State of Vermont
Department of Health
Board of Medical Practice
108 Cherry Street–PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-657-4220
[fax] 802-657-4227

Agency of Human Services

April 10, 2018

Senate Health & Welfare Committee
Vermont General Assembly
115 State Street
Montpelier, VT 05633-5301

Re: Additional Comments Regarding H.684, An Act Relating to Professions and Occupations Regulated by the Office of Professional Regulation

To the Committee:

The Board of Medical Practice offers this on some points raised during discussion of H.684.

1. What Is the Question Before the Committee?

The Board is concerned that Section 15 of H.684 proposes to remove standards that are essential for maintaining minimal of regulatory standards necessary to protect the public interest. During witness presentations the discussion of this bill has strayed from:

What state regulation is necessary to ensure an advanced practice registered nurse has the minimum training and experience to practice safely, or to practice independently?

And instead focused on a discussion of:

What are some examples of APRNs who have more than the minimum requirement for clinical training, and who work in high-functioning practices?

APRN witness spoke about the many hours of clinical training they completed. They spoke about the excellent collaboration that occurs in their practices. They spoke about difficulty they encountered in setting up independent practices, and forces that deter independent practice. All that information is irrelevant to the fundamental question for the State of Vermont, which must be an inquiry as to **what <u>can</u> happen**? What is the <u>minimal training</u> that someone needs to be granted a license? Does Vermont law allow a newly-licensed APRN with no experience to open a practice? What is the minimum that the State owes to the patients who will see an inexperienced health care provider? What will happen if an inexperienced APRN works independently or in a practice that does not effectively promote collaboration? Should the state create a regulatory floor to ensure, or at least promote, the availability of mentorship for the least experienced health care providers? We submit that if you consider those questions, you will

hesitate to remove the minimal regulatory measures that would be eliminated by the proposal before the Committee.

On Friday we offered a comparison to the requirement for physicians to take Continuing Medical Education (CME) as a condition of license renewal. Most physicians engage in many more hours of CME than required to renew a medical license under Vermont law and Board Rules. Yet, the General Assembly has determined it appropriate for the State of Vermont to require CME to renew a license because it is the duty of the state to establish reasonable measures to ensure that a health care provider who is allowed to provide medical care maintains current knowledge. There's some burden to physicians who must maintain evidence of completion of training, and some burden to the Board, which must administer the requirement. However, there is value in establishing regulatory standards to promote maintenance of current knowledge. The need for regulation of a profession is not determined by all that is right with the profession; regulations establish minimal standards that members must meet.

The Board's position is not that APRNs do not collaborate. The Board's position is that without a requirement for inexperienced APRNs to maintain collaboration agreements, it increases risk that patients will be treated by inexperienced licensees who do not have access to mentorship.

The Board submits that if the Committee focuses on the right question – what is the minimum that must be done to protect the public? – you will agree that the existing requirements, which are not unduly burdensome, should be maintained.

2. The National Standard for Clinical Training Hours for APRN Programs is 500 Hours

APRN program curricula are set according to a document by the National Task Force on Quality Nurse Practitioner Education, a collaboration of bodies prominent in APRN education. Criterion III.E on page 12 states: "The *NP program/track* has a minimum of 500 supervised direct patient care clinical hours overall." A copy is enclosed.

On Friday we heard examples of APRNs with more hours of clinical training. The question is not if some or many APRNs have more than 500 hours. The critical question for patients who will be cared for by a newly-licensed, newly-graduated APRN is: how many clinical training hours are required to obtain a license? The answer is 500. Nothing more is required under law or the Rules.

3. Elimination of Practice Guidelines Will Leave It to the Discretion of APRNs to Practice in New Fields.

Elimination of 26 V.S.A. § 1612 and its requirement for practice guidelines will take away all formal limits that tie APRN practice to an area for which the APRN has been trained and leave it to APRNs to decide that their knowledge and experience is sufficient to practice in a new area. On Friday it was suggested that APRNs would be restricted by scope of practice. However, the BoN Rules define scope of practice in this way:

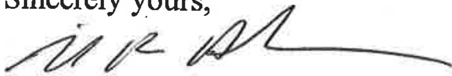
8.5 Scope of Practice
(a) Nurse practitioners providing primary care may be primary care providers of record.

(b) The scope of an APRN includes:
(1) registered nurse scope of practice;
(2) acts of medical diagnosis including, ordering and interpreting diagnostic tests and procedures;
(3) prescribing medications;
(4) prescribing medical, therapeutic, or corrective measures;
(5) initiating written or verbal orders to other health care providers; and
(6) managing and evaluating care.

There is nothing more in the law or in the BoN Rules to tell APRNs what the limits are. The Committee heard that OPR has an enforcement division that can take care of APRNs who work out of scope. There are some problems with that. First, with the wide-open standards that would be left in statute and the BoN Rules, it would be difficult to bring such a case. Second, and more importantly, that statement implies that OPR would be bringing enforcement cases in response to problems. But how do problems typically come to the attention of medical regulators? Patients file complaints because they have been harmed or had a bad experience. The State of Vermont should not leave it to patients to discover instances in which APRNs err in deciding they are ready to practice in new areas.

The Board submits that this proposal leaves an unacceptable gap in the regulation of APRN practice. As noted by the APRN witnesses themselves, the administrative burdens associated with these requirements are minimal – just a couple of pages to submit. An enclosed copy of the Board of Nursing template for Practice Guidelines and Collaborative Agreements confirms how limited the requirements are. Although brief, these documents play the important roles of defining the outer limits of an APRN's scope of practice and promoting access to collaboration for inexperienced APRNs. The minimal burden they pose is not too much to ask in order to protect the public from an APRN who is not prepared for fully independent practice, or from APRNs who might err in deciding that they are prepared to practice in a new area of medicine.

Sincerely yours,



David K. Herlihy
Executive Director

Enclosures
1. Excerpt, Criteria for Evaluation of NP Programs
2. Template for APRN Practice Guidelines/Collaboration Agreement

2016 CRITERIA FOR EVALUATION *of* NURSE PRACTITIONER PROGRAMS

5th Edition

A Report of the National Task Force on Quality Nurse Practitioner Education

requirements to apply upon successful completion of the program.
- Documentation demonstrating that a program prepares graduates to meet educational eligibility requirements for the national certification examination(s) for each NP track.

Criterion III.C.2: Official documentation states the NP role and population focus of educational preparation.

Elaboration:
Official documentation (e.g., transcripts or official letters with institutional seal) states the NP role and *population-focused* area of educational preparation to include primary care or acute care or both, as applicable. The official transcript is preferred as it is the permanent documentation of the student's coursework and graduation from an educational program.

Required Evidence of Meeting Criterion:
- A sample transcript for a NP graduate showing educational preparation for the NP role and at least one (1) population focus
  and/or
- A sample official letter with institutional seal used to specify the educational preparation for the NP role and at least one (1) population focus.

Criterion III.D: The *curriculum* plan demonstrates appropriate course sequencing.

Elaboration:
The *curriculum* plan documents the course sequencing and prerequisites designed to promote development of *competencies*. Clinical experiences are supported by preceding or concurrent didactic content. A student completes the basic graduate coursework and APRN core coursework (advanced physiology/pathophysiology, advanced health assessment, and advanced pharmacology) prior to or concurrent with commencing clinical coursework.

Required Evidence of Meeting Criterion:
- The program of study for graduate degree and post-graduate (full and part-time), including pre-requisites.

Criterion III.E: The *NP program/track* has a minimum of 500 supervised direct patient care clinical hours overall. Clinical hours are distributed to support competency development that represents the population needs.

Elaboration:
Direct patient care clinical hours refer to hours in which direct clinical care is provided to individuals and families in one of the six *population-focused* areas of NP practice; these hours do not include skill lab hours, physical assessment practice sessions, or a community project if it does not include provision of direct patient care. Clinical experiences and time spent in each experience are varied and distributed in a way that prepares the student to provide care to the populations served, which may include telehealth and international direct care experiences. For example, an FNP student receives experiences with individuals/families across the life span, and the adult-gerontology NP student receives experiences with adults across the adult age spectrum from adolescent to older adult, including the frail older adult. In addition, whereas 500 direct patient care clinical hours is regarded as a minimum, it is expected that programs preparing NPs to provide direct care to multiple age groups, e.g., FNP (or lifespan), will exceed this minimum requirement. The distribution of hours is based on the program's *population-focused* area of practice.

Simulation is recommended to augment the clinical learning experiences, particularly to address the high-risk low-frequency incidents; however, *simulation* experiences may only be counted as clinical hours over and above the minimum 500 direct patient care clinical hours. Programs are encouraged to track the use of *simulation* to enhance the clinical experience. (See Sample Form H to record *simulation* experiences used for *evaluation* and/or teaching above the minimum required 500 clinical hours for the *population-focused* area of practice and role.)

Combined nurse practitioner/clinical nurse specialist programs include content in both the CNS and NP roles and *population-focused* areas of practice and prepare graduates to meet educational eligibility requirements for *certification* in an NP *population-focused* area of practice. Content and clinical experiences in the CNS and NP areas of practice are addressed and clinical experiences in both role areas are completed. There is an expectation that a minimum of 500 direct patient care clinical hours is needed specifically to address NP *competencies* in the preparation of the NP role and *population-focused* area of practice. An overlap of direct patient care clinical hours may occur across NP and CNS preparation; however, faculty must document the overlap of these hours. It is recommended that programs retain this documentation as well as provide it to students in the event future verification is needed for credentialing and other purposes.

Dual track NP programs include content in two NP *population-focused* areas or in both primary care and acute care NP practice and prepare graduates to meet educational eligibility requirements for *certification* in these NP *population-focused* areas of practice or for both primary care and acute care NP practice. Content and clinical experiences in both *population-focused* areas are addressed and clinical experiences in both areas are completed. While a minimum of 500 clinical hours is needed in each single *population-focused* area of practice to meet the NP *competencies*, an overlap of clinical hours might occur across the two roles (primary care and acute care) or the two NP *population-focused* areas. However, NP programs must

Template for
APRN Practice Guidelines / Collaborative Agreement

Follow this template – all elements must be present for approval.

Section A:
Personal Data
Name:
Certification:
Certification organization:

Examples of what the above should look like:

Jane Doe
Family Nurse Practitioner
American Academy of Nurse Practitioners (AANP)

John Doe
Family Psychiatric Mental Health Nurse Practitioner
American Nurses Credentialing Center

Jane Doe
Certified Nurse Midwife
American Midwifery Certification Board

John Doe
Certified Registered Nurse Anesthetist
National Board on Certification & Recertification of Nurse Anesthetists

Section B:
Collaborating APRN, MD, or DO: (Needs to fulfill transition to practice hours)
Name:
Specialty:
Vermont License Number:
Contact Telephone Number:

Examples of what the above should look like:

John Smith, APRN	Jane Smith, MD
Pediatric Nurse Practitioner	Pediatrician
Vt. License # 101-XXXX	Vt. License # XXXX
802-xxx-xxxx	802-xxx-xxxx

If you have fulfilled the transition to practice hours and have a "Transition to Practice Attestation" form on file with the Board of Nursing, you do not need to have this section in your practice guidelines.

Section C:
Clinical Practice:
- Practice Name:
- Physical Practice Address:
- Practice Telephone Number:
- Client Population (you will be serving):
- Type of Care (you will be providing):

> **Examples of what the above should look like:**
>
> Pediatric Care, Inc
> 15 South Street
> Somewhere else, VT
> 802-yyy-yyyy
>
> **Client population you will serve:** Pediatrics - up to age 18
> **Type of care you will provide:** A brief description of the type of care you are providing (eg: primary care, urgent care. If in a specialty practice or department such as cardiology, endocrinology, etc, provide a brief description of the care you will be providing)

Section D:
Quality Assurance Plan:

A description of the quality assurance plan.

> **Examples of what the above should look like:**
>
> I will follow the quality assurance plan as performed by (place of employment.) This includes but is not limited to retrospective chart review, monthly peer review meetings and evaluation of specific quality goals and outcomes. I will maintain my national certification which requires a minimum number of continuing education units including pharmacology.

Section E:
( ) APRN Signature ( ) APRN Date

If transition to practice hours are not met:
( ) Collaborating Providers Signature ( ) Collaborating Providers Date

Unsigned practice guidelines will not be approved. Dates MUST be current.

APRN Practice Guideline Template 2015 0422