotion, education about chronic disease management, control of high blood pressure, diagnosis of strep throat, routine maternity care, problem-solving social determinants of health or lifestyle issues that interfere with health or chronic disease management). Management of health care costs should include determining the requisite education and training needed to provide the level of health care needed by a patient at a particular time in the health care experience.

APRNs deliver safe, effective care. APRNs, like physicians, have a moral obligation to provide safe, optimal care and to avoid causing any harm to their patients. Physicians and APRNs alike occasionally have outliers in their professions who do not conform to all recommended standards of care. Nothing in this bill or in the health professionals' practice acts can completely prevent a physician or APRN from causing harm to a patient. However, there is a substantial 20-year body of evidence demonstrating that APRNs deliver safe, effective health care. There is no evidence to show that there has been harm or detriment to the public in the 19 states and D.C. that already allow APRNs to practice to the full extent of their education and training without

physician oversight. APRN practice is monitored by and under the regulation of the MN Board of Nursing. This bill seeks a second licensure based on specific educational and certification requirements for APRNs that would enhance public protection and provide increased authority to the Board of Nursing to increase monitoring of APRN practice and collection of APRN data.

4. **Could Minnesotans effectively receive the impacted services by a means other than the proposed changes to scope of practice?**
   Physicians, physician assistants, and APRNs can all provide primary care and other types of health care needed by Minnesotans. The fact remains that we have 106 primary care HPSAs and 53 mental health HPSAs in Minnesota. We need "all hands on deck" to meet the health care needs of our citizens. Removing barriers from APRN practice and preventing restraint of trade of APRN practice will remove barriers and permit APRNs to provide services to the full extent of their education and training. Removing these barriers will improve Minnesota's APRN practice environment and lessen the likelihood that APRNs will choose to leave Minnesota to practice in states where APRNs have full practice authority.

5. **How would the new or expanded services be compensated? What other costs and what savings would accrue and to whom?**
   Cost effective care. This bill does not increase the APRN scope of practice nor does it seek to change reimbursement rates for APRNs in Minnesota. However, removing the requirements that APRNs practice in settings that require a specific physician (or group of physicians) to manage patients with APRNs and require that APRNs have an annual written prescribing agreement, allows for flexibility and innovation in new models of health care and allows for cost-effective alternatives to current models of care. APRNs provide high quality care at a lower cost. APRNs agree with physicians that team-based care is optimal for patients with complex health care or social determinants of health problems (e.g. poverty, language barriers, lack of transportation, poor housing or access to nutritional food, etc.). However, there is no evidence warranting that physicians must always lead the team.

   Team leadership should be determined by the patient care goals. Helping patients holistically manage social determinants of health is a core function of nursing practice. Cost-effective, culturally sensitive, nursing models of care have been created in states that do not require physician oversight. For example, a CNM and CNP-run clinic for racially and ethnically diverse, low-income women and children in Washington D.C. has been highly successful in dramatically decreasing premature births, infant or maternal mortality, and Caesarean section rates while increasing breast-feeding rates. Healthier mothers and babies significantly reduce future Medicaid costs for the state. This type of health care model would not be possible in Minnesota under current statute.

   Lower cost for effective care. Retail clinics in Minnesota that provide easy access to care and lower costs must still add the costs of having physician oversight of prescriptive agreements and practice to their bottom lines in Minnesota. Team-based care is costly and not always necessary for healthy citizens who simply require preventative care, health screening, or minor illness management. Requiring APRNs to provide care for all of their patients within a team model with physicians is simply not cost-effective. The most cost-effective model is to require APRNs to collaborate, consult with, or refer patients to other health care providers such as physicians when the condition of the patient warrants this escalation in care and cost.

6. **What, if any, economic impact is foreseeable as a result of the proposed change?**
This bill requires a second licensure in addition to the RN license. There will be initial costs accrued to operationalize this new licensing process. These costs will be recovered within five-years through licensure fees. The licensure fees will fund needed tracking of APRN workforce and practice data.

   APRNs provide high quality care at lower cost to the system and are educated and trained to provide 60-80% of most primary health care needs. This bill removes barriers that currently prevent some cost-effective models of care delivery. The state Medicaid program, state mental health programs, and other state-run health care services would experience a positive economic impact.

7. **What other professions are likely to be impacted by the proposed changes?**
Positive impact on physicians. This bill has the potential to have a positive practice impact for physicians who serve in a more consultant-type role or focus their practice more on patients whose care requires the increased complex pathophysiology knowledge and skills physicians acquire during their education and training. It may also positively impact physicians by reducing the burden or misperceived liability of having to provide practice oversight or sign written prescribing agreements for APRN colleagues.

   Physician Assistants. Physician assistants may perceive that this bill gives APRNs an advantage in the health care marketplace. Physician assistants practice a more limited scope of medicine and currently do so under physician supervision. APRNs practice advanced practice nursing, a different discipline than medicine, although there are some overlapping skills. The bill could have the opposite effect of causing some physicians to prefer hiring physician assistants who require supervision.

   Possible financial impact on physicians. This bill has the potential to have a negative financial impact for physicians who are currently benefitting from limited health provider competition or receiving reimbursement or financial payment as a result of overseeing APRN practice or prescriptive authority in the following ways:
   - The bill removes opportunity for any physician to restrain the ability of an APRN to practice, which in turn could increase competition or decrease the physicians' patient numbers.
   - The bill removes practice and prescribing agreement requirements between physicians and APRNs that currently result in some physicians receiving payment of money they charge an APRN.

   Anesthesiologists may oppose this bill for financial reasons. Anesthesiologists who medically direct four CRNAs simultaneously delivering perioperative anesthesia to patients with surgeries in four different anesthetizing areas receive an insurance or Medicare/Medicaid payment per each patient as a result of this supervision. This payment is in addition to the CRNAs reimbursement for anesthesia services. Patients having similar types of surgeries in rural hospitals receive CRNA-delivered anesthesia care without anesthesiology medical direction in collaboration with the surgeon, dentist, podiatrist or obstetrician. Thus, there is a substantial financial incentive for anesthesiologists to oppose this bill.

8. **What position, if any, have professional associations of the impacted professions taken with respect to your proposal?**

Opposition. The Minnesota Medical Association, the Minnesota Chapter of the American Academy of Family Practice, the Minnesota Society of Anesthesiologists, Minnesota physician members of the American Society of Interventional Pain Physicians, the Minnesota Psychiatric Society, and the Minnesota Chapter of the American College of Emergency Physicians oppose H.F. 435.

Support. There is a growing list of physicians who support this bill. Among them are notable leader-physicians who stand in strong support of this bill: Dr. Frank Cerra, MD, current faculty member in the University of Minnesota's National Center for Interprofessional Education and Collaboration, and former VP and Provost of the University of Minnesota Academic Health Center; Dr. Theresa Zink, MD, co-chair of the Governor's Health Reform Task Force Workforce Group; and Dr. Steven Calvin, MD, medical director of the Minnesota Birth Center.

Consumer groups who support this legislation include the Minnesota AARP, national AARP, the Childbirth Collective (a Minnesota non-profit serving birthing families).

Professional nursing organizations who support this bill include the Minnesota Nurses Association, the Minnesota Organization of Registered Nurses, the Minnesota Organization of Leaders of Nursing, the Minnesota Action Coalition, the Minnesota Center for Nursing, the American Psychiatric Nurses Association, Minnesota Nurse Practitioners, Northern Minnesota Nurse Practitioners, Association of Southeastern Minnesota Nurse Practitioners, the Minnesota Chapter of National Pediatric Nurse Practitioners, the Minnesota Association of Nurse Anesthetists, the Minnesota Affiliate of National Association of Clinical Nurse Specialists, and the Minnesota Affiliate Chapter of the American College of Nurse-Midwives.

Additionally, the Institute of Medicine's *Report on the Future of Nursing* (2010) recommends that state legislatures pass the national APRN Consensus model language. This recommendation is also included in the 2012 Governor's Health Reform Task Force Report: *Roadmap to a Healthier Minnesota.*

9. Please describe what efforts you have undertaken to minimize or resolve any conflict or disagreement described above.

Efforts to mitigate opposition. The MN APRN Coalition lobby team and several members met with opposition representatives during the 2013 legislative session twice to discuss concerns with the bill. Both groups' lobby teams met again in fall 2013.

On December 11, 2013 physicians, APRNs, and lobbyists from both sides met again with the aid of a neutral attorney facilitator. The meeting focused on four areas of disagreement: (1) level of required collaboration, (2) the written prescribing agreement, (3) physician oversight of Schedule II narcotics (APRNs may currently prescribe Schedule II narcotics under a written prescribing agreement), and (4) interventional pain management performed by CRNAs. At the conclusion of our two hour discussion, parties agreed that the physician opposition group would provide language revisions. A further meeting was proposed for in mid-January after having time to review revised language. The physician groups submitted revised language on January 15th accompanied by an email that indicated the physician opposition group posited another meeting between clinicians would not be helpful.

The language submitted pertained only to a revised definition of collaboration that defines collaboration as a formal, mutually agreed upon plan for all APRN patient management and states that each APRN role must practice in such a collaborative environment. The proposed language is not a movement or change as it continues to limit the authority of APRNs to practice to the full extent of their education and training. This language poses the same barriers, particularly in rural areas where team care is not always necessary or feasible for all patients. APRNs agree that all health care providers must at times collaborate, consult, refer, etc. However, APRNs assert a more prudent, cost-effective approach is to require all APRNs to collaborate, consult, or refer patients *when warranted by the patient's condition* not require it when it will limit access and increase cost without added benefit. The revised language, as written by the physician group, still ties all APRN practice to a collaborative team, whether or not the patient or patient condition warrants that level of collaboration. Because the physician group did not propose language revisions for the other three identified areas of concern, the APRN group is in process of drafting some revised limitations and requirements for CRNAs who engage in chronic pain management services as a significant portion of their practice. Language limiting CRNA practice in pain intervention should address the interventional pain management physician concerns. The language will be sent to the physician group in the next week.

214.002 Subdivision 1., 2., and 3 Materials

Subd. 2. Contents of Report

1. **The harm to the public that is or could be posed by the unregulated practice of the occupation or by continue practice at its current degree of regulation:**

   The bill does not remove or lessen current MN Board of Nursing regulation of APRN practice. APRNs are still held to the current standard of care that a prudent APRN would use in a similar patient situation. This bill continues to mandate MN Board of Nursing regulation and disciplinary action for failure of the APRN to practice based on acceptable standards of care. The bill enhances the MN Board of Nursing's ability to standardize APRN practice by enacting a national, standardized APRN consensus model of practice, and increases the Board's funds through APRN licensure to improve APRN data tracking. The bill removes two requirements for physician/medical practice oversight of the practice of advanced practice nursing. Evidence is lacking to support any notion that the public has been harmed by removing physician oversight of APRN practice in 19 states and the District of Columbia.

2. **Any reason why existing civil or criminal laws or procedures are inadequate to prevent or remedy any harm to the public:**

   The existing Nurse Practice Act contains requirements that pose barriers that prevent some APRNs from being able to practice. Barriers that prevent every available health care provider from being able to provide health care poses potential harm to Minnesotans who live in health provider shortage areas and will not be able to seek health care until it is too late. This bill removes barriers that decrease access to care.

3. **Why the proposed level of regulation is being proposed and why, if there is a lesser degree of regulation, it was not selected:** (Please see response #1 on page 1.)

   Bill eliminates physician oversight. The bill does not expand the scope of practice of what each APRN role may perform. The bill removes the requirements for physician oversight in order for APRNs to practice to the full extent of their education and training All four categories of APRNs are currently authorized to practice nursing care, diagnose, treat, manage patient care, order

necessary diagnostic tests and procedures, prescribe pharmacological and non-pharmacological agents, and consult and collaborate with, and refer patients to other health professionals as appropriate to their role (e.g. CNS, CNM, CNP, CRNA) and their specific focus population (e.g. Pediatric NP or Adult/Geriatric NP). However, under current law, APRNs must practice this advanced practice nursing scope in settings where a specific physician or group of physicians: (1) has agreed to work with the APRN to manage the care of patient, and (2) has signed an annual written prescriptive agreement that lists a broad group of drug categories (not specific drugs) that may be prescribed by the APRN. (CNMs are an exception to the second requirement. CNMs may prescribe all drug categories without a written prescribing agreement.) These two oversight requirements create barriers for APRN practice and patient access to care. Some APRNs in Minnesota are not able to practice at all because they cannot find a physician willing to provide this oversight. Current law does not protect APRNs from restraint of trade. Some APRNs are required to pay physicians significant amounts of money (e.g. $5,000, $10,000, etc.) in order to meet these requirements. This bill removes these barriers, and eliminates a misperception of physician liability.

4. **Any associations, organizations, or other groups representing the occupation seeking regulation and the approximate number of members in each in Minnesota:**
   There are four groups of APRNs and their numbers are as follows (MN Board of Nursing 1-26-2014): 269 CNMs, 3,726 NPs, 1,720 CRNAs, and 541 CNSs.

5. **The functions typically performed by members of this occupation group and whether they are identical or similar to those performed by another occupational group or groups:**
   Overlapping scopes of practice. APRNs care for patients based on their nursing science framework and use all of their previously learned nursing skills in addition to performing some skills that overlap with those of physicians and physician assistants. These areas of overlap differ depending on the APRN's role and population focus. Overlapping skills for CNPs and CNSs include performing physical examinations, ordering and interpreting laboratory and diagnostic tests, diagnosing, treating, or managing acute and chronic illnesses, prescribing medications, consulting with or referring to specialists or other health care providers, and performing various health care procedures such as suturing, splinting a fracture, or debriding a wound. In addition to the above list of overlapping skills, CNMs manage women's reproductive needs, provide prenatal care, assist women during labor, birth, and postpartum recovery, and provide examination and initial care of babies during the first few weeks of life. CRNAs perform essentially the same perioperative cares and procedures as those performed by anesthesiologists.

   APRNs are already experienced registered nurses when they enter APRN graduate education programs. The discipline of nursing is unique and different than the discipline of medicine. Basic nursing education is grounded in a holistic mind-body-spirit view of persons and focuses on the import role people's environment (family, work, education, socioeconomic status, housing, social stress) plays in whether or not they achieve optimal health.

6. **Whether any specialized training, education, or experience is required to engage in the occupation and, if so, how current practitioners have acquired that training, education, or experience:**
   APRN education requirements include the following:

d. Persons admitted to APRN programs must have a bachelor's degree (or equivalent) in nursing; admitted students are already practicing registered nurses in good standing.
e. All four APRN roles require completion of a graduate degree (either Master's or Doctorate).
f. All APRN programs require completion of courses in advanced pathophysiology, pharmacology, and physical assessment in addition to numerous, specific CNS, CNM, CNP, or CRNA course requirements, competencies and preceptor-supervised clinical hours.

This bill enhances public protection by requiring APRNs to obtain a second APRN license (in addition to the RN license). The bill introduces new license requirements including that the APRN has graduated from an accredited APRN program that includes standardized educational requirements and also mandates that the APRN be certified for competence by an approved national certifying body.

7. **Whether the proposed regulation would change the way practitioners of the occupation acquire any necessary specialized training, education, or experience and, if so, why:**
This bill does not change the way APRNs are currently educated or clinically trained.

8. **Whether any current practitioners of the occupation in Minnesota lack whatever specialized training, education, or experience might be required to engage in the occupation and, if so, how the proposed regulation would address that lack:**
Currently, a very small number of CRNAs, CNMs, and CNPs have post-baccalaureate certificates and do not have a graduate degree. These APRNs graduated prior to a national standardized change to move all APRN education programs into graduate schools. APRNs are all required to be certified by a national certifying body which requires an entry-level examination. The bill provides any advanced practice registered nurse with authority to practice as an advanced practice registered nurse in this state that is valid at time of enactment shall be eligible to apply for licensure as an advanced practice registered nurse.

9. **Whether new entrants into the occupation would be required to provide evidence of any necessary training, education, or experience, or to pass an examination , or both:**
To obtain an APRN license, an APRN would need to submit proof of passing a national certification exam in his/her APRN role and population focus. In order for an APRN to qualify to take the certification exam, they must submit proof of graduation from an accredited graduate program in the APRN role and population focus. All APRN education programs must be nationally accredited and comply with the national standards for APRN education. To maintain APRN licensure, APRNs would be required to submit proof of ongoing certification maintenance that includes continuing education.

10. **Whether current practitioners would be required to provide evidence of any necessary training, education, or experience, or to pass an examination, and if not, why not:**
Current statute requires proof of certification so no change is expected.

11. **The expected impact of the proposed regulation on the supply of practitioners of the occupation and on the cost of services or goods provided by the occupation:**

There are currently 6,256 APRNs in Minnesota. Some APRNs are choosing to leave Minnesota to practice in states where APRNs have full practice authority. Neighbors Iowa and North Dakota have full APRN practice authority. North Dakota and Wisconsin grant APRNs full prescriptive authority. Removing barriers to practice is important to recruiting and keeping APRNs in Minnesota's healthcare workforce.

Subd. 3.

1. **Typical work settings and conditions for practitioners of the occupation;**
   Often, APRNs work in environments that include other interprofessional health care providers. Working conditions are typically environmentally safe and respectful. However, institutional barriers as well as regulatory and statutory barriers often limit APRN practice to a level significantly less than APRNs' level of education and training.
   a. CNPs work in a large variety of settings including but limited to: ambulatory outpatient clinics; inpatient medical centers; public health departments; occupational health centers; schools, retail clinics; rehabilitative, transitional and long-term care facilities; hospice and home health services; Indian Health Service clinics; federally qualified health clinics; Minnesota's correctional system; homeless shelters; and schools of nursing.
   b. CNMs typically work in birth centers; women's health and obstetrical care clinics; hospital child birth units; high school clinics, public health or community-based clinics; federally qualified health centers; and schools of nursing.
   c. CRNAs work in urban and rural hospitals and medical centers, critical access hospitals, EDs, outpatient surgery and procedure centers (e.g. endoscopy centers, etc.); podiatry facilities; dental offices; obstetrical units; and schools of nursing.
   d. CNSs work in inpatient hospitals/medical centers; ambulatory clinics; entrepreneurial practices (e.g. diabetes management consultation); occupational health settings; and schools of nursing.

2. **Whether practitioners of the occupation work without supervision or are supervised and monitored by a regulated institution or by regulated health professionals:**
   This bill does not expand or change the scope of practice for APRNs. It removes the barriers to APRNs practicing to the full extent of their education and training. It imposes the same obligations of public trust expected of physicians and other health care professionals. That is to be accountable: (1) to patients for the quality of health care provided; (2) for recognizing limits of knowledge and experience; (3) for planning for the managements of situations beyond the health professional's expertise; and (4) for accepting referrals from and referring to, and consulting and collaborating with other health care professionals as warranted by the needs of the patient.