Questionnaire B – Scope of Practice

Proposal Summary/ Overview

To be completed by proposal sponsor. (500 Word Count Limit for this page) Please read the entire questionnaire before completing this page.

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Is this proposal regarding:

- *New or increased regulation of an existing profession/occupation? If so, complete Questionnaire A.*
- *Increased scope of practice or decreased regulation of an existing profession? If so, complete this form, Questionnaire B.*
- *Any other change to regulation or scope of practice? If so, please contact the Committee Administrator to discuss how to proceed.*

1) State the profession/occupation that is the subject of the proposal.

Certified Nurse Practitioners (CNPs) and Clinical Nurse Specialists (CNSs), two of the four roles of Advanced Practice Registered Nurses (APRNs).

2) Briefly describe the proposed change.

Under current MN Statute 148.211, Subd.1c, a nurse practitioner or clinical nurse specialist who qualifies for licensure as an advanced practice registered nurse must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care.

This proposal would remove this 2080 transition-to-practice requirement. In doing so, this proposed change would align MN statute with 16 other states that do not require this type of collaborative agreement arrangement for new graduates.

This change would allow newly graduated Clinical Nurse Specialists (CNSs) and Certified Nurse Practitioners (CNPs) to seek employment in settings where a physician is not part of the clinical or administrative staff. These settings may be APRN-owned primary care clinics, mental health centers, or other integrated health and wellness settings with a multidisciplinary team of APRNs, psychologists, social workers, and behavior health specialists.

3) If the scope of practice of the profession/occupation has previously been changed, when was the most recent change? Describe the change and provide the bill number if available.

APRNs were granted full practice authority in 2015. See SF 511 of 2013-2014 legislative session.

https://www.revisor.mn.gov/bills/bill.php?b=Senate&f=SF0511&ssn=0&y=2014

4) If the proposal has been introduced, provide the bill number and names of House and Senate sponsors. If the proposal has not been introduced, indicate whether legislative sponsors have been identified. If the bill has been proposed in previous sessions, please list previous bill numbers and years of introduction.

2025-2026
This year's bill has received bill jackets and is being signed in both the Senate and the House. It is chief-authored by Senator Kupec and Representative Virnig. It has not received bill numbers yet.

2023-2024
HF3440 / SF4303
House: Virnig, Reyer, Hemmingsen-Jaeger, Schomacker
Senate: Kupec, Abeler

Questionnaire B: Change in scope of practice or reduced regulation of a health-related profession (adapted from Mn Stat 214.002 subd 2 and MDH Scope of Practice Tools)

This questionnaire is intended to help legislative committees decide which proposals for change in scope of practice or reduced regulation of health professions should receive a hearing and advance through the legislative process. It is also intended to alert the public to these proposals and to narrow the issues for hearing.

This form must be completed by the sponsor of the legislative proposal. The completed form will be posted on the committee's public web page. At any time before the bill is heard in committee, opponents may respond in writing with concerns, questions, or opposition to the information stated and these documents will also be posted. The Chair may request that the sponsor respond in writing to any concerns raised before a hearing will be scheduled.

A response is not required for questions that do not pertain to the profession/occupation (indicate "not applicable"). Please be concise. Refer to supporting evidence and provide citation to the source of the information where appropriate.

While it is often impossible to reach complete agreement with all interested parties, sponsors are advised to try to understand and to address the concerns of any opponents before submitting the form.

1) Who does the proposal impact?

a. Define the occupations, practices, or practitioners who are the subject of this proposal.

APRNs, specifically Clinical Nurse Specialists (CNS) and Certified Nurse Practitioners (CNP)

b. List any associations or other groups representing the occupation seeking regulation and the approximate number of members of each in Minnesota.

The MN APRN Coalition represents APRNs in the state. Minnesota has between 12,000 and 13,000 licensed APRNs (CNS, CNP, CNM, CRNA). There are approximately 8,000 CNPs and 450 CNSs (the proposed change does not impact CNMs or CRNAs).

Other Supporting Organizations:

1. *Minnesota Nurse Practitioner Association*
2. *MN Association of Nurse Anesthetists*
3. *MN Affiliate of American College of Nurse Midwives*
4. *MN Affiliate of the National Association of Clinical Nurse Specialists*

c. Describe the work settings, and conditions for practitioners of the occupation, including any special geographic areas or populations frequently served.

CNPs and CNSs practice in a variety of settings across the state of Minnesota.

The specific group of CNSs and CNPs impacted by the existing statute are those seeking employment in settings where a physician is not part of the clinical or administrative staff. These settings may be

APRN-owned primary care clinics, mental health centers, or other integrated health and wellness settings with a multidisciplinary team of APRNs, psychologists, social workers, and behavior health specialists.

In Minnesota, healthcare providers are predominantly located in urban areas, resulting in a pronounced shortage of healthcare professionals in rural regions, especially in primary care and mental health. Notably, around 80% of Minnesota's counties are officially designated as lacking adequate mental health professionals, and a considerable portion of rural healthcare providers is nearing retirement. While the health status of rural and urban Minnesotans seems comparable, rural areas grapple with higher suicide rates, and rural residents often encounter difficulties when seeking timely appointments with primary care providers (Minnesota Department of Health, 2022).

APRNs play a critical role in bridging these gaps in care, particularly in mental health, primary care, obstetrics, and pediatric services. However, the transition-to-practice regulation, which mandates physician involvement, poses significant obstacles to APRNs aiming to establish independent practices and alleviate healthcare disparities. The existing statute also hampers other clinics from hiring new graduate CNPs and CNSs, making it challenging to recruit healthcare professionals for underserved rural areas, thus exacerbating the shortage of qualified mental healthcare providers in these regions.

Private Practice Ownership Among Minnesota APRNs

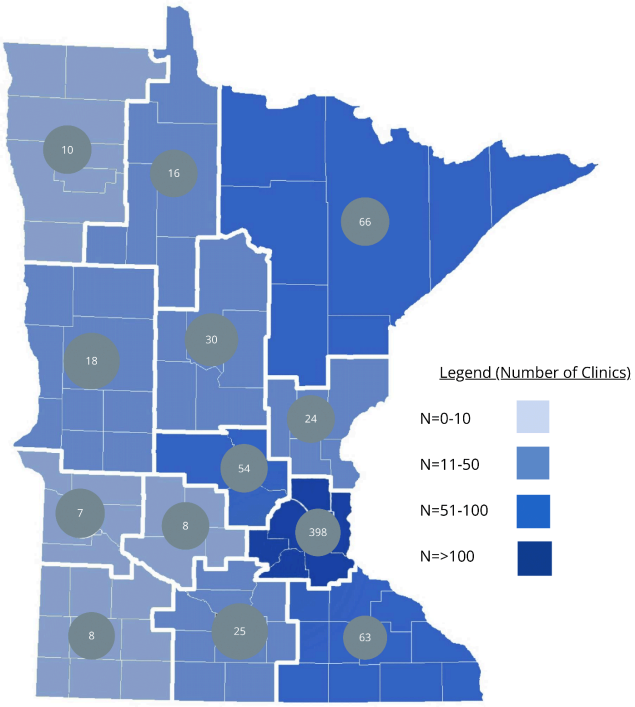
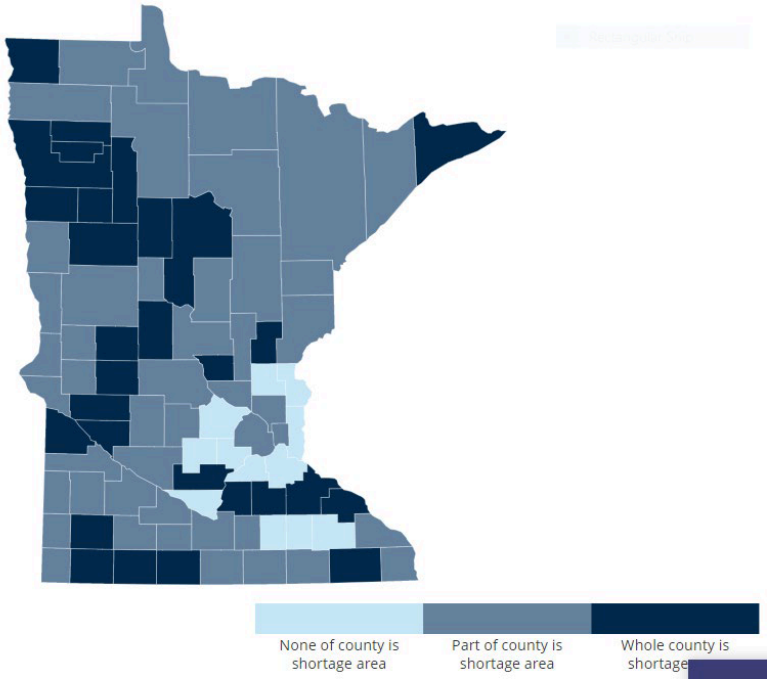
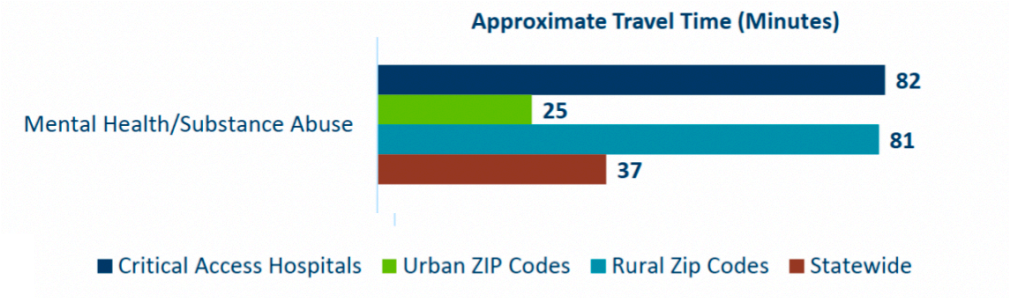


Figure 1. Adapted from an MDH Healthcare Workforce Survey "Private Practice Ownership or Co-Ownership Among APRNs by EDR", *Minnesota Department of Health*, 2023-2024 and additional data retrieved from the Minnesota Board of Nursing, 2024.

Developed by L.French, February 2025

Health Professional Shortage Areas Primary Care





d. Describe the work duties or functions typically performed by members of this occupational group and whether they are the same or similar to those performed by any other occupational groups.

The scope and practice standards of an advanced practice registered nurse are defined by the national professional nursing organizations specific to the practice as a clinical nurse specialist, nurse-midwife, nurse practitioner, or registered nurse anesthetist in the population focus. APRN practice includes functioning as a primary care provider, direct care provider, case manager, consultant, educator, and researcher. Scope includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering.

Clinical Nurse Specialist practice:

(1) the diagnosis and treatment of health and illness states;
(2) disease management;
(3) prescribing pharmacologic and nonpharmacologic therapies;
(4) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) prevention of illness and risk behaviors;
(6) nursing care for individuals, families, and communities;
(7) consulting with, collaborating with, or referring to other health care providers as warranted by

the needs of the patient; and
(8) integration of care across the continuum to improve patient outcomes.

Nurse Practitioner practice:

(1) health promotion, disease prevention, health education, and counseling;
(2) providing health assessment and screening activities;
(3) diagnosing, treating, and facilitating patients' management of their acute and chronic illnesses and diseases;
(4) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
(5) prescribing pharmacologic and nonpharmacologic therapies; and
(6) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

The practice of advanced practice registered nursing requires the APRN to be accountable: (1) to patients for the quality of advanced nursing care rendered; (2) for recognizing limits of knowledge and experience; and (3) for planning for the management of situations beyond the advanced practice registered nurse's expertise. The practice of advanced practice registered nursing includes accepting referrals from, consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

The Minnesota Nurse Practice Act is described in MS 148.171
https://www.revisor.mn.gov/statutes/cite/148.171

e. Discuss the fiscal impact.

The proposal would have no cost and would lower administrative overhead at the state Board of Nursing by eliminating the need for filing, documenting, maintaining, and auditing submissions related to completing the transition-to-practice hours.

2) Specialized training, education, or experience ("preparation") required to engage in the occupation

a. What preparation is required to engage in the occupation? How have current practitioners acquired that preparation?

The individual must have completed a graduate-level APRN program accredited by a nursing or nursing-related accrediting body that is recognized by the United States Secretary of Education or the Council for Higher Education Accreditation as acceptable to the board. The education must be in one of the four APRN roles for at least one population focus.

For APRN programs completed on or after January 1, 2016, the program must include at least one graduate-level course in each of the following areas: advanced physiology and pathophysiology; advanced health assessment; and pharmacokinetics and pharmacotherapeutics of all broad categories of agents; or must demonstrate compliance with the advanced practice nursing educational requirements that were in effect in Minnesota at the time the applicant completed the advanced practice nursing education program; must be currently certified by a national certifying body recognized by the board in the APRN role and population foci appropriate to educational preparation.

The national nursing certification organization must:

(1) Be endorsed by a national professional nursing organization that describes scope and standards statements specific to the practice as a clinical nurse specialist, nurse-midwife, nurse practitioner, or registered nurse anesthetist for the population focus for which the individual will be certified;
(2) Be independent from the national professional nursing organization in decision-making for all matters pertaining to certification or recertification;
(3) Administer a professional nursing certification program that is psychometrically sound and legally defensible, and meets nationally recognized accreditation standards for certification programs; and
(4) Require periodic recertification or be affiliated with an organization that provides recertification.

b. Would the proposed scope change or reduction in regulation change the way practitioners become prepared? If so, why and how? Include any change in the cost of entry to the occupation. Who would bear the increase or benefit from reduction in cost of entry? Are current practitioners required to provide evidence of preparation or pass an examination? How, if at all, would this change under the proposal?

This proposal would make no change in educational, certification, or licensure requirements. It would make no change to the scope of practice, training, or mentorship experience upon initiation of clinical practice.

Current practice allows a new graduate CNP and CNS to have a collaborative agreement with a licensed MN APRN instead of a physician as long as a physician is employed at the organization.

c. Is there an existing model of this change being implemented in another state? Please list state, originating bill and year of passage?

19 states and the District of Columbia have Full Practice Authority (FPA) for APRNs without requiring transition-to-practice hours with a collaborative agreement (see Marymount University, 2023). That list of states is below, with some additional linked references to statutory language, rules, or FAQs from the relevant Board.

1. Alaska
2. **Arizona**: *According to the AZ State Board of Nursing Rules for the Nurse Practice Act, Arizona does not require physician supervision or collaboration for independent practice of nurse practitioners (regardless of specialty). The requirement is for the RNP (registered nurse practitioner) to consult with or refer clients to other health care providers when appropriate.*
3. **Delaware**. *House Bill 141 passed in 2021. The legislation allows APRNs and nurse practitioners to practice independent of a physician under the authority of the Delaware Board of Nursing. This legislation "removes the requirement for a collaborative agreement for licensure purposes..." (Sources: National Nurse Consortium and the Delaware legislature https://legis.delaware.gov/BillDetail/58536)*
4. **Hawaii**: *The Hawaii State Board of Nursing recognizes the full practice authority of NPs. Prior to prescribing medications, NPs must take advanced coursework in pharmacology.*
5. Idaho
6. Iowa
7. Kansas
8. **Montana**: *NPs are granted full practice authority in Montana. They must be board certified and have graduated from an accredited NP program that included a preceptorship.*
9. Nevada
10. New Hampshire
11. New Mexico
12. **North Dakota**. *In North Dakota, the only continuing education after graduation is 30 hours of pharmacology specific CE in the past 3 years, for which the pharmacology courses apply to the required CE for recent graduates. (Source: North Dakota Board of Nursing.)*

13. **Oregon:** *As an NP, CNS, or CRNA, you are a licensed independent practitioner (LIP) in Oregon. This means that collaborative agreements or supervised practice with a physician is not needed, e.g., no physician co-signing of charts, orders, or prescriptions*. Source: Oregon State Board of Nursing and Oregon Nurse Practice Act.
14. Rhode Island
15. South Dakota
16. Utah
17. Washington State
18. Wyoming
19. District of Columbia

3) Supervision of practitioners

a. How are practitioners of the occupation currently supervised, including any supervision within a regulated institution or by a regulated health professional? How would the proposal change the provision of supervision?

This proposal will make no change in the provision of supervision.

CNPs and CNSs have Full Practice Authority upon licensure; there is no supervision at a practice or prescribing level. CNPs and CNSs are supervised within a typical staff management structure in professional settings. The evaluation of their nursing practice must be completed by a professional nurse under MS 148.171 Sub 15(10).

b. If a regulatory entity currently has authority over the occupation, what is the scope of authority of the entity? (For example, does it have authority to develop rules, determine standards for education and training, assess practitioners' competence levels?) How does the proposal change the duties or scope of authority of the regulatory entity? Has the proposal been discussed with the current regulatory authority? If so, please list participants and date.

The Board of Nursing (BON) is the entity that oversees nursing education, licensure, and practice. The BON has the authority to promulgate, revise rules, license, renew licensure, and prosecute APRNs who violate the Nurse Practice Act (MS 148.171-148.285).

This proposal would make no change to the scope or authority of the Board of Nursing. It would decrease administrative work on the part of the BON licensing staff. Minnesota APRN Coalition Leadership is scheduled to meet with the BON's Executive Director (Kristin Battson) on October 31, 2023 to discuss this proposed change.

Statute regarding Board of Nursing (Officers; Staff; Powers): MS 148.191
https://www.revisor.mn.gov/statutes/cite/148.191

c. Do provisions exist to ensure that practitioners maintain competency? Under the proposal, how would competency be ensured?

CNSs and CNPs are required to maintain current certification at all times. This requirement includes periodic recertification procedures and continuing education within their specialty. Renewal of the APRN licensure is required every two years. Records of certification and licensure are maintained and assessed by the BON. This proposal makes no change to current provisions related to maintaining competency.

4) Level of regulation (See Mn Stat 214.001, subd. 2, declaring that "no regulations shall be imposed upon any occupation unless required for the safety and wellbeing of the citizens of the state." The harm must be "recognizable, and not remote." Ibid.)

a. Describe how the safety and wellbeing of Minnesotans can be protected under the expanded scope or reduction in regulation.

The high standards for quality care and patient safety remain unchanged. Research does not indicate that removing the transition to practice collaborative agreement requirements negatively impacts patient safety or public well-being. On the contrary, removal of this requirement would expand the number of clinical settings in which new graduates can practice, helping to address provider shortages in key practice areas and geographies. This proposal also makes no change in grounds for disciplinary action or type of action taken by the Board of Nursing upon a CNS or CNP license.

b. Can existing civil or criminal laws or procedures be used to prevent or remedy any harm to the public?

The existing statute poses a barrier to free trade, employment, patient access to care, and fair business practices. These restrictions can hinder healthy market competition, increase costs, limit access to essential healthcare services, and stifle innovation in care delivery (Federal Trade Commission, 2014; National Academy of Sciences, 2021). This proposal also makes no change to existing statute related to disciplinary action, which is designed to protect the public from harm (See Minn Statute 148.26 and 148.262).

5) Implications for Health Care Access, Cost, Quality, and Transformation

a. Describe how the proposal will affect the availability, accessibility, cost, delivery, and quality of health care, including the impact on unmet health care needs and underserved populations. How does the proposal contribute to meeting these needs?

Patients in underserved and rural areas will benefit from increased access to skilled healthcare providers and services (NAS, 2021; Yang et al., 2021). Patients can select from a broader spectrum of qualified professionals to address their healthcare needs effectively (FTC, 2014; Adams & Markowitz, 2018; Martin & Alexander, 2019; NAS, 2021).

Promoting a more competitive healthcare landscape can yield cost-effective care as diverse providers vie to deliver high-quality services at competitive rates. This change addresses the escalating demand for healthcare services and contributes to a more agile and responsive workforce (FTC, 2014; Adams & Markowitz, 2018).

APRNs are positioned to lead innovative care models in line with contemporary healthcare trends (Institute of Medicine, 2010; FTC, 2014; NAS, 2021). Enabling the adoption of alternative delivery approaches, like APRN-led clinics, can enhance patient outcomes, reduce costs, and streamline care delivery (FTC, 2014; Adams & Markowitz, 2018; Yang et al., 2021).

b. Describe the expected impact of the proposal on the supply of practitioners and on the cost of services or goods provided by the occupation. If possible, include the geographic availability of proposed providers/services. Cite any sources used.

Evidence suggests that reducing barriers to APRN practice positively influences the healthcare delivery system by building structural capabilities, such as increased supply, that improve access to care and utilization without negatively affecting patient outcomes or costs (Yang et al., 2021).

Removing barriers to practice and competition could enable new healthcare clinics to be established across Minnesota. This expansion would provide more job options for new graduates, stimulate economic activity, and attract out-of-state nurse entrepreneurs to open businesses in Minnesota.

In an interview with owners of APRN-led clinics, the following comments were shared:

"The cost of opening a business in MN with these regulations is higher than in North Dakota. This is why Fargo has a lot more business than the MN side."

"I'm not willing to move to Minnesota because I wouldn't be able to practice the same way. There are a lot of bordering states that are working independently and doing well."

In some instances, the expenses imposed on independent APRNs seeking collaborative practice agreements can be exorbitant, potentially undermining the economic sustainability of existing APRN practices or discouraging others from entering the field (FTC, 2014). The costs associated with setting up and sustaining collaborative agreements may surpass $6,000 annually (Martin & Alexander, 2019). In a national survey of over 8,700 APRNs, many participants reported fees exceeding $10,000 and, in some cases, going as high as $50,000 per year (American Medical Group Association, 2016).

The stability of an APRN practice may also be jeopardized as physicians maintain the authority to terminate agreements without cause or opt not to renew them. Furthermore, independent APRNs may encounter difficulties if their collaborating physician relocates, retires, or passes away and they are unable to find a replacement promptly.

The costs associated with meeting the regulatory requirement risk diverting health services away from, and increasing costs in, traditionally underserved areas, contributing to geographic inequities in care.

Removing regulatory barriers can extend geographic access, making it easier for patients to receive care closer to their homes (FTC, 2014). This enhances convenience, lowers healthcare-related and transportation expenses, and offers additional benefits, including improved satisfaction and quality of life (FTC, 2014; Yang et al., 2021).

c. Does the proposal change how and by whom the services are compensated? What costs and what savings would accrue to patients, insurers, providers, and employers?

This proposed change will not impact how the CNSs and CNPs are compensated, although they may be more able to practice within their own communities. There may be administrative cost savings to organizations by removing the paperwork associated with the transition to practice. Patients may save on transportation and travel costs. Improved access to healthcare services could help mitigate chronic health issues and ultimately reduce long-term costs for insurers and employers (NAS, 2021).

d. Describe any impact of the proposal on an evolving health care delivery and payment system (eg collaborative practice, innovations in technology, ensuring cultural competency, value based payments)?

Patients would have greater autonomy to select from a spectrum of qualified professionals to address their healthcare needs effectively (FTC, 2014; Adams & Markowitz, 2018; Martin & Alexander, 2019; NAS, 2021).

Responsiveness and respect for individual patient needs and preferences are critical elements of cultural competence and patient-centeredness, core domains of quality health care (Finkelman, 2022). This policy change could also drive economic efficiency and foster innovation in care delivery. Alternative healthcare delivery approaches, such as APRN-led clinics and interprofessional mental health centers, can enhance patient outcomes, reduce costs, and streamline care (FTC, 2014; Adams & Markowitz, 2018; Yang et al., 2021).

This change would also not undermine interprofessional collaboration and consultation, which is an established norm and a professional standard of APRN practice. APRNs consistently engage in collaborative and consultative efforts with physicians and other healthcare practitioners in the best interest of their patients. These collaborative interprofessional team-based approaches should remain adaptable and emphasize the common objective of delivering comprehensive, high-value, quality patient care.

e. What is the expected regulatory cost or savings to state government? How are these amounts accounted for under the proposal? Is there an up-to-date fiscal note for the proposal?

Savings – the change to the regulation will reduce the administrative expenses associated with documentation and recordkeeping related to the 2080 transition-to-practice hours for the Board of Nursing.

6) Evaluation/Reports

Describe any plans to evaluate and report on the impact of the proposal if it becomes law, including focus and timeline. List the evaluating agency and frequency of reviews.

Future Minnesota Department of Health reports (access and utilization for underserved areas) will indicate whether this proposed change results in an increase of providers, particularly in greater MN.

Minnesota APRN Coalition annual survey will also provide regular data on the practices of CNPs and CNSs.

7) Support for and opposition to the proposal

a. What organizations are sponsoring the proposal? How many members do these organizations represent in Minnesota?

The Minnesota APRN Coalition is sponsoring the bill. Minnesota has between 12,000 and 13,000 licensed APRNs (CNS, CNP, CNM, CRNA). There are approximately 8,000 CNPs and 450 CNSs. The proposed change does not impact CNMs or CRNAs, but the APRN Coalition represents all four roles.

b. List organizations, including professional, regulatory boards, consumer advocacy groups, and others, who support the proposal.

Removing superfluous barriers to APRNs aligns with current evidence and recommendations from prominent policy organizations, including the National Academy of Medicine (formerly the Institute of Medicine), National Governors Association, National Conference of State Legislatures, National Council of State Boards of Nursing, the AARP, and the Federal Trade Commission (IOM, 2011; FTC, 2014; NAS, 2021; AARP 2023). This proposal is also supported by the following local organizations: Minnesota Nurse Practitioner Association, MN Association of Nurse Anesthetists, MN Affiliate of Nurse Midwives, and MN

Affiliate of the National Association of Clinical Nurse Specialists.

c. List any organizations, including professional, regulatory boards, consumer advocacy groups, and others, who have indicated concerns/opposition to the proposal or who are likely to have concerns/opposition. Explain the concerns/opposition of each, as the sponsor understands it.

In December of 2023, The MN APRN Coalition reached out to the Minnesota Medical Association (MMA) and the Minnesota Academy of Family Physicians (MAFP) requesting to discuss the bill and its proposed changes. The three entities met and the MMA and MAFP raised concerns about the bill and could not support the repeal of the Transition to Practice requirement.

In February of 2024, the MN APRN Coalition discussed and proposed compromised language to the MMA and the MAFP. In March of 2024, the associations did not agree to the proposed compromise language.

This year, the MN APRN Coalition is introducing the full repeal language and has requested to meet with the MMA and MAFP to discuss the bill and their position.

d. What actions has the sponsor taken to minimize or resolve disagreement with those opposing or likely to oppose the proposal?

Last session (2023-2024), the MN APRN Coalition requested to meet and met with the MMA and MAFP to understand their concerns on the bill. The MN APRN Coalition proposed compromise language that was not agreed upon by the associations.

This session, the MN APRN Coalition has requested to meet with the MMA and MAFP to discuss the bill language and their position.

References

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