



OLR RESEARCH REPORT

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ADVANCED PRACTICE REGISTERED NURSE COLLABORATIVE AGREEMENTS

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You asked for information on the state law requiring advanced practice registered nurses (APRNs) to work in collaboration with physicians, including possible implications of removing this requirement. You also wanted to know which states (1) allow APRNs to practice independently and (2) enacted, but subsequently repealed, a collaborative practice requirement.

SUMMARY

The Department of Public Health (DPH) licenses APRNs, who perform advanced levels of nursing, including diagnosing and treating patients and prescribing medications. State law requires APRNs to perform these functions in collaboration with a licensed physician. Written documentation of this collaboration is required only for an APRN to prescribe medication. Among other things, this written agreement must specify which Schedule II and Schedule III controlled substances (e.g., drugs such as morphine, oxycodone, and anabolic steroids) the APRN can prescribe.

Removing this collaborative practice requirement would allow the state's 3,796 DPH-licensed APRNs to practice independently without physician involvement.

Proponents of allowing APRNs' independent practice cite recent studies that found (1) properly trained APRNs can independently provide core primary care services as safely and effectively as physicians and (2) physician earnings are unaffected by APRNs' independent practice. A widely cited 2010 report by the Institute of Medicine (IOM) on the future of nursing recommended that APRNs should be able to practice "to the full extent of their education and training."

Opponents, including the American Medical Association (AMA), American Osteopathic Association (AOA), American Academy of Family Physicians (AAFP), and American Academy of Pediatrics (AAP) express concerns over patients' health and safety. A recent AAFP report on the future of primary care cites APRNs as being unqualified to practice primary care independently due to their less extensive education and training compared to physicians (generally six years versus 11 for a physician).

Currently, 18 states and the District of Columbia allow APRNs to diagnose and treat patients and prescribe medications independently; eight states require APRNs to collaborate with physicians only when prescribing medications; and 24 states, including Connecticut, require APRNs to collaborate with physicians to diagnose and treat patients and prescribe medications. Connecticut, Indiana, Minnesota, and Pennsylvania require a written collaborative agreement to prescribe medication but not to diagnose and treat patients.

We found two states, North Dakota and Vermont, that removed their collaborative practice requirements in 2011. Previously, North Dakota required APRNs to collaborate with physicians when prescribing medications; Vermont required a collaborative agreement for diagnosing and treating patients and prescribing medication. Vermont now requires new APRN graduates to work in a collaborative agreement with a physician or independently practicing APRN until they complete 2 years or 2,400 hours of clinical work. After meeting this requirement, an APRN can practice independently with full prescriptive authority.

CONNECTICUT

APRN Collaborative Practice Requirement

DPH licenses nurse practitioners as APRNs. They are recognized as primary care providers and can hold hospital privileges. APRNs perform advanced levels of nursing, including diagnosing and treating changes in a patient's health status, in collaboration with a licensed physician.

In all settings, an APRN can, in collaboration with a licensed physician, (1) prescribe, dispense, and administer medical therapeutics and corrective measures and (2) request, sign for, receive, and dispense drug samples. But, an APRN can prescribe and administer medical therapeutics during surgery only if (1) he or she is currently certified by the American Association of Nurse Anesthetists and (2) the physician directing the prescriptive activity is physically present at the surgery's location ([CGS § 20-87a\(b\)](#)).

The law defines a "collaboration" as a mutually agreed upon relationship between an APRN and a physician educated, trained, or experienced in APRN-related work. The collaboration must address a reasonable and appropriate level of consultation and referral, patient coverage in the absence of the APRN, and methods to review patient outcomes and disclose the relationship to the patient ([CGS § 20-87a\(b\)](#)).

Concerning an APRN's prescriptive authority, the collaboration must be in writing and specify which Schedule II and III controlled substances the APRN can prescribe. The collaboration must also provide a method to review patient outcomes, including medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures that the APRN may prescribe, dispense, and administer ([CGS § 20-87a\(b\)](#)).

IMPLICATIONS OF REMOVING CONNECTICUT'S COLLABORATIVE PRACTICE REQUIREMENT

Removing Connecticut's collaborative practice requirement would allow DPH-licensed APRNs to independently perform all functions within their scope of practice without physician involvement. Allowing APRNs to practice independently has been debated by states for many years, with both proponents and opponents citing implications for primary care delivery, patient safety and quality of care, and physician income.

Primary Care Delivery

According to the American Association of Medical Colleges, the nation is facing a significant primary care physician shortage (approximately 45,000) over the next 10 years. This shortfall is due to several factors, including (1) increased health insurance coverage provided under the federal health care reform law; (2) demographic changes, including a growing and aging population; and (3) physicians' decreased interest in primary care because it pays less than specialty care.

Proponents argue that allowing APRNs to practice independently will help alleviate this shortage because they (1) are educated and trained to provide a range of primary care services, (2) complete their training in six years versus an average of 11 years for physicians, and (3) are paid less than physicians for providing the same health care services. A 2010 IOM [report](#), “*The Future of Nursing: Leading Change, Advancing Health*” recommended that APRNs should be able to practice “to the full extent of their education and training.”

Generally, physician groups including the AMA, AOA, AAFP, and AAP oppose APRNs’ independent practice. According to a 2011 AMA [article](#), these groups published a letter in the December 15, 2010 issue of the *New England Journal of Medicine*, in which they advocated for a physician-led, team-based approach to health care delivery, with every team member playing the role they have been “educated and trained to play.”

In addition, in its September 2012 [report](#) on the future of primary care, the AAFP called for addressing the nation’s primary care shortage through a continuing transition to physician-led, team-based care. The report cites APRNs as being unqualified to practice primary care independently due to their less extensive education, training, and clinical experience as compared to physicians.

Patient Safety and Quality of Care

Many physician organizations argue that allowing APRNs to practice independently may negatively affect patients’ health and safety. Specifically, they cite physicians’ education and training as enabling them to provide patients with a broader and more extensive expertise. At a minimum, physicians complete four years of medical school and three years of residency training compared to four years of nursing school and two years of graduate school for APRNs.

In contrast, the above referenced 2010 IOM report, which reviewed existing medical literature on patient care provided by APRNs, found that properly trained APRNs can independently provide core primary care services as safely and effectively as physicians. The report recommended that the Federal Trade Commission (FTC) identify APRN-related state regulations that have an anticompetitive effect without contributing to patient health and safety and encourage states to change these policies. In 2012, the FTC testified on proposed legislation in Kentucky,

Louisiana, and West Virginia that would allow APRNs to practice independently. The FTC suggested, provided states found no adverse patient safety evidence, that these proposals would be a competitive improvement that would benefit patients.

In addition, a 2011 New England Journal of Medicine [article](#) by Fairman *et. al* found no data suggesting that APRNs in states with greater practice restrictions provide safer and higher quality care than those in less restrictive states.

Physician Income

Opponents of allowing APRNs’ independent practice express concerns that doing so will negatively affect physicians’ income. But, a 2012 [study](#) by George Washington University’s School of Public Health and Health Services found that family physician, general physician, and pediatrician earnings were unchanged in states with fewer APRN practice restrictions.

COLLABORATIVE PRACTICE REQUIREMENTS IN OTHER STATES

APRN scope of practice requirements vary by state. According to an October, 2012 *Health Affairs* [policy brief](#), 18 states and the District of Columbia allow APRNs to practice independently, without physician involvement; eight states require APRNs to collaborate with physicians only when prescribing medications; and 24 states, including Connecticut, require APRNs to collaborate with physicians to diagnose and treat patients and prescribe medications. But, four of these 24 states (Connecticut, Indiana, Minnesota, and Pennsylvania) require a written collaborative agreement only to prescribe medication and not to diagnose and treat patients. Table 1 lists each state by category.

Table 1: APRN Practice Requirements By State

<i>No Physician Involvement Required to Diagnose, Treat, or Prescribe</i>	<i>Physician Involvement Required Only to Prescribe</i>	<i>Physician Involvement Required to Diagnose, Treat, or Prescribe*</i>
Alaska	Arkansas	Alabama
Arizona	Kentucky	California
Colorado	Massachusetts	Connecticut
District of Columbia	Michigan	Delaware
Hawaii	New Jersey	Florida
Idaho	Oklahoma	Georgia
Iowa	Tennessee	Illinois
Maine	West Virginia	Indiana

Table 1: -Continued-

No Physician Involvement Required to Diagnose, Treat, or Prescribe	Physician Involvement Required Only to Prescribe	Physician Involvement Required to Diagnose, Treat, or Prescribe*
Maryland		Kansas
Montana		Louisiana
New Hampshire		Minnesota
New Mexico		Mississippi
North Dakota		Missouri
Oregon		Nebraska
Rhode Island		Nevada
Utah		New York
Vermont		North Carolina
Washington		Ohio
Wyoming		Pennsylvania
		South Carolina
		South Dakota
		Texas
		Virginia
		Wisconsin

*Connecticut, Indiana, Minnesota, and Pennsylvania require written documentation of physician collaboration only to prescribe and not to diagnose or treat.

Source: Health Policy Brief: "Nurse Practitioners and Primary Care." *Health Affairs*, October 25, 2012.

We found two states, North Dakota and Vermont, that repealed their statutory collaborative practice requirements in 2011. The North Dakota legislature passed a bill removing the requirement that APRNs enter into a written collaborative agreement to prescribe medications ([SB 2148](#), codified as North Dakota Century Code [43-12.1-19](#)). Vermont also passed a law allowing APRNs to practice independently after meeting certain supervision requirements. Specifically, new APRN graduates must enter into a written collaborative agreement with either a physician or an independently practicing APRN for two years or 2,400 hours of clinical practice. APRNs completing this requirement earn the authority to practice independently ([H. 420](#), codified as § 1.3 VSA § 1613).

According to Vermont’s 2012 legislative [report](#), “Optimizing Vermont’s Primary Care Workforce,” these statutory changes were in response to recommendations of the 2010 IOM report and Vermont’s Blue Ribbon Commission on Nursing. By allowing APRNs to practice independently, the state hopes to attract more APRNs both to Vermont and to its areas underserved by physicians. The report notes that it is too early to determine whether these goals have been achieved and that APRNs’ independent practice may be limited by health insurance reimbursement rules, which in many cases require APRNs to have a collaborative relationship with a physician.

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