



**COLORADO**

**Department of  
Regulatory Agencies**

Division of Professions and Occupations

**The Nurse Physician  
Advisory Taskforce  
for  
Colorado Healthcare**

**Final Report  
and  
Recommendations  
on the  
Requirements for Advanced Practice  
Registered Nurses Seeking  
Prescriptive Authority**

**November 10, 2014**



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Healthcare Branch  
Nurse-Physician Advisory Taskforce  
for Colorado Healthcare

November 10, 2014

Dear Executive Director Kelley,

It is an important time for healthcare in our State. In the course of just a few short years, the landscape of healthcare has begun to change and will continue to change. The expansion of health insurance coverage to new populations, coupled with changing population demographics, places new demands on access to and quality of healthcare delivery. Healthcare organizations are working to curb costs and improve effectiveness through team-based, collaborative delivery models, distance learning and telehealth, and prevention-centered care. Colorado is not alone. These new approaches are changing the way healthcare is practiced throughout the country. States across the nation are confronted with shortages in primary care providers and, at the same time, are facing unprecedented growth in the number of consumers and healthcare costs. States have made and are making changes to their healthcare workforce to more effectively utilize different types of providers in response to new demands.

The Nurse-Physician Advisory Task Force for Colorado Healthcare (NPATCH) respectfully presents this report and recommendations regarding the ability of Advanced Practice Registered Nurses (APRNs) to fully access and utilize the prescriptive authority granted them by Colorado law. This report presents the process we undertook to carefully analyze the current statutory requirements, the impact on delivery of healthcare and workforce in Colorado, and recommendations for legislative and regulatory changes.

APRNs are a vital component of the health workforce across the care spectrum. These recommendations would support a successful transition to practice and enable APRNs to practice to the full scope of their education, experience and training, while ensuring safety and access to quality and cost effective care.

Thank you for your consideration of these recommendations.

Sincerely,

*Christie Bryant, Nursing Community*  
*Patricia McGuire Cullen, Colorado State Board of Nursing*  
*Marion Thornton, Statewide Professional Nursing Organization*  
*Mary Ciambelli, Statewide Professional Nursing Organization, Co-Chair*  
*Edward Dauer, Consumer*  
*Ilana Fischer, Consumer*  
*Gregory F. McAuliffe, Colorado Medical Board*  
*Steven Holt, Statewide Professional Physician Organization*  
*Lloyd Lifton, Medical Community*  
*Susan Townsend, Statewide Professional Physician Organization, Co-Chair*  
*Douglas Warnecke, Statewide Professional Nursing Organization*



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## **EXECUTIVE SUMMARY**

In 2013, nurse and physician communities partnered with other healthcare stakeholders to request that the NPATCH examine the efficacy of current requirements for APRNs to attain independent prescriptive authority. The NPATCH accepted the challenge after determining this work supported its mission to promote public safety and to improve health care in Colorado by supporting collaboration and communication between the practices of nursing and medicine. This issue has been a focal point of their work throughout 2014.

Stakeholders initially voiced a number of concerns for NPATCH to examine. First, that the existing shortage of primary care providers in rural and urban underserved communities would be further exacerbated by newly insured populations and changing demographics. Second, that the current regulatory requirements and other market conditions were presenting challenging barriers to nurses who wanted to obtain prescriptive authority. Finally, that neighboring states were establishing less restrictive requirements for APRNs and that these neighboring states were actively recruiting nurses from Colorado, causing Colorado to lose its competitive edge for parts of the health workforce in high demand.

The NPATCH examined legislative and regulatory history regarding APRN prescriptive authority, heard presentations from stakeholder organizations and individuals, and commissioned research to identify perceived and real barriers to APRN prescriptive authority in the first half of 2014. Of particular significance to the NPATCH's work on this issue was the 2008 Board of Nursing Sunset Review and subsequent 2009 re-authorizing legislation, Senate Bill 09-239. In addition to establishing the current regulatory framework for APRN prescriptive authority, this legislation created the NPATCH as a collaborative, interdisciplinary workgroup to promote public safety and improve health care in Colorado by supporting collaboration and communication between the practices of nursing and medicine. The NPATCH was also tasked with making recommendations to the Colorado State Board of Nursing and the Colorado Medical Board regarding the transition to the articulated plan model and harmonizing language for articulated plans.

After concluding their analysis, the NPATCH discussed the evidence and made consensus-based findings and recommendations to address barriers to APRNs achieving prescriptive authority. This report presents recommendations made by the NPATCH to both streamline and improve the process by which APRNs in Colorado may obtain prescriptive authority. The recommendations are summarized below and described more fully later in this report.

*Recommendation #1: Upon acceptance into the advanced practice registry, APRNs seeking prescriptive authority should be eligible for provisional prescriptive authority.*

*Recommendation #2: Requirements for APRNs to transition from provisional to full prescriptive authority should be modified by reducing the number of existing practice hours required and by expanding the universe of experienced prescribers that may assist the APRN seeking full prescriptive authority.*

*Recommendation #3: The State Board of Nursing should review and amend, to the extent of its authority, its current waiver process in Chapter 15 of the Board of Nursing Rules toward eliminating barriers and clarifying processes to align with other recommendations made by the NPATCH.*

*Recommendation #4: DORA should engage professional regulatory boards and other stakeholders to improve education and outreach regarding the requirements for APRNs to obtain prescriptive authority.*

*Recommendation #5: DORA should further examine the barrier of liability for experienced providers wishing to assist an APRN in meeting prescriptive authority requirements. The NPATCH recommends DORA identify appropriate liability levels for APRNs practicing independently, which may vary from the requirements for APRNs practicing in a team-based environment.*

## **Introduction**

### ***The Context: A Rapidly Changing Healthcare Environment***

Healthcare is in a rapidly evolving state, creating both challenges and opportunities for healthcare consumers and providers in Colorado and the United States. How we best provide care, educate practitioners, optimize scope of practice, harness technology, reform payment, contribute to research, analyze data, and regulate healthcare must be continually evaluated. Value, quality, access to care, and consumer protection guide our regulatory framework.

Of particular importance to Colorado's healthcare system is the role of primary care. Coloradans in every community turn to primary care providers to prevent, identify, manage, and treat disease and illness. Colorado has made many commitments over the years to building a robust primary healthcare system. Although primary care is provided by physicians, nurses, physician assistants and other health professionals in a variety of organizational environments, including public health agencies, community clinics, private practices, and settings with both primary and acute care, among others, individuals and families in rural and urban underserved communities often have challenges accessing primary care due to Colorado's shortage of primary care providers.

Increasingly, primary care is being delivered in team-based settings that utilize a force of different types of professionals to provide patient-centered, comprehensive primary care. Team-based care models represent a market transition that supports inter-professional collaboration and efficiencies in practitioner expertise, time, and cost. In addition to physicians and nurses, physician assistants (PAs) are also important to the provision of primary care in multiple settings. PAs, regulated by the Colorado Medical Board (CMB) have significant training, including a physician education program and passing a national certifying examination. Requirements vary from APRNs, however, in that PAs must be supervised and cannot achieve independent prescriptive authority.

These trends in care delivery are important to recognize in the context of other market and societal changes as well. Recent expansions in coverage mean 540,000 Coloradans will be newly-insured in the next several years, placing additional demand on both primary and specialty care across the state.<sup>1</sup> At the same time, demographic shifts mean there will be more elderly Coloradans and individuals burdened with chronic conditions such as diabetes, cardiovascular disease, and mental health issues. These shifts will contribute to increased demand in the healthcare system.

With only 10 percent of physicians practicing in rural America, despite approximately one-fourth of the population residing in rural America, nurses and other healthcare professionals can help meet increasing demand.<sup>2</sup> The solution is necessarily one that focuses on nurses, physicians, and other health care practitioners to redesign how healthcare is provided in Colorado and in the

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<sup>1</sup> Colorado Health Institute (2014). *Colorado's Primary Care Workforce: A Study of Regional Disparities*.

<sup>2</sup> National Rural Health Association (2010). What is different about Rural Health Care?  
<http://www.hrsa.gov/about/news/pressreleases/2010/100922nursingworkforce.html>

United States. Colorado should responsibly consider ways to ensure all healthcare providers are able to practice to the full extent of their training in an increasingly complex, dynamic healthcare system.<sup>3,4</sup>

### *An Overview: Advanced Practice Registered Nurses*

“Lone Rangers” was the term Loretta Ford used in reference to herself and other nurses who provided basic healthcare to rural Colorado communities in the 1940s and 50s. Ford was recognized as the founder of the nurse practitioner movement and advocated for more independent practice by nurses. Ford worked with pediatrician Henry K. Silver at the University of Colorado to address the regional shortage of family care physicians and pediatricians that hampered healthcare delivery to rural and underserved areas. As a result, they co-founded the United States’ first nurse practitioner education program at the University of Colorado in 1965.<sup>5</sup> As this example demonstrates, Colorado has a long history of trailblazing healthcare models that serve the state’s unique needs.

Historically, APRNs have been a significant presence in rural and urban underserved areas, particularly in primary care.<sup>6</sup> While the licensure data show a net increase in the number of APRNs in Colorado with prescriptive authority, there remain large disparities between urban and rural communities. The number of actively licensed APRNs in rural areas has more than doubled, increasing from 117 in 2000 to 295 in 2013. On the other hand, urban areas have seen the number of actively licensed APRNs triple, increasing from 787 in 2000 to 2,374 in 2013 according to the licensee data from the Department of Regulatory Agencies.<sup>7</sup>

APRNs are key to serving the changing needs and growing demands of Colorado health care consumers. The educational standards for APRNs are nationally standardized and include the requirement to graduate from a nationally accredited institution and passing a national certification examination, making APRNs capable to play a larger role in providing services. APRNs are important providers of primary and other health care in Colorado and engage in diagnosing disorders, prescribing treatments and medications, and providing primary care services in hospitals, clinics, community health centers, nursing facilities, and schools. They collaborate with physicians, other mental health professionals, pharmacists, dentists and other

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<sup>3</sup> Institute of Medicine (Oct. 2010). *The Future of Nursing Focus on Education*. Institute of Medicine of the National Academies Report Brief.

<sup>4</sup> Institute of Medicine (Oct. 2010). *The Future of Nursing Focus on Scope of Practice*. Institute of Medicine of the National Academies Report Brief.

<sup>5</sup> Silver, Henry, Ford, Loretta, Stearly, Susan (1967). A program to increase health care for children: the pediatric nurse practitioner program. *Pediatrics*. 39:756-760.

<sup>6</sup> Colorado Health Institute (April 2011; Rev. Jan. 2012). *A Profile of Colorado’s Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey*. Note: CHI collected data only four months following the implementation of these policy changes. CHI’s survey questions were not worded to capture the impact of the new policy changes effective in July 2010. The data are best used to generally describe perceived barriers to practice and policy concerns of APRNs.

<sup>7</sup> Colorado Health Institute (Aug. 2014). *Urban and Rural Trends in Prescriptive Authority for Colorado’s Advanced Practice Nurses*. Note: CHI notes that by 2013 approximately 12 percent of APRNs with prescriptive authority have addresses in rural areas compared to 11 percent of the state’s population. This recent growth re-balanced the distribution of APRNs with prescriptive authority to more accurately reflect the distribution of the population.

important community and healthcare practitioners. There are four types of APRNs: Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs). These roles may also include specific population foci congruent with education, including family/individual across life span, adult-gerontology, neonatal, pediatrics, women’s health, and psychiatric. Note, that CRNAs are not required to have prescriptive authority to administer anesthesia, unless they are providing pain management or other services that require a prescription.<sup>8</sup>

### *A Brief History: Nurse Prescriptive Authority*

Independent practice for nurses was first authorized in Colorado in 1980; however, nurses did not have prescriptive authority. In 1995, APRNs gained the ability to prescribe medication (HB 95-1007) after satisfying requirements established by the State Board of Nursing. At that time, nurses had to have an ongoing collaboration with a physician and a collaborative agreement, and prescriptive authority was restricted to three distinct categories: chronic and stable conditions; acute and self-limiting conditions; and palliative and end of life care. Maintenance of the prescriptive authority required ongoing collaboration with a physician with a formal collaborative practice agreement. This model is sometimes called the “dependent” model.

In 2008, the Board of Nursing’s Sunset Review (“2008 Sunset Review”) published by the Department of Regulatory Agencies, recommended a number of changes to broaden nurses’ prescriptive authority. A Sunset Review is a report required by Colorado law to determine whether the State’s current regulatory requirements are the least restrictive form of regulation to protect the public. First, the 2008 Sunset Review recommended removing limitations on the types of medications APRNs could prescribe. Second, the Sunset Review recommended eliminating the requirement for a formal collaborative agreement between a physician and an APRN with prescriptive authority, thereby establishing a new framework for independent prescriptive authority referred to as “the articulated plan model.” This model was adopted through Senate Bill 09-239.

The 2008 Sunset Review found that restrictions on the types of medications that APRNs with prescriptive authority could prescribe compromised patient care by arbitrarily prohibiting APRNs from prescribing medications within their scope of practice. The report noted that the State Board of Nursing’s requirements already restricted nurses to tasks explicitly authorized in their scope of practice and for which they possess the specialized knowledge, judgment and skill required. Regarding physician-APRN collaborative agreements, the Sunset Report noted the difficulty for APRNs in rural or underserved areas to find a collaborating physician, which created barriers to healthcare and disproportionately affected the areas of Colorado that most needed primary care providers. The Sunset Review established that the formal mechanism of a collaborative agreement was not ensuring meaningful collaboration and was overly restrictive, particularly because appropriate collaboration was viewed as an established part of a healthcare professional’s duty.

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<sup>8</sup> National Council of State Boards of Nursing APRN Advisory Committee (July 2008). Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education; Section 12-38-111.6(8)(c)(2)(II), C.R.S.



Other recommendations in the Sunset Report included exempting collaborating physicians from liability, and requiring joint rules to be adopted by the Colorado Medical Board and the State Board of Nursing to establish standards for remote consultation.

The legislation initiated by the 2008 Sunset Review (Senate Bill 09-239) created a revised framework, process, and transition to practice for APRNs seeking prescriptive authority. Instead of the collaborative agreement between an APRN and a physician (“dependent model”), which was eliminated, the new framework required an 1,800 hour mentorship in addition to an existing requirement for an 1,800 hour preceptorship (“articulated plan model”). Under this framework, which became effective in July 2010, APRNs could gain independent prescriptive authority after the completion of these 3,600 hours. This framework was developed as a compromise between APRNs and physicians. The framework was a compromise between groups, not a recommendation firmly based on any particular body of evidence at the time.

The legislation eliminated the collaborative agreement requirement, and created a longer transition to practice for APRNs. It did not adopt other Sunset Review recommendations to exempt physicians from liability when they participated in mentorship arrangements.

The following table illustrates the key changes made to prescriptive authority requirements over time from prior to the 2008 Sunset Review to today:

<b>Timeline/ Authority</b>	<b>Educational Attainment/Coursework</b>	<b>Post-Graduate Experience</b>	<b>Nurse-Physician Partnership</b>	<b>Prescriptive Authority Limits (after other requirements met)</b>
<b>1996 to 2001  (HB 95-1007) “Dependent Model”</b>	<p>certificate program post diploma, AD or BSN</p> <p>required coursework in 45 contact hours/3 semester hours in each:</p> <ul style="list-style-type: none"> <li>-advanced health/physical and psychological assessment</li> <li>-advanced pathophysiology/psychopathology</li> <li>-advanced pharmacology, pathology and assessment</li> </ul> <p>Either continuing education or upper level or post-baccalaureate level coursework</p>	1800 hour preceptorship in relevant clinical setting	collaborative agreement required to obtain and retain prescriptive authority	<ul style="list-style-type: none"> <li>-chronic and stable conditions</li> <li>-acute and self-limiting conditions</li> <li>-palliative and end of life care</li> </ul>

<b>Timeline/ Authority</b>	<b>Educational Attainment/Coursework</b>	<b>Post-Graduate Experience</b>	<b>Nurse-Physician Partnership</b>	<b>Prescriptive Authority Limits (after other requirements met)</b>
<b>2001 to 2010 (HB 95-1007) “Dependent Model”</b>	<p>Master’s Degree or higher in nursing required for prescriptive authority</p> <p>required coursework at the graduate level in 45 contact hours/3 semester hours in each:</p> <ul style="list-style-type: none"> <li>-advanced health/physical and psychological assessment</li> <li>-advanced pathophysiology/ psychopathology</li> <li>-advanced pharmacology, pathology and assessment</li> </ul>	1800 hour preceptorship in relevant clinical setting	Physician collaborative agreement required in perpetuity to obtain and retain prescriptive authority	<p>Prescriptive authority for 3 categories only:</p> <ul style="list-style-type: none"> <li>-chronic and stable conditions</li> <li>-acute and self-limiting conditions</li> <li>-palliative and end of life care</li> </ul>
<b>2010-present (SB 09-239) “Articulated Plan Model”to Present</b>	<p>Nursing graduate degree;</p> <p>required coursework at the graduate level in 45 contact hours/3 semester hours in each:</p> <ul style="list-style-type: none"> <li>-advanced health/physical and psychological assessment</li> <li>-advanced pathophysiology/ psychopathology</li> <li>-advanced pharmacology, pathology and assessment</li> </ul> <p>national certification exam;</p>	1800 hour preceptorship to receive provisional prescriptive authority; 1800 hour mentorship	Physician required for preceptorship and mentorship; independent authority granted upon completion	Must prescribe within scope of the population focus of the Advanced Practice Nurse

*The NPATCH and Senate Bill 09-239*

The NPATCH was created through SB 09-239, after a series of nurse-physician negotiations regarding the legislation highlighted the value of inter-professional collaboration. The NPATCH’s mission is to support public safety and improved health care by facilitating communication between the practices of nursing and medicine and addressing areas of mutual concern. SB 09-239 tasked the NPATCH with making recommendations to the State Board of Nursing and the Colorado Medical Board regarding the transition to the new articulated plan model and harmonizing language for articulated plans, making consensus recommendations to policy-making and rule-making entities, and supporting and collaborating between the practices of nursing and medicine to promote public safety and improve health care.

Since 2009, the NPATCH has met its mandates with regard to APRN prescribing through the following actions:

- Facilitated collaboration among the State Board of Nursing and Colorado Medical Board to develop complementary rules concerning prescriptive authority;

- Developed sample templates of Preceptorship and Mentorship Agreements in order to facilitate a smooth transition to the articulated plan model<sup>9</sup>;
- Developed a sample template of an articulated plan to meet the mandate of creating sample articulated plans; and
- Provided resources in the sample template of an articulated plan to address quality assurance mechanisms for all medication prescribers and to provide decision support tools.

### Requirements for Prescriptive Authority in Other States

As of May 2014, Colorado is one of 20 states that offer APRNs the opportunity to obtain independent prescriptive authority.<sup>10</sup> Not surprisingly, most of the states are more rural, like Colorado, where primary care workforce shortages have a larger impact, and the need to maximize each provider's scope of practice is essential to ensuring access to care.

Most states do not require additional training after graduation from an APRN program, unlike that required by Colorado's mentorship and preceptorship model. Among states in the Western U.S. that allow independent prescriptive authority by APRNs, Colorado and New Mexico are the only two with post-graduate hours required. New Mexico requires 400 hours of additional training after graduation, which is significantly below Colorado's total of 3600 hours. Of the 20 states that permit APRNs to obtain independent prescriptive authority, none require more than 400 hours of supervision.<sup>11,12</sup>

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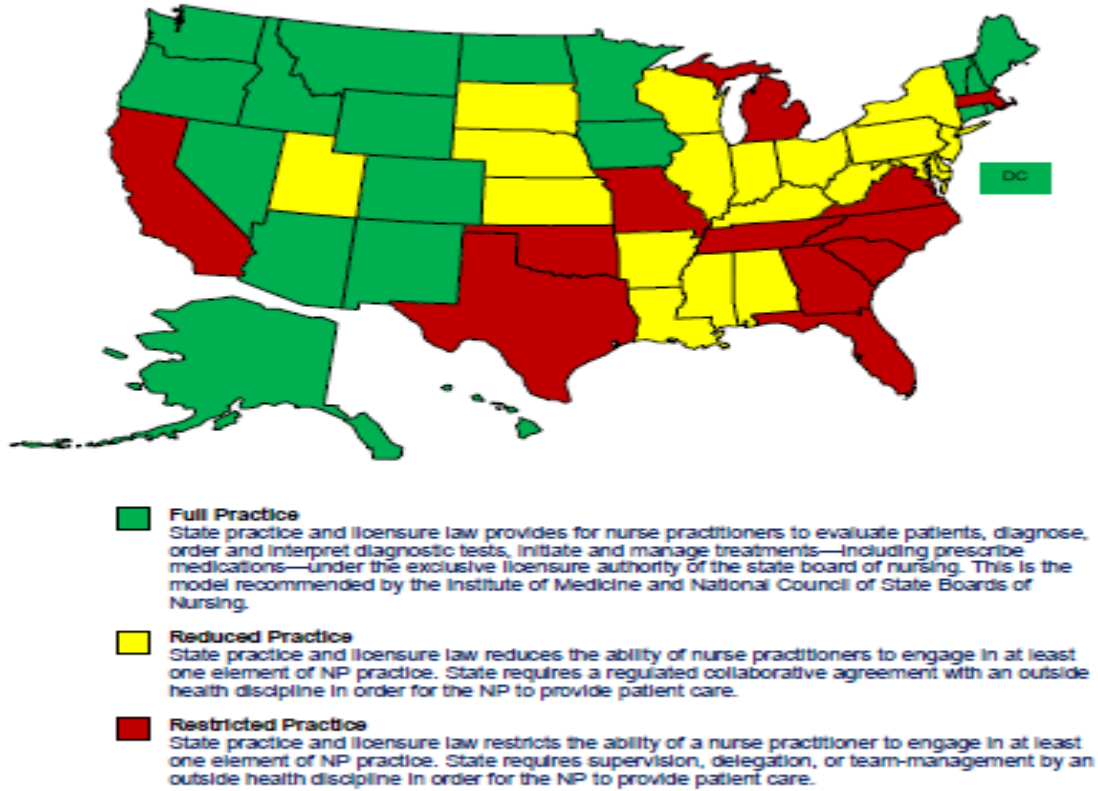
<sup>9</sup> Section 12-38-111.6 (4.5)(b)(II)(A-D) identifies the contents of an articulated plan to be developed by an APRN to ensure safe prescribing. The plan should include a mechanism for consultation and referral for issues regarding prescriptive authority, a quality assurance plan, decision support tools, and documentation of ongoing continuing education in pharmacology and safe prescribing.

<sup>10</sup> National Council of State Boards of Nursing (May 2014). APRNs in the United States: Consensus Model Implementation. <https://www.ncsbn.org/2567.htm>

<sup>11</sup> National Council of State Boards of Nursing (May 2014). APRNs in the United States: Consensus Model Implementation. <https://www.ncsbn.org/2567.htm>. **Note:** The 20 states that allow independent prescriptive authority include: AK, AZ, CO, CT, HI, IA, ID, ME, MN, MT, ND, NH, NM, NV, OR, RI, UT, VT, WA, WY. Institute of Medicine. (Oct. 2010). The Future of Nursing Focus on Scope of Practice Report Brief.

<sup>12</sup> The Board of Nursing in Maine confirmed certified nurse practitioners have full independent prescriptive authority upon licensure. After initial licensure, any certified nurse practitioner must practice under a physician or supervising certified nurse practitioner for two years. However, prescriptive authority is not dependent on this relationship. The certified nurse practitioner must complete the two years in order to practice independently regardless of whether the practitioner chooses to prescribe.

### 2014 Nurse Practitioner State Practice Environment



Source: State Nurse Practice Acts and Administrative Rules, 2014  
©American Association of Nurse Practitioners, 2014

Update: 5.13.2014

<sup>13</sup> American Association of Nurse Practitioners (2014). 2014 Nurse Practitioner State Practice Environment.

## **Identified Barriers & Key Findings**

The NPATCH was asked to evaluate the perception that the current (2010) requirements, including the pre-prescribing 1,800 hour preceptorship, additional 1,800 hour prescribing mentorship with a physician, and the development of an articulated plan for safe prescribing were burdening both physicians and APRNs without delivering the desired outcome for consumer protection. The NPATCH was also asked to develop recommendations if they were able to validate barriers for APRNs in providing safe, timely, effective, efficient, equitable, and patient-centered care.

In approaching its task, the NPATCH began by seeking to identify any associated barriers – real or perceived, intentional or unintentional, justified or unjustified. To accomplish this, the NPATCH researched the changing healthcare landscape in Colorado; gathered primary and secondary data and researched peer-reviewed articles; compared Colorado’s statutes and regulations to other states; invited individuals to share experiences with barriers to employment for APRNs in Colorado; heard presentations from individuals, professional associations, and other subject matter experts; reviewed documents regarding SB 09-239 and the transition to the articulated plan model; and held monthly open forums for stakeholder feedback and reviewed written comments over approximately a ten-month period in 2014.

The NPATCH sought and received public and stakeholder input from a diversity of perspectives. Industry experts that were consulted included APRNs, employers, hospitals, clinics, physicians, representatives of correctional healthcare, insurance providers, and professional associations. See, **Appendix A** for a summary of the work plan developed by the NPATCH. See also, **Appendix B** for a summary of the expert and stakeholder testimony, presentation and consultation considered by the NPATCH during this phase. As a result of these presentations, research, materials and extensive and varied witness testimony, the NPATCH engaged in a detailed and well-informed discussion of barriers facing Colorado APRNs seeking prescriptive authority, to identify and prioritize defined barriers, and to methodically analyze each barrier.

***Barrier #1:** Employers perceive that new graduates cannot be hired because they are unable to prescribe. In addition, there are too few physicians available to mentor the new graduates.*

***Research and Data Examined:*** The NPATCH evaluated and reviewed educational requirements, including the notable additional requirements to graduate from an accredited university that complies with national standards and the need to pass a certification examination. The evaluation by the NPATCH was supplemented by the efforts of Patsy Cullen, PhD, PNP-BC, NPATCH Member, Professor and Director, Doctor of Nursing Practice and Nurse Practitioner Programs, Regis University. The NPATCH reviewed the requirements by the Commission on Collegiate Nursing Education or Accreditation Commission for Education in Nursing, Inc. to assist in making the recommendations and findings in this report.

The NPATCH also noted the key message of the Institute of Medicine report, which supports that APRNs should be able to practice to the full extent of their education and training.<sup>14</sup> Recent studies have found that primary care services offered by nurse practitioners, certified nurse midwives, and certified nurse anesthetists resulted in no adverse patient health outcomes or adverse safety effects.<sup>15</sup>

Since 2008, APRNs have been required to graduate from a nationally accredited institution and the National Council of State Boards of Nursing adopted the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education for broad based graduate and post-graduate education. The NPATCH found that although there is a perception in the marketplace that new graduates lack expertise in pharmacology, advanced pathophysiology and advanced health assessment, and that new graduates lack standardized education and training, in fact these national guidelines and standards are governed by the Commission on Collegiate Nursing Education and enforced through accreditation by the American Association of Colleges of Nursing. According to these standards, all collegiate programs seeking accreditation must demonstrate evidence of a school curriculum that provides a minimum of three (3) semester hours (which is equivalent to 45 contact hours) each in advanced pharmacology, advanced pathophysiology, and advanced health assessment. These requirements are the standard for any APRN. Note, Colorado had this same requirement for those seeking prescriptive authority seven years earlier in 2001, and all accredited programs in Colorado are currently in full compliance with these requirements.

Since 2010, APRNs seeking prescriptive authority also must sit for a national certification examination and retain that certification in order to be granted and retain prescriptive authority, including testing on the three areas of pharmacology, advanced pathophysiology and advanced health assessment. Additional programs, such as residency programs found at Denver Health and University of Colorado Health, support efforts to improve training and nursing education to allow for a shorter transition to practice.

*Findings:* The NPATCH concluded that the barrier is real. There is no evidence substantiating that 3,600 hours of training and a longer transition to practice are necessary for prescriptive authority that protects patients.

Given the need for improved access to healthcare, nurses, including APRNs, are educated and capable of playing a larger role in providing services from health promotion to disease prevention.<sup>16</sup> APRN education has become more standardized nationally and Colorado's requirements for APRN education and training have continued to evolve in support of these trends. As training and education models advance, a lengthy transition to practice may not be warranted for patient safety. Continued improvements in nursing

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<sup>14</sup> Institute of Medicine of the National Academies. The Future of Nursing Leading Change, Advancing Health. Report Recommendations. <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf>

<sup>15</sup> Robert Wood Johnson Foundation. (May 2011). Quality of Care. Evidence Brief. Nursing Research Network.

<sup>16</sup> Institute of Medicine. (Oct. 2010). The Future of Nursing Focus on Scope of Practice Report Brief.

education include models such as compressing new information into educational curriculum to address the rapidly growing health research and knowledge and adding more instruction through these additional layers of content that will allow for fundamental concepts to be applied across settings. As curriculums move from task-based competencies to higher-based competencies, APRNs are provided a foundation for care management and decision making in a variety of clinical settings and care situations.<sup>17</sup> The NPATCH agreed that employment opportunities and opportunities for additional, qualified practitioners to serve as mentors could be expanded through a shortened transition to practice, focusing on collaborative relationships, lifelong and continued learning to improve practice environments, and safety for patients.

The NPATCH strongly considered the evaluation of nursing education including the requirement to graduate from a nationally accredited institution and to pass a national certification examination, testimony of APRNs appearing before the NPATCH, and other evidence that demonstrates action is appropriate to maintain APRNs in our state.

***Barrier 2: Adequacy of Workforce and Barriers Related to Employment for APRNs seeking prescriptive authority.***

***Barrier #2a: The role for preceptors and mentors is burdensome.***

*Research and Data Examined:* The NPATCH reviewed the existing roles and qualifications of preceptors and mentors, the statutory requirements for preceptors and mentors, the previous work by the NPATCH in facilitating the development of the complementary rules adopted by the State Board of Nursing and the Colorado Medical Board, and the expectations, liability and risks for preceptors and mentors. In addition, the NPATCH analyzed various forms of research and data to better understand the barriers for preceptors and mentors, heard testimony and anecdotal evidence from stakeholders appearing before the NPATCH, reviewed a survey by the Colorado Medical Society to understand the knowledge base of physicians on the structure for APRNs to obtain prescriptive authority and the willingness of physicians to participate in the relationship with the APRN, and compared Colorado's requirements with other states for prescriptive authority requirements for APRNs.

Illustrative examples of testimony from APRNs seeking prescriptive authority highlighted the confusion with regard to the process and necessary roles of the preceptors and mentors and extreme difficulty in locating a willing preceptor and mentor. The NPATCH heard many anecdotal stories about APRNs having difficulty finding preceptors and mentors, a similar issue identified in the 2008 Sunset Report. In addition, the Colorado Medical Society assisted the work of the NPATCH by conducting a survey of member physicians on the topic. The survey results demonstrated a lack of awareness of the requirements, a lack of understanding of or the ability to make the necessary time commitment (with approximately 60 percent member physicians being definitely willing or probably willing to work as a mentor), the need for a streamlined process for

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<sup>17</sup> Institute of Medicine. (Oct. 2010). The Future of Nursing Focus on Scope of Practice Report Brief.

preceptors and mentors in serving in the role, and the liability and risks associated with assuming such a role.<sup>18</sup>

In addition, the NPATCH considered where Colorado's regulatory requirements sit compared to other states with independent prescriptive authority as stakeholders reported a concern that surrounding states may be more attractive to new APRNs because of fewer requirements to obtain prescriptive authority, and ease of finding employment. This concern was also identified by those responding to the Colorado Center for Nursing Excellence survey.<sup>19,20</sup>

Colorado is an outlier among states in its 3,600 hour requirement for prescription authority. While the scope and prescribing authority of APRNs varies across states based upon specific statutory requirements, as noted above, Colorado requirements exceed those found in other states. Requirements in other Western states range from no additional post-graduate training to up to 400 hours of post-graduate training, in comparison to the Colorado 3,600 hour requirement. Other Western states, including Montana, Idaho, Wyoming, Utah, Arizona, Oregon and Washington, do not have requirements that align with Colorado's mentorship and preceptorship model.<sup>21</sup>

A literature review by the NPATCH suggests that APRNs are able to provide quality care to patients, including preventing medication errors, reducing or eliminating infections, and easing the transition of patients from hospital to home. APRNs may enter specialty fields, including roles as nurse anesthetist, nurse midwives, and most commonly – primary care, where they may administer anesthesia, monitor patients, provide airway management, and other advanced health assessment and intervention skills.<sup>22</sup> In many states, regulatory barriers may have resulted in some APRNs leaving primary care to work as specialists in hospital settings or leaving independent practice altogether to work as registered nurses or in other healthcare positions.<sup>23,24</sup> Additional factors may include

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<sup>18</sup> Kupersmit Research (2014). 2014 APN Prescriptive Authority Survey.

<sup>19</sup> Colorado Center for Nursing Excellence (2013). Colorado APN Background Information -- Data, Charts, Maps and Survey Responses from APNs, APN Employers, and APN students.

<sup>20</sup> Additional information to track APRNs through their educational organization showed that data was lacking and that education organizations confirmed that tracking graduates is an ongoing problem for most schools. The National Council of State Boards of Nursing conducted a 2012 "environmental scan" and found only 9 states collect workforce data in any deliberate manner, and none specifically tracked graduates.

<sup>21</sup> National Council of State Boards of Nursing (May 2014). APRNs in the United States: Consensus Model Implementation. <https://www.ncsbn.org/2567.htm>. **Note:** The 20 states that allow independent prescriptive authority include: AK, AZ, CO, CT, HI, IA, ID, ME, MN, MT, ND, NH, NM, NV, OR, RI, UT, VT, WA, WY. Institute of Medicine. (Oct. 2010). The Future of Nursing Focus on Scope of Practice Report Brief.

<sup>22</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey*.

<sup>23</sup> Institute of Medicine (Oct. 2010). The Future of Nursing Focus on Scope of Practice. Institute of Medicine of the National Academies Report Brief.

<sup>24</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey*.



insufficient wages, lack of professional challenge, lack of respect for APRNs by physicians and employers, as well as retirement.<sup>25</sup>

*Findings:* As a result of this review, the NPATCH concluded that this barrier exists. A review of statutory requirements highlights the 3,600 hour model is extensive and creates administrative burdens for preceptors and mentors, whose roles require sufficient experience to manage the extensive and confusing responsibilities. The NPATCH agreed that barriers continue to exist in the identification of and availability of experienced physicians to participate in active collaboration, as originally noted in the 2008 Board of Nursing Sunset Report and as supported by the recent Colorado Medical Society survey. In addition, Colorado is an outlier among states that allow for independent prescriptive authority. With burdensome regulatory requirements to obtain prescriptive authority, there is at least some evidence that new APRNs are finding surrounding states more attractive given the lower regulatory requirements and ease of finding employment opportunities.

These barriers are exacerbated by a lack of understanding of the requirements and a lack of streamlined processes and procedures to support physicians and APRNs in fulfilling these roles. Healthcare employers such as hospitals, community health organizations, health clinics, private practices, and others play a key role in helping APRNs successfully meet the requirements to obtain prescriptive authority. If APRNs cannot recruit assistance in fulfilling the preceptor and mentor roles, they simply cannot obtain prescriptive authority.

*Barrier #2b: Adequacy of workforce is impacted by workplace barriers faced by APRNs, including the opportunity to work independently or in team-based healthcare, and practicing without scope limitations, empanelment practices and credentialing procedures.*

*Research and Data Examined:* As the NPATCH looked to the evolving nature of healthcare in the state and nationally, considering workplace settings as one element of how to best provide care and how the issues faced by APRNs seeking prescriptive authority may best support the needs of patients. A review by the NPATCH looked at workforce data, geographic distribution of workforce, data obtained from hiring professionals and the current model and process for billing and payment structures, including a review of presentations by Colorado Association of Health Plans and Centura on hiring issues, payment model barriers, and cost drivers.

With this in mind, the NPATCH reviewed licensure data that provided a snapshot of what the APRN workforce looks like in Colorado and whether there have been any significant changes since the 2009 Nurse Practice Act changes were implemented.

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<sup>25</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey.*

- Prior to the 2008 Sunset Report, there were 1,936 APRNs with prescriptive authority in Colorado. In 2013, there were 2,698. The number of actively licensed APRNs with prescriptive authority nearly tripled since 2000 (when there were 916).
- Newly licensed APRNs with prescriptive authority entering into the Colorado market from other states have increased since 2009. From 2000-2009, there were only a couple each year. In recent years, the numbers are in the double-digits, with a high of 24 in 2011.<sup>26</sup>
- The percent of APRNs with an active prescriptive authority license increased from 35.9 percent in 2000 to a high of 59.9 percent in 2011.<sup>27</sup>

Although the numbers of APRNs with prescriptive authority are listed above, it is notable to review the overall numbers of APRNs in Colorado and the characteristics for geographic and practice type distribution of those APRNs. For this, the NPATCH looked to a 2010 Colorado Health Institute (CHI) report that noted there were approximately 4,000 APRNs registered to practice in Colorado. Of these, 3,106 were actually working in Colorado, with primary care the most common practice area.<sup>28</sup> CHI's more recent report, *Colorado's Primary Care Workforce: A Study of Regional Disparities* (February 2014), identified that approximately 56 percent of nurse practitioners in Colorado are most likely practicing in a primary care setting. Geographic distribution was provided by the CHI 2010 Advanced Practice Nurse Survey, which included a sample size of 1,000 APRNs in Colorado. This 2010 CHI report of survey findings provided perspective with regard to the scope of the APRNs practicing in rural Colorado. Overall, the 2010 Advanced Practice Nurse Survey highlighted that these rural practitioners are more likely to have a Drug Enforcement Administration (DEA) registration number than those not practicing in a rural area.

With these practitioners having prescriptive authority as evidenced by their DEA numbers, it is likely that they are able to assist in filling service gaps in those areas.<sup>29,30</sup> It is important to consider that post-Affordable Care Act (ACA) more Coloradans have insurance and the demand for primary care is rising. Statewide, 125,402 individuals enrolled in private health insurance plans under ACA; 263,452 have enrolled in Medicaid between the summer of 2013 and April 2014 based upon a Wallet Hub 2014 Health Insurance Coverage Report. With the combined addition of these 388,854 enrollees in Medicaid and private insurance combined, it is clear that the analysis of Colorado Health

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<sup>26</sup> Colorado Health Institute (March, 2014). Trends in Prescriptive Authority for Colorado's Advanced Practice Nurses.

<sup>27</sup> Colorado Health Institute (March, 2014). Trends in Prescriptive Authority for Colorado's Advanced Practice Nurses.

<sup>28</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey.*

<sup>29</sup> Colorado Health Institute (2014). *Colorado's Primary Care Workforce: A Study of Regional Disparities.*

<sup>30</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey.*

Institute in its recent report on the primary care workforce that noted a 1,900:1 panel size translates to a need for increases in the primary care workforce.<sup>31</sup>

In further exploring the role of employers and barriers in the workplace and geographic distribution of APRNs in the state, the NPATCH reviewed the Nurse Practitioner Prescriptive Authority Online Discussion Group survey by BBC Research and anecdotal references by stakeholders appearing before NPATCH.<sup>32</sup> In April 2014, BBC Research and Consulting presented the results of two online discussions they conducted among hiring professionals: one with rural area medical organizations and another among urban medical organizations. The online discussions were facilitated by working closely with the GBSM, Inc., the Colorado Rural Health Center and the Colorado Hospital Association. The discussions focused on four main areas: roles of NPs at healthcare organizations; the importance of prescriptive authority; the process of obtaining prescriptive authority; and the effects of 2010 Nurse Practice Act changes. The study found that APRNs have wide ranging responsibilities in both rural and urban organizations. Additionally, the study found the following:

- Healthcare organizations anticipate expanded roles and responsibilities for APRNs in the future, with rural organizations indicating they were looking to hire more APRNs;
- Rural participants expect they will hire and will need to hire more APRNs in the future, primarily to fill the shortage of physicians;
- Prescriptive authority is important to both urban and rural organizations but even more highly valued by rural counties because physicians were not readily available;
- Both urban and rural participants find the requirements to obtain prescriptive authority to be burdensome identifying time and limited resources as the main challenges. Urban organizations were more willing to help APRNs obtain prescriptive authority; and
- All hiring personnel prefer experienced practitioners to new graduates.

While the data reflect the results of only two focus groups, it provides insight into what hiring professionals are thinking and doing when hiring APRNs. It also highlights the recurring theme of urban versus rural, and confirms that the most common reasons for non-participation in prescriptive authority training are time and additional resources. A summary of the online discussion groups can be found in **Appendix C**.

Finally, the NPATCH reviewed data relating to empanelment practices and credentialing procedures. The 2010 CHI Profile of the Advanced Practice Nurse Workforce highlights that many APRNs working in primary care reported having many, but not all, privileges

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<sup>31</sup> Colorado Health Institute (2014). *Colorado's Primary Care Workforce: A Study of Regional Disparities*.

<sup>32</sup> BBC Research and Consulting is a Denver based private consulting firm that focuses on economic, market and policy research. After opening in 1970, BBC now has seven principals and 19 staff who serve clients around the world. The work provides insightful analysis of emerging markets and public sector issues and was consulted by Colorado Health Foundation Advanced Practice Nurse Prescriptive Project.

relating to practicing near their full scope. While many APRNs had National Provider Identifiers, which identify providers for making insurance claims, many reported problems with the ability to bill independently and to receive reimbursement reflective of an APRN's experience. This was particularly true for those working in APRN-only practices. In evaluating challenges for APRNs, the survey reflected that the ability to bill for services under their own license and to be reimbursed appropriately were among the most problematic factors for APRNs.<sup>33</sup> Specifically, Ben Price of Colorado Association of Health Plans (CAHP), presented to the NPATCH to highlight CAHP and information about network adequacy and how the ACA has impacted the market. In addition, the information provided highlighted the challenges faced by APRNs practicing independently, including empanelment issues for primary care providers. Mr. Price noted how some carriers' billing systems make it difficult for carriers to reimburse APRNs for primary care services currently (also noted in the CHI 2010 survey report). CAHP has stated a willingness to work with carriers to address specific empanelment concerns, particularly to ensure rural access to healthcare.

*Findings:* With a view of workforce data, workplace settings and APRNs in the state today, the NPATCH sought to clarify the barriers faced by APRNs in practicing to the full scope of their authority as well as ensuring adequacy of workforce in Colorado. While the data above demonstrate that Colorado experienced an increase in the percentage of APRNs with prescriptive authority, this increase may not be sufficient to meet the projected need for nurse practitioners and physician assistants as generated by the Affordable Care Act or to otherwise meet the needs and demands of healthcare consumers or to address the need based upon those leaving the field.<sup>34</sup>

There are many areas that highlight and demonstrate the barriers for APRNs with prescriptive authority to find employment and to practice to the full extent of their authority. APRNs in Colorado have diverse practices and roles in providing care and are hindered by these barriers, including those highlighted in the CHI 2010 APRN Survey. These barriers may include empanelment practices and credentialing procedures that impact the ability to obtain prescriptive authority, may impact the APRN's ability to practice independently and to provide collaborative care.<sup>35</sup>

***Barrier #3:*** *There are administrative and regulatory challenges for out-of-state applicants seeking prescriptive authority by endorsement and those seeking military waivers.*

*Research and Data Examined:* The review by NPATCH of this barrier was facilitated by a review of anecdotal information by stakeholders providing information, including a

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<sup>33</sup> A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey.

<sup>34</sup> Colorado Health Institute (2011). A Half Million Newly Insured: Is Colorado Ready. [http://www.coloradohealthinstitute.org/uploads/downloads/A\\_Half\\_Million\\_Newly\\_Insured\\_Is\\_Colorado\\_Ready\\_2\\_pg.pdf](http://www.coloradohealthinstitute.org/uploads/downloads/A_Half_Million_Newly_Insured_Is_Colorado_Ready_2_pg.pdf)

<sup>35</sup> Colorado Health Institute (April 2011; Rev. Jan 2012). A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey.

representative example of a stakeholder who had prescriptive authority in multiple other states and several years of practice as an APRN with prescriptive authority in the military, but was not aware of or did not understand the possibility to request a waiver from the Board of Nursing from the 3,600 hours based upon her experience and training. Additional APRNs came to the NPATCH with examples of where existing Board of Nursing rules were presenting barriers for those coming to Colorado with prescriptive authority in a military setting or from another state. In some instances, the Board of Nursing was able to grant a waiver and to address the needs of those testifying – highlighting a bigger issue that the requirements were not clear, concise or well understood.

The NPATCH reviewed the existing Nursing Practice Act, rules promulgated by the Board of Nursing (see, Section 12-38-111.6(4.5)(d), C.R.S.) which outline the process for applicants seeking provisional prescriptive authority, the evidence that must be provided if an applicant had authority in another state, and presentations by the Board of Nursing staff of the Board of Nursing Chapter XV rules. This review allowed the NPATCH to consider the barrier and concerns identified by stakeholder testimony with regard to current processes, special circumstances and waiver processes.

For clarity, the State Board of Nursing Chapter XV Rules and Regulations for Prescriptive Authority for Advanced Practice Nurses, sections 2.2.1; 3.1.1, and 9.2 provide the ability for an applicant to petition the Board for exceptions to certain education and experience requirements (request a “waiver”). All sections identify that the applicant may petition the Board for an exception. Exceptions are reviewed on a case-by-case basis and must demonstrate a comparable basis for meeting the requirements of these rules. The decision to grant an exception “shall be at the sole discretion of the Board.” The most common circumstances in which waiver requests are made of the State Board of Nursing are: (1) requests by licensees to find that either in preceptorship or mentorship situations that there is a corresponding Role/Specialty and Population Focus between the applicant and the respective preceptor or mentor such that the hours are accepted toward completion of the requirements; (2) requests of waiver seeking to have the Board accept credit hours toward completion of the 1800 hour preceptorship or mentorship experience; or (3) waiver requests to have the Board accept available documentation regarding issue of whether the educational requirements for prescriptive authority have been met, in particular that the required coursework in physical assessment, pathophysiology, and pharmacology is integrated into broad categories of advanced practice courses or when course titles do not accurately reflect course content, or in respect to the national certification requirement.

The NPATCH review highlighted the barriers for those APRNs seeking to obtain prescriptive authority, military provider transition to civilian practice and specific licensee circumstances presented to NPATCH, and confusion or lack of clarity around the requirements for licensees or other stakeholders.

*Findings:* The regulatory and administrative barrier faced by military APRNs transitioning to civilian life and for out of state APRNs is one of more clearly understanding the rules and processes, and requires more transparency and less

ambiguity. As a result, the barrier is one that may be resolved by existing rules. However, the need for rule and process improvements and clarity are supported by the anecdotal evidence provided to the NPATCH. The State Board of Nursing will continue to allow for waivers in specific instances, while ensuring adequate training, education and practice requirements are met. Currently, the State Board of Nursing requires that out of state APRNs, even those with prescriptive authority in other states, will meet the same hour requirements for equivalence in preceptorship and mentorship as Colorado APRNs seeking prescriptive authority. With these requirements being significantly higher than other states that allow APRNs to obtain prescriptive authority, it seems likely that Colorado's ability to attract highly qualified APRNs will continue to be difficult. With these challenges, it is even more important that the rules governing APRNs and providing the requirements to attain independent prescriptive authority are clear, concise and outline the path for those seeking to pursue this goal.

***Barrier #4:*** *There are educational and outreach challenges in ensuring an accurate and adequate understanding of the requirements to obtain prescriptive authority that are essential to the successful implementation of the requirements for prescriptive authority.*

***Research and Data Examined:*** Based upon repeated testimony by stakeholders noting the significant confusion around existing requirements to obtain prescriptive authority, the NPATCH consulted with DORA staff, including program staff for the Board of Nursing, the Division of Professions and Occupations and related staff to determine what efforts are currently in place to allow for innovative education and outreach efforts to occur based upon the existing requirements for APRNs to obtain prescriptive authority, as well as to educate about any possible changes resulting from the recommendations and findings herein. In addition, in an offer of assistance to the NPATCH, the Colorado Medical Society (CMS) surveyed its members to collect information, highlighting the confusion or lack of awareness of the current requirements for APRNs to obtain prescriptive authority.

As evidenced by testimony from stakeholders, including APRNs, existing requirements are unclear and have resulted in unnecessary or mistaken barriers for many seeking prescriptive authority. In addition to this testimony, the CMS survey was quite informative in providing information of how CMS member physicians' overall knowledge of the current process and requirements, and whether or not the extension of prescriptive authority is meeting the objectives of increased access, controlled costs, consumer safety, and improved public health, and physician members' view of potential changes to the current requirements for APRNs seeking prescriptive authority, including the CMS. After assessing the knowledge base of the existing requirements and then being informed of requirements in other states, specifically New Mexico, responding primary care physicians and other physicians that currently work with APRNs were more likely to want to see a reduction in the required 3,600 hours (46% PCPs supporting a reduction to 1,800 hours, 54% PCPs supporting a reduction to 3,000 hours). Generally, primary care physicians (42% supporting), OBGYNs (60% supporting), General Pediatrics (48% supporting) and those already working with APRNs tend to favor a

reduction in the required hours necessary for an APRN to obtain prescriptive authority.<sup>36</sup> A summary of additional notable results can be found in **Appendix D**.

*Findings:* In consideration of the anecdotal evidence provided to the NPATCH and the representative sample of CMS physician members highlighting the current state of understanding of existing requirements and opinions of proposed changes to the requirements, the NPATCH was able to determine that additional partnerships were needed and these partnerships will likely be readily available as evidenced by the presence of stakeholder attendees at the NPATCH meetings and willingness to collaborate on this important topic. In an effort to ensure future requirements are clearly communicated to APRNs seeking prescriptive authority, to mentors seeking to act in that role, and to the public utilizing the services offered, it will be essential that the Division and the impacted boards actively engage in outreach and education to its licensee population to ensure success in the transition to practice.

*Barrier #5:* *There may be risks associated with acting as a preceptor or mentor, as well as with insufficient access, burdens or risks associated with access to adequate liability insurance for APRNs with prescriptive authority that are in private practice outside of a team-based setting.*

*Research and Data Examined:* Primary resources regarding evaluation of this barrier include stakeholder testimony, a review of historical information provided to the NPATCH on liability issues for mentors and preceptors, as well as a presentation by COPIC on March 14, 2014. Stakeholder testimony also highlighted the confusing and extensive nature of the responsibilities of preceptors and mentors that may further prohibit practitioners from assuming the role. The NPATCH reviewed previous issues around liability for physicians acting in the role of preceptor or mentor, which often resulted in physicians declining to serve in the role of preceptor or mentor as COPIC and other insurance companies would not automatically cover for a medical incident related to non-employed APRNs when a physician signed a written agreement to serve as a mentor or preceptor in certain circumstances. Now, in addition to change in the commitment level for preceptors/mentors in the proposed transition to practice in this report, some physicians acting in that role may not face the same liability or risk given a recent change by COPIC as COPIC is providing greater coverage for medical incidents involving non-employed APRNs. This change only applies to those physicians insured by COPIC.

The NPATCH considered the COPIC presentation and anecdotal reports from members, including the Colorado Hospital Association in analyzing whether APRNs are able to obtain liability insurance. APRNs do have access to obtain professional liability insurance and are in fact required to hold professional liability insurance under Sections 12-38-111.8 & 12-38-111.6 (4.5)(b)(III), C.R.S. The State Board of Nursing reviews

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<sup>36</sup> Kupersmit Research (2014). 2014 APN Prescriptive Authority Survey for Colorado Medical Society. (Note: 599 CMS Member physicians completed the survey; 51% report working with APRNs, and 45% reporting they do not currently work with APRNs. Additionally, 56% report being primary care physicians; 41% reporting being specialists; 3% reporting “other role.” 46% of those completing the survey were from “Denver metro”, 36% from “city outside of Denver”, 15% from “town/rural”, and 6% “not sure how to answer.”

compliance as part of its regular complaint-driven process and the coverage is verified through an attestation of current compliance with the required coverage in applications for licensure and renewal. This requirement may be more burdensome and difficult to meet for those APRNs in a private practice outside of a team-based setting, including those in rural or underserved areas. However, professional liability insurance premiums may vary by practice type and location as evidence in a review of the CHI Report on *A Profile of Colorado's Advanced Practice Nurse Workforce*, which highlighted that even in rural areas that APRNs may not be able to afford the cost of liability insurance and may be a key factor for consideration in ensuring rural and other areas have the necessary providers.<sup>37</sup>

*Findings:* The NPATCH found that physician liability has, at least in part, been addressed by changes to policies by COPIC that now allow for more coverage for physicians when they collaborate with APRNs they do not employ although other professional liability insurers may have different policy provisions. The NPATCH also found that APRNs, when employed by a healthcare facility or a physician, are provided liability coverage by the facility or the physician's carrier. In addition, stakeholders generally confirmed that there are sufficient sources available for APRNs seeking to obtain liability insurance to meet the statutory requirements. However, concerns are raised by the possible burdensome and cost-prohibitive barriers that may exist in obtaining liability insurance for those seeking APRNs with prescriptive authority seeking to practice in private practice outside a team based setting. These burdens and barriers would particularly impact APRNs with prescriptive authority seeking to practice in a private practice outside a team based setting in rural and underserved areas.

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<sup>37</sup> Colorado Health Institute (April 2011; Rev. Jan. 2012). *A Profile of Colorado's Advanced Practice Nurse Workforce – Key Findings from the 2010 Advanced Practice Nurse Survey*.



## **Recommendations**

Based on investigations, research, and the opinions and testimony received, the NPATCH offers the following recommendations, after reaching unanimous consensus among members of the NPATCH.

### **Recommendation No. 1**

*Upon acceptance into the advanced practice registry, APRNs seeking prescriptive authority should be eligible for provisional prescriptive authority.*

*Provisional Prescriptive Authority* status may be defined as the "authority" to prescribe under either (1) a mentorship; or (2) if endorsing from another state, it is the "authority" to prescribe for no longer than 3 years during which time an articulated plan for safe prescribing is being developed.

The NPATCH makes this recommendation in response to Barrier 1, which identifies that employers perceive graduates cannot be hired because they are unable to prescribe, and the research, data and findings identified above.

### **Recommendation No. 2**

*Requirements should be amended so that in order to transition from provisional to full prescriptive authority, within 3 years of achieving the designation as advanced practice nurse with provisional prescriptive authority, the advanced practice nurse with provisional prescriptive authority shall complete:*

- *Either 6 months full-time or 1000 practice hours involving active collaboration on a representative sample of typical and complex cases;*
- *This active collaboration will be with an unrestricted prescriber lawfully practicing in Colorado in a corresponding population focus, i.e. either with an experienced physician or experienced advanced practice nurse with prescriptive authority; and*
- *Collaboration should occur through synchronous communication.*

*Active collaboration* should be defined as full and active engagement by the APRN and the mentoring physician or APRN with prescriptive authority; the two must work together willingly and fully; and the interaction must be synchronous, directed and conducted on a regular basis, with frequent opportunities for feedback, education and improvement.

*Representative sample* should include a sufficient mixture of typical and complex cases to assure competency in prescribing in the population focus.

The NPATCH makes this recommendation as a result of its evaluation of the research and data and in support of the findings for Barrier 2, which highlights the burdensome aspects of the 3,600 hour requirement for preceptors, mentors, and APRNs seeking prescriptive authority. In addition, Barrier 2 findings support that not only do employers perceive that new graduates are not viable hires, but other barriers are faced by APRNs as a result of empanelment practices and credentialing procedures. These barriers are directly linked to the need to support a shorter transition to practice as identified in this Recommendation 2.

Recommendation No. 3

*The Board of Nursing should review and amend, to the extent of its authority, its current waiver process in Chapter 15 of the Board of Nursing Rules toward eliminating barriers and clarifying processes to align with other recommendations made by the NPATCH.*

The NPATCH makes this recommendation after evaluation of the research and data provided and supported by the findings in Barrier 3, which highlight the existing regulatory process outlined under Board of Nursing Chapter 15 rules to obtain waivers for military and out of state applicants is confusing and requires education and outreach to better understand the options available as an applicant seeking prescriptive authority.

Recommendation No. 4

*DORA should engage professional regulatory boards and other stakeholders to improve education and outreach regarding the requirements for APRNs to obtain prescriptive authority.*

Education and understanding of requirements by the Colorado Medical Board, the State Board of Nursing, and stakeholders is a key to the success of any change to the requirements for prescriptive authority. Therefore, the NPATCH recommends that the Division of Professions and Occupations engage pertinent stakeholders to improve education and outreach regarding the requirements for APRNs to obtain prescriptive authority.<sup>38</sup>

The NPATCH makes Recommendation No. 4 after reviewing the data and evidence associated with Barriers 3 and 4, highlighting the need for more education and outreach on existing or new requirements as essential for the success of the Colorado APRN workforce.

Recommendation No. 5

*DORA should further examine the barrier of liability for experienced providers wishing to assist an APRN in meeting prescriptive authority requirements. We recommend DORA identify appropriate liability levels for APRNs practicing in a private setting, which may vary from the requirements for APRNs practicing in a team-based environment.*

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<sup>38</sup> Based upon stakeholder testimony, it is clear that the State Board of Nursing, Chapter 15 Rules are complex and require focused outreach and education to APRNs seeking prescriptive authority and to health care practitioners serving as mentors so that the requirements can be met.

The NPATCH finds that liability for experienced physicians acting in a collaborative role around prescriptive authority continues to be a concern. The 2008 Board of Nursing Sunset Report also noted this issue. The NPATCH recommends that DORA consider and address liability issues as barriers to participation by experienced prescribers in the transition to practice for APRNs seeking prescriptive authority. In addition, the NPATCH finds that although APRNs have access to liability coverage, barriers continue to exist for those that may seek to practice privately and outside of a team based setting. These burdens and barriers may particularly impact APRNs with prescriptive authority seeking to practice privately outside a team based setting in rural and underserved areas. The NPATCH also recommends that DORA consider and recommend appropriate liability levels for APRNs practicing independently, which may vary from the requirements for APRNs practicing in a team-based environment.

The NPATCH makes Recommendation No. 5 as a result of its findings with respect to Barrier 5. Specifically, the research and data support the finding that barriers and burdens do exist with respect to access to liability insurance for practitioners seeking to act in the mentor role, as well as for APRNs that choose to practice in a private setting in obtaining liability insurance most.

### **Conclusion**

Colorado's healthcare needs are evolving. The role of the primary care provider is central to accessing quality care in both urban and rural contexts. The NPATCH finds APRNs are poised to play a vital role in filling the increasing demands for primary care. The recommendations made in this report create a framework that verifies APRNs are educated, trained and robustly prepared to deliver safe and effective treatment to Colorado patients. The NPATCH recommendations alleviate regulatory barriers to allow the state's qualified providers to train new practitioners and deliver care.

The NPATCH's purpose is to promote public safety and improve healthcare in Colorado by supporting collaboration and communication between the practices of nursing and medicine. In looking to the changing landscape of healthcare in Colorado, the NPATCH is pleased and honored to offer these recommendations.

The NPATCH wishes to thank the Executive Director of the Colorado Department of Regulatory Agencies for consideration of these recommendations. In addition, the NPATCH acknowledges its work and the resulting recommendations are possible as a result of the all those who attended and participated in the monthly meetings, who provided anecdotal evidence on this important topic, experts who came to educate the NPATCH, and the professional associations dedicated to ensuring Colorado consumers have quality and safe healthcare. These recommendations are the result of the high level of interest and the dedication of Colorado's stakeholders throughout the process.

Thank you.

**APPENDIX A**

<b><u>IDENTIFIED BARRIER</u></b>	<b><u>AREAS OF RESEARCH AND DISCUSSION</u></b>	<b><u>RESEARCH PRESENTED</u></b>
<i>Extensive Role and Responsibilities of Preceptors and Mentors</i>	Clarify preceptor and mentor qualifications and roles	Review of current statutes and regulations Presented by DORA Staff
	Review recruitment strategies for preceptors and mentors	Nurse Practitioner Prescriptive Authority: Online Discussion Groups BBC Research & Consulting CMS Survey Results: What do CMS members think of the current requirements and the potential for change? Alfred Gilchrist, Chief Executive Officer, Colorado Medical Society Benjamin Kupersmit, Kupersmit Research
	Review expectations, liability and risks for preceptors and mentors.	Presentation by COPIC regarding limits and coverage for physicians serving as preceptor or mentor and Q&A George Dikeou, Consultant, COPIC Brad Ash, Senior Vice President, COPIC CMS Survey Results: What do CMS members think of the current requirements and the potential for change? Alfred Gilchrist, Chief Executive Officer, Colorado Medical Society Benjamin Kupersmit, Kupersmit Research

<b><u>IDENTIFIED BARRIER</u></b>	<b><u>AREAS OF RESEARCH AND DISCUSSION</u></b>	<b><u>RESEARCH PRESENTED</u></b>
	Compare CO laws and regulations regarding structure of preceptor and mentor programs	Prescriptive Authority Requirements in Nurse Compact States Georgia Roberts and Hannah Zippin, Division of Professions and Occupations, DORA Additional Information on Non-Compact States DORA Staff
<i>Qualifications and Experience of New Graduates</i>	Research any changes in required clinical hours since 2010	Education of Advanced Practice Nurses and Pharmacology Patsy Cullen, Board of Nursing, NPATCH Member, Regis University Advanced Practice Nurse Education Karren Kowalski, Executive Director, Colorado Center for Nursing Excellence
	Research latest requirements for pharmacology	Education of Advanced Practice Nurses and Pharmacology Patsy Cullen, Board of Nursing, NPATCH Member, Regis University Advanced Practice Nurse Education Karren Kowalski, Executive Director, Colorado Center for Nursing Excellence
<i>Access to Adequate Liability Insurance</i>	Research # of insurance carriers	Discussion among NPATCH members confirmed several carriers are offering liability insurance
	Research premiums around Colorado	Outside scope of the NPATCH discussion.

<b><u>IDENTIFIED BARRIER</u></b>	<b><u>AREAS OF RESEARCH AND DISCUSSION</u></b>	<b><u>RESEARCH PRESENTED</u></b>
<i>Out of State Applicants, Endorsements and Military Waivers</i>	Does Colorado allow for certain circumstances?	Q &A regarding current State Board of Nursing Rules and Current Practice Georgia Roberts, Program Director, State Board of Nursing, DORA
	How does Colorado compare to other states?	Q &A regarding current State Board of Nursing Rules and Current Practice Georgia Roberts, Program Director, State Board of Nursing, DORA
<i>3600 Hours Requirement</i>	How does the amount of hours compare to other states?	Prescriptive Authority Requirements in Nurse Compact States Georgia Roberts and Hannah Zippin, Division of Professions and Occupations, DORA Additional Information Provided for Non-Compact States and Western Region DORA Staff
<i>Education and Outreach Initiatives</i>	What efforts are currently in place?	BON APRN-subcommittee is producing Q&A Description of Current Efforts Lauren Larson, Director, Division of Professions and Occupations
	Where can DORA form partnerships?	Description of Current Efforts and Potential Opportunities Lauren Larson, Director, Division of Professions and Occupations

## APPENDIX B

### Summary of Expert and Stakeholder Testimony, Presentations and Consultations

The NPATCH gathered and analyzed information from a variety of sources. Specific presentations made during the monthly meetings included:

Education of Advanced Practice Nurses and Pharmacology	<i>Patsy Cullen, State Board of Nursing, NPATCH member, Regis University</i>
Advanced Practice Nurse Education	<i>Karren Kowalski, Executive Director, Colorado Center for Nursing Excellence</i>
Prescriptive Authority Requirements in Nurse Compact States	<i>Georgia Roberts and Hannah Zippin, Division of Professions and Occupations, DORA</i>
Overview of the Colorado Medical Society's Perspective and Q&A regarding Barriers	<i>Alfred Gilchrist, Chief Executive Officer, Colorado Medical Society</i>
Presentation by COPIC regarding limits and coverage for physicians serving as preceptor or mentor to APRNs seeking prescriptive authority and Q&A	<i>George Dikeou, Consultant, COPIC Brad Ash, Senior Vice President, COPIC</i>
Overview of research from various articles and reports and presentation of DORA workforce data collection capabilities.	<i>Ronne Hines, Deputy Director for Healthcare, Division of Professions and Occupations</i>
Overview, Reports and Recommendations of Colorado Health Foundation Advanced Practice Nurse Prescriptive Project	<i>Cassidy Smith, Colorado Health Foundation Amy Downs, Colorado Health Institute Alicia Haywood, Colorado Rural Health Center Kelly Johnson, Children's Hospital Colorado</i> (This collaborative effort includes the Colorado Rural Health Center, Colorado Nurses Association, Colorado Center for Nursing Excellence, Children's Hospital Colorado, Caring for Colorado Foundation, the Colorado Health Institute, AARP,

	Regis University and the University of Colorado.)
Public testimony and expert resource	<i>Gail Finley, Colorado Hospital Association</i>
CMS Survey Results: What do CMS members think of the current requirements and the potential for change?	<i>Alfred Gilchrist, Chief Executive Officer, Colorado Medical Society</i> <i>Benjamin Kupersmit, Kupersmit Research</i>
Empanelment Processes in Private Insurance	<i>Ben Price, Colorado Association of Health Plans</i>

Each monthly meeting agenda also included one or two Open Forum segments. These segments provided anyone in the audience the opportunity to address the NPATCH members in the public forum. The Open Forum segments resulted in significant public and stakeholder participation. Several witnesses were representatives of healthcare organizations, while others were APNs in the workforce who discussed the barriers and difficulties they have encountered. The witnesses represented both urban and rural locations. Twenty-four individuals spoke publicly. These discussions were vital in helping the NPATCH understand how the current requirements are affecting the healthcare workforce.



**APPENDIX C**  
**Summary of BBC Research Online Discussion Groups**

On April 11, 2014, Russ Rizzo, Senior Associate at GSBM, presented BBC Research & Consulting's (BBC) report *Nurse Practitioner Prescriptive Authority: Online Discussion Groups*.

BBC conducted two online discussion groups at the request of the Colorado Health Foundation. The first discussion group was held with hiring professionals who work for rural-area medical organizations. The second discussion group was held with hiring professionals who work for urban medical organizations.

The discussions focused on four main areas:

- Roles of NPs at medical organizations
- Importance of prescriptive authority
- Process of obtaining prescriptive authority
- Effects of 2010 Nurse Practice Act changes

The data gives some insight into what employers are thinking and doing when it comes to hiring APNs. It also highlights the recurring theme of urban versus rural, and confirms that the most common reasons for non-participation are time and additional resources.

Key Findings:

- NPs have wide ranging responsibilities at both rural and urban organizations. These roles and responsibilities are expected to expand in the future.
- Rural participants expect they will hire more NPs in the future, primarily because of the shortage of physicians. Urban participants expect their numbers to remain stable.
- Prescriptive authority is important to both urban and rural organizations; more in rural because of physician shortage.
- In general, representatives from both urban and rural area organizations believe the 2010 Nurse Practice Act both benefits and harms their organizations. They feel the ability for NPs to obtain independent prescriptive authority is invaluable. However, it hurts their organizations because the additional training hours make it very difficult for organizations – particularly rural- to hire NPs who do not already have independent prescriptive authority.
- Urban and rural participants believe that the 2010 changes affect new graduate NPs the most. New graduate NPs may have difficulty finding positions in Colorado, particularly in rural areas.
- Both urban and rural participants identify time and limited resources as the main challenges associated with helping NPs obtain prescriptive authority.
- Urban area medical organizations are more willing than rural to hire NPs without prescriptive authority and help them obtain it.
- Despite the long process associated with obtained prescriptive authority in Colorado, representatives for neither rural- nor urban-area medical organizations report that NPs are leaving the state to find positions in neighboring states with more lax prescriptive authority requirements. However, several hiring professionals report that the 2010 Nurse Practice Act acts as a deterrent for qualified NPs from neighboring states who are looking to relocate to Colorado.
- Representatives from both rural- and urban-area medical organizations would like to see changes to the prescriptive authority process whereby the number of training hours are reduced. Several hiring professionals would like to see at least part of those training hours become part of NPs education in nursing school. Other hiring professionals consider the 3,600 hour requirement excessive and arbitrary.

**APPENDIX D**  
**Summary of Colorado Medical Society Survey**

On August 8, 2014, Alfred Gilchrist, Chief Executive Officer at the Colorado Medical Society (CMS), and Benjamin Kupersmit, President of Kupersmit Research, presented the results of the 2014 CMS Member Survey Concerning Prescriptive Authority for Advanced Practice Nurses in Colorado. The survey was initiated by CMS following a presentation in May 2014 by Mr. Gilchrist that emphasized CMS' willingness to work with the NPATCH to find areas where consensus and mutual goals can be reached. At that time, the NPATCH requested that CMS conduct a survey of its members to ensure their voices were heard as NPATCH continued its stakeholder engagement and analysis. CMS contracted with Kupersmit to develop and administer the survey.

The survey probed two main issues:

- Awareness and attitudes toward the 2010 Nurse Practice Act and potential changes, and
- Attitudes regarding hiring and working with APNs among those who currently work with APNs, and potential barriers among those who do not currently work with APNs.

A total of 599 CMS member physicians completed the survey in the following categories:

- 51% reported working with APRNs
- 45% report they do not currently work with APRNs
- 56% reported being primary care physicians
- 41% reported being specialists
- 3% reported "other role"
- 46% reported they practice mostly in "Denver metro"
- 36% reported they practice mostly in "city outside of Denver"
- 15% reported they practice mostly in "town/rural"
- 6% reported they were "not sure how to answer" where they practice most

The data were divided and analyzed by specialty. Of the different types of physicians, anesthesiologists were most skeptical of APRN prescriptive authority followed by other specialties. Other key findings from the survey include:

- Overall, CMS physicians express general opposition to changing the requirements for APRNs seeking prescriptive authority, although some physician specialties are in favor, such as primary care physicians and those currently working with APRNs.
- The majority (59%) of CMS physicians believe it is important for APRNs to have independent prescriptive authority. For those that work with APRNs, 71% of the responding physicians believe it is important for APRNs to have independent prescriptive authority.
- APRNs with clinical experience were favored by physicians and found to be more effective.
- Physicians are willing to mentor APRNs seeking prescriptive authority. However, they desire more recognition of the time commitment, streamlined paperwork, reduced reporting, clearer curriculum and an allowance to share mentoring responsibilities to jointly train APRNs.