

HJR 187 -- HEALTHCARE

SPONSOR: Overcast

Upon voter approval, this proposed constitutional amendment exempts an advanced practice registered nurse (APRN) who is not a certified registered nurse anesthetist from being required to enter into or remain in a collaborative practice arrangement in order to practice in this State if the advanced practice registered nurse:

(1) Has a license in good standing and has been in a collaborative practice arrangement or arrangements for a cumulative total of 2000 documented hours with a collaborating physician or physicians; or

(2) Has applied for and received licensure by endorsement and successfully demonstrated at the time of such application to the State Board of Nursing the completion of a cumulative total of 2000 documented hours of practice.

Any law requiring a collaborative practice arrangement or delegation will not apply to an exempt APRN.

An APRN will not have authority to prescribe, dispense, or administer a medication unless:

(1) The APRN has entered into a collaborative practice arrangement and the prescribing authority is designated to the APRN by the collaborating physician; or

(2) The APRN has satisfied all requirements for such prescriptive authority unrelated to practice in a collaborative practice arrangement that are provided by general law. The Board cannot deny an APRN a certificate of controlled substance prescriptive authority or any other prescriptive authority on the basis that the APRN does not practice in a collaborative practice arrangement.

If there is a collaborative practice arrangement between physicians and APRNs, that arrangement cannot:

(1) Contain any geographic proximity restrictions, including any mileage or distance restrictions for APRNs or physicians. Any such collaborative practice arrangements that contain provisions relating to geographic proximity requirements will be deemed unenforceable; or

(2) Require a collaborating physician to determine and document the completion of a period of time during which the APRN practices with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present.

A collaborating physician cannot enter into a collaborative practice arrangement with more than 10 full-time equivalent advanced practice providers. A collaborating physician may exceed the cap of 10 advanced practice providers under circumstances provided by general law. A collaborating physician will not be required to limit the number of advanced practice providers with whom he or she collaborates to a number less than 10.

Upon voter approval, this proposed constitutional amendment would create a State-accredited residency program for physicians. Any health care provider may apply to sponsor a State-accredited residency program. The State Board of Registration for the Healing Arts shall not require national or private accreditation of a residency program as a condition of State approval. The Board will promulgate rules to implement application procedures for residency programs that apply for approval.

For a health care provider to qualify to have a State-accredited residency program, the health care provider must create a program that meets certain requirements as outlined in the constitutional amendment.

The Board cannot vary the requirements for licensure as a physician based on whether the physician completed a national accredited residency program or a State-accredited residency program. Additionally, the privilege of a physician licensed to practice medicine in any hospital, clinic, or health care facility in this State cannot vary based on whether the physician completed a national accredited residency program or a State-accredited residency program.

This constitutional amendment does not guarantee eligibility for Federal graduate medical education funding or require any other state to accept completion of a state-accredited residency program for the purposes of licensure or authorization to practice in that state.

Before January 1, 2037, and every 10 years thereafter, the Board must submit a report to the General Assembly containing:

(1) Data on the State-accredited residency programs approved by the bBoard including, but not limited to:

(a) The number of programs approved by the Board;

(b) The geographic regions in which the programs primarily operate;

(c) The number and type of specialties offered by the programs; and

(d) The number of physicians who graduated from the programs;

(2) Data on the workforce participation of graduates of state-accredited residency programs, including data disaggregated by specialty, type of employer, and geographic region;

(3) Data on the outcomes for clinical proficiency, patient safety, and scope-of-practice readiness achieved by graduates of State-accredited residency programs as compared to the outcomes achieved by graduates of nationally accredited residency programs; and

(4) Data on insurance reimbursement practices for health care services provided by resident physicians and graduates of State-accredited residency programs.