Minnesota’s new APRN law
What it means for physicians and their practices

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Since a high-profile Institute of Medicine report in 2010 called for all in health care to practice to their full potential, there has been a growing national movement to allow advanced practice registered nurses (APRNs) to practice independent of physician supervision.

An advanced practice registered nurse is a nurse who has post-baccalaureate education in nursing and expanded skills and knowledge. APRNs include:

- Certified nurse practitioners (CNPs), who generally provide primary care in the areas of adult medicine, pediatrics, geriatrics, women’s health and mental health
- Clinical nurse specialists (CNSs), who often specialize in clinical management, quality improvement, mental health and women’s health
- Certified nurse midwives (CNMs), who work in obstetrics and delivery
- Certified registered nurse anesthetists (CRNAs), who administer anesthesia and generally practice in hospitals and surgical centers. (Some CRNAs are moving into pain management, but this is controversial.)

Historically, physicians and APRNs worked collaboratively through practice agreements. Many states, including Minnesota, have long required APRNs to maintain a collaborative practice agreement with a licensed physician. Over the last decade, APRN professional associations have argued that APRNs have enough training and expertise to be able to practice independently. This led to successful efforts in a number of states to expand APRNs’ scope of practice.

In 2014, the Minnesota APRN Coalition proposed legislation to revise the Minnesota Nurse Practice Act, allowing APRNs to practice independently. Physician groups, including the Minnesota Medical Association, opposed the bill, as they were concerned that complete APRN autonomy would compromise patient care and safety. These groups led efforts to modify the bill, and they successfully narrowed its scope. Ultimately, that legislation passed with broad bipartisan support.

Physicians across the state have a number of questions about the new law, which took effect January 1. They want to know what their obligations are under it and what options remain. Most important, they want to know how they can continue to facilitate team-based care. This article describes what has—and has not—changed under the new law.

What’s changed
Licensure
Under the new law, all APRNs (CNPs, CNSs, CNMs and CRNAs) will be licensed by the Minnesota Board of Nursing. Previously, they were only licensed as RNs and registered with the Board of Nursing as APRNs. In order to obtain licensure, an APRN must have completed the appropriate educational requirements beyond a baccalaureate RN degree and be certified by a national nursing certification organization approved by the Board of Nursing. For example, a CNP wanting to practice in family medicine would need to have completed a master’s or doctoral degree and passed a board-certification exam in family medicine. New APRNs must also complete a clinical practice requirement. The law includes a provision for the grandfathering of APRNs who were on the registry in July 2014 but do not otherwise meet the requirements for APRN licensure.

Independent practice
The new law will have the biggest impact on CNPs and CNSs, as it grants them the authority to practice independently, including to prescribe. It also removes the requirement that CNPs and CNSs practice under a collaborative management agreement and have a written prescribing agreement with a physician. In order to practice independently, however, a new CNP or CNS must have completed 2,080 hours of clinical practice within a collaborative management setting in a hospital or integrated clinical environment in which APRNs and physicians work together. The clinical component must take place under the oversight of an APRN or physician with experience providing care in the same or a similar field.

CRNAs can continue to provide anesthesia services in a hospital or surgical center without physician supervision. Those CRNAs who provide nonsurgical therapies for acute and chronic pain are required to have a “mutually agreed-upon plan” with a physician who designates the scope of collaboration needed to provide those treatments. CRNAs who provide nonsurgical therapies for chronic pain must have a written prescribing agreement with a physician that defines the delegated responsibilities related to prescribing drugs.
Liability under the law
APRNs who practice independently will assume additional medical liability exposure. As a practical matter, APRNs who engage in more independent practice should carry increased malpractice coverage. This is true even though neither physicians nor nurses are required by statute to carry malpractice insurance. The risk of personal liability, coupled with hospital privileging and health plan credentialing standards, renders medical malpractice coverage mandatory for all health care providers who practice independently (and even for many who do not practice independently, such as RNs and PAs).

Most APRNs carried malpractice liability coverage in the past and will continue to do so under the new law. Whether that coverage is carried by the individual or by the hospital or clinic on behalf of the APRN will depend on employment status or other factors.

Physicians who collaborate with APRNs may assume some oversight responsibility, as was the case before this law went into effect. This may expose them to some liability risk related to the APRN’s decisions. Most of the time, however, physician liability and APRN liability are separate issues.

What hasn’t changed
Credentialing
The law does not mandate changes to credentialing or privileging. Health plans will credential APRNs according to their own standards, and hospitals will determine privileging according to their own standards.

Physician supervision in certain clinical settings
As before, the standard of care in certain settings may require some APRNs to be supervised at times. For example, it would be outside of the standard of care for an APRN to perform a heart transplant; however, it would be well within the standard of care for an APRN to work collaboratively with a physician to provide care before, during and after transplant. The new law does not change the standard of care.

Therefore, it may be appropriate for physicians to supervise APRNs in certain clinical settings in order to meet the applicable standard of care. Employment relationships, clinical relationships and personal choice will continue to inform when and how physicians supervise or collaborate with APRNs.

Although the new law does not require CNPs and CNSs to have collaborative management agreements with physicians, it is important to note that it does not prohibit such agreements from being used. It is up to each hospital, clinic or practice group to set its own standards regarding clinical care and collaboration.

Also, a physician who has clinical experience in the CNP’s or CNS’s field of practice and who works in an integrated setting may agree to participate in the clinical training required for licensure. To do so, the physician and the CNP or CNS must have a mutually agreed upon collaborative management plan. Physicians are not required to supervise the training of a new CNP or CNS.

Conclusion
In Minnesota and many other states, the distinctions between the practice of nursing and the practice of medicine have become less clear. Many things that were historically done by physicians are now done by APRNs and other clinicians.

Before the new APRN law went into effect, there was already overlap between the practice of nursing and the practice of medicine. The area of overlap will continue to grow. The changes the new law brings may seem broad, but their effect is likely to be moderate because of practical considerations such as employment agreements, privileging and credentialing imperatives, and medical liability realities. The law was difficult for many physicians to accept; however, now that it is in effect, they can comfortably renew their focus to ensuring high-quality, team-based care for all Minnesotans.

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