VERMONT MEDICAL SOCIETY

Date: **April 6, 2018**

To: **Senate Health & Welfare**

From: **Jessa Barnard, VMS Executive Director**

Re: **H. 684, Section 15 - Transition to Practice for APRNs**

The Vermont Medical Society appreciates the opportunity to testify before you today regarding H. 684, Section 15, related to practice guidelines and transition to practice requirements for Advance Practice Registered Nurses. The VMS is the state's largest physician membership organization, representing approximately 2000 physicians and medical students and 100 physician assistants across specialties and geographic and practice location.

As introduced in the House, H. 684 proposed to both:

- eliminate the need for APRNs to file practice guidelines outlining the APRNs role, population focus, and specialty and
- eliminate a transition to practice requirement, or the need for a collaborative practice agreement with a more experienced physician or APRN for an APRN new to practice (the first 24 months and 2,400 hours of licensed practice in an initial role and population focus or 12 months/1600 hours for a new practice area)

Our members oppose the elimination of a transition to practice requirement for the following reasons:

- 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.[1] Our members reported appreciating the collaborative, team approach taken with the APRNs with which they work.
- No new graduate of a health professional program is fully prepared to practice without a relationship with a more experienced clinician. Physicians are required to participate in a minimum two year accredited residency training after medical school before being eligible to become a licensed healthcare provider in Vermont.[2] In order to obtain specialty board certification, including primary care specialties, physicians need to complete three or more years of supervised residency training.[3] Physicians typically have provided 12,000-16,000 hours of total patient care through training. According to the Institute of Medicine Future of Nursing report, APRNs are required to have 500-700 hours of total patient care hours through their training. Models of training APRNs are developing and include pathways to becoming a nurse practitioner without prior clinical experience.[4]

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[1] Amalberti R, Auroy Y, Berwick D, Barach P. Five System Barriers to Achieving Ultrasafe Health Care. Ann Intern Med. 2005;142:756–764, available at: http://annals.org/aim/fullarticle/718374. The article finds that: "Given the interdisciplinary nature of health care and the need for cooperation among those who deliver it, teamwork is critical to ensuring patient safety and recovery from and mitigation of error."

[2] http://www.healthvermont.gov/sites/default/files/documents/pdf/BMP_Board%20Rules%20Effective%202017.pdf (Section 18)

[3] http://www.uwmedicine.org/education/Pages/specialties-subspecialties.aspx

[4] https://www.nursepractitionerschools.com/faq/can-a-non-nurse-become-an-np

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- This change would increase the divergence in regulatory oversight between APRNs and physician assistants (PAs). PAs are required to work under physician supervision and with written delegation agreements for their entire professional career[5] while having two year training with 2,000 hours of clinical care.
- Many physicians reported that the APRNs new to practice with whom they work seek more guidance and collaboration, not less.
- A collaborative practice agreement requirement puts in place the minimum necessary pathway for all new APRNs to reach out to a more experienced professional (either a physician or APRN) for collaboration.
- A collaborative practice requirement is particularly important in the operating room environment and provides the minimum assurance to the public that a new nurse anesthetist can safely practice and has received sufficient support in their transition-to-independent practice. The operating room is an environment that is higher risk than other health care settings and the practice of anesthesiology, itself, is a complex, high-risk, dynamic patient care system. Patients in these settings are exposed to a higher risk of complications with potential to threaten health and life. In these settings, there are abundant data supporting greater safety when teams provide anesthesia care.[6]

In the House, VMS testified that we welcomed the opportunity to meet with the Office of Professional Regulation, the Board of Nursing and others to discuss approaches that maintain adequate support for newly-graduated APRNs but minimize the regulatory burden of APRN practice.

VMS is in support of the compromise language being offered by OPR for Section 15 as it addresses many of our concerns. Our physicians believe that this approach adequately supports new graduates, protects patient safety and reduces administrative burden. It would:

- Eliminate the practice guideline requirement for all APRNs.
- Reduce the transition to practice requirement for a new practice area from 1600 hours to 1200 hours
- Offer two options for a transition to practice: (1) maintain a collaborative practice agreement or (2) practice primarily on site with a more experienced physician or APRN who practices in the same area. Our members are primarily concerned that all new graduates have access to a more experienced clinician for mentoring, collaboration and consultation. VMS agrees that such support can be meaningfully provided either through a collaborative practice agreement or by having a provider on site with the new graduate. Having two options will also provide both graduates and employers more flexibility.

Thank you for considering our comments and we look forward to continuing to work with your Committee and the Senate Government Operations Committee on this bill.

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[5] http://www.healthvermont.gov/sites/default/files/documents/pdf/BMP_Board%20Rules%20Effective%202017.pdf (Section 23.0 & 27.0)

[6] Jeffrey H. Silber, Sean K. Kennedy, Orit Even-Shoshan, Wei Chen, Laurie F. Koziol, Ann M. Showan, David E. Longnecker; Anesthesiologist Direction and Patient Outcomes. *Anesthesiology* 2000;93(1):152-163; http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1945839