Questions & Answers

For Physicians
Entering into Prescribing or Collaborative Agreements with Advanced Practice Registered Nurses

Prepared by the Minnesota Medical Association
## Table of Contents

### Collaborative Agreements Q&A

<table>
<thead>
<tr>
<th>Definition of an APRN</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of a collaborative management plan/agreement</td>
<td>2, 3</td>
</tr>
<tr>
<td>Definition of a collaborating physician</td>
<td>5, 8, 9</td>
</tr>
<tr>
<td>The difference between a collaborative management plan/agreement and a prescribing agreement</td>
<td>7</td>
</tr>
<tr>
<td>Written/oral collaborative management agreement/plan</td>
<td>7</td>
</tr>
<tr>
<td>Retired physician APRN collaborative agreement</td>
<td>5, 8</td>
</tr>
<tr>
<td>Criteria for a collaborative management plan/agreement</td>
<td>11, 12</td>
</tr>
<tr>
<td>APRN supervision</td>
<td>14, 16</td>
</tr>
<tr>
<td>APRN as an independent provider, contractor, or business owner</td>
<td>16</td>
</tr>
<tr>
<td>APRN reimbursement</td>
<td>17</td>
</tr>
<tr>
<td>Physician's liabilities</td>
<td>18</td>
</tr>
<tr>
<td>CRNA collaborative agreement/plan</td>
<td>12, 13</td>
</tr>
<tr>
<td>Issues for physician consideration</td>
<td>5, 11, 12, 18</td>
</tr>
</tbody>
</table>

### Prescribing Agreements Q&A

| Delegation of prescribing authority to an APRN | 19 |
| Delegation of prescribing authority to an RN | 19 |
| Changes in 1999 APRN prescribing legislation | 20 |
| Prescribing definition | 21 |
| APRN scope of practice | 16, 22, 25 |
| Certified nurse midwife prescribing | 23 |
| Prescribing agreement criteria | 24, 31, 33, 34 |
| Supervision of APRN prescribing practice | 14, 16, 25 |
| Delegating prescribing authority | 22, 26, 27 |
| APRN prescribing authority | 26, 28, 30, 32 |
| Considerations prior to delegating prescribing authority | 24, 25, 26 |
| Delegating prescribing of psychiatric drugs | 29, 30 |
| Information mandatory for a physician/APRN prescribing agreement | 31, 33, 34 |
| Frequency of review of prescribing agreement | 34 |
| CRNA prescribing agreements | 35 |
| Prescribing agreement forms | 36 |
| APRN prescribing agreements with several physicians | 32, 37, 38 |
| Prescribing agreements in a nursing facility/long term care setting | 39 |

Physicians are encouraged to contact the MMA for a copy of a model prescribing agreement form and the MNA/MMA Memorandum of Understanding.
Considerations for Physicians Delegating Prescribing Authority and Entering Into a Collaborative Management Plan/Agreement with an Advanced Practice Registered Nurse (APRN)

Section I:  Development of a Collaborative Management Plan/Agreement Between a Physician and an APRN

1. Who is considered an APRN under Minnesota law?
A new law regulating advanced practice registered nurses (APRN) was passed during the 1999 Minnesota legislative session. The law specifies the following nurses who are authorized to practice as an advanced practice nurse: Clinical Nurse Specialist in Psychiatric and Mental Health Nursing;

- Clinical Nurse Specialist, other than Psychiatric and Mental Health Nursing;
- Certified Nurse Midwife;
- Certified Registered Nurse Anesthetist; and
- Certified Registered Nurse Practitioner

2. What is the legislative intent of requiring an APRN to have a “collaborative management plan” with a physician?
According to statute, APRNs have a distinct and independent scope of nursing practice. Within their legal scope of practice, APRN practice can include functioning as a direct care provider, case manager, consultant, educator, and researcher, and APRNs can provide non-pharmacologic treatment within a health care system that provides for consultation, collaborative management, and referral. When caring for patients an APRN in some circumstances will need to consult with and refer to a physician or other health care provider. To assure that patients are receiving appropriate care, the APRN is required by law to have a collaborative management plan/agreement with one or more physicians who have experience in providing care to patients with the same or similar types of medical problems as the patients that are being cared for by the APRN.

3. How does Minnesota law define the term “collaborative management”?
According to Minnesota statute, 148.171. subdivision 1.(5), an APRN “must practice within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient.” The term “collaborative management” is defined in law as “a mutually agreed upon plan between an APRN and one or more physicians [including surgeons] that designates the scope of collaboration necessary to manage the care of patients.”

4. What does the term “scope of collaboration” mean?
Although the law does not specifically define the term “scope of collaboration,” a collaborative plan/agreement could address issues such as what type of patients will be managed by the APRN, the circumstances when an APRN will make referrals to physicians and others, and the type of oversight of the APRN’s practice, if any, that will be provided by the collaborating physician. These types of specifications found in a collaborative agreement could be described as the “scope of collaboration” that has been mutually agreed to by a physician and an APRN.

5. According to the law, who can become a “collaborating” physician?
A collaborating physician is one who is licensed in the state of Minnesota, has agreed to work jointly with an APRN to manage the care of patients, and has experience in providing care to the same or similar types of patients as those being managed by the APRN.

The information in this document should not be construed as having the effect of law, the provision of legal advice, or the creation of rules or regulations by the Minnesota Medical Association. The information is provided to assist physicians in regard to issues that should be considered prior to the development of a prescribing agreement and/or collaborative plan/agreement between a physician and an advanced practice registered nurse (APRN).

Physicians are encouraged to discuss with their malpractice insurer the liability considerations involved in entering into a collaborative plan/agreement or delegating the authority to prescribe to an APRN.

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collaborating physician must mutually agree upon a plan of collaboration that will effectively provide appropriate care to a specified group of patients.

Physicians and APRNs who jointly agree to collaborate need to first consider the complementary nature of their practices. If a physician and APRN do not share the same type of clinical experience, it may not be a wise idea to form a collaborative agreement. For instance, a gerontologist would probably not choose to have a collaborative plan/agreement with a pediatric nurse practitioner. A neurologist would probably not choose to have a collaborative plan/agreement with a clinical nurse specialist or a certified registered nurse practitioner engaged in family practice.

6. Why does this document refer to the “collaborative management plan” as an “agreement”?

The law specifically states that a physician and an APRN must mutually agree to designate the scope of collaboration necessary to manage the care of patients. Therefore, an agreement must be reached between a physician and an APRN.

7. How does a “collaborative management plan/agreement” differ from the “prescribing agreement” that is also required in the law?

The 1999 statute regulating APRNs describes a “prescribing agreement” as a written agreement between a collaborating physician and an APRN that defines the delegated responsibilities related to the prescription of drugs and therapeutic devices. Although the law does not require that a collaborative management plan/agreement be in writing, the MMA strongly encourages physicians to utilize written agreements.

A collaborative management plan between a certified registered nurse practitioner or a certified clinical nurse specialist and one or more physicians licensed under chapter 147 must designate the scope of collaboration necessary to manage the care of patients. A collaborative management plan may also contain prescribing parameters in the context of the total plan, but if prescribing is included, a separate and distinct written prescribing agreement must also be developed.

If the APRN is a certified registered nurse anesthetist (CRNA), the law requires the CRNA to develop a collaborative management plan with a physician, podiatrist, or dentist who provides anesthesia services at the same hospital, clinic, or health care setting as the CRNA.

Although patient care could be managed by an APRN without delegated prescribing authority, to fully and adequately manage the care of patients many APRNs also want to have the authority to prescribe. Therefore, it would not be unusual to have a collaborative management plan/agreement that includes, among other parameters, the specific prescribing authority that has been delegated by a physician who has agreed to collaborate with the APRN. Although the law does not require that a collaborative management plan/agreement be in writing, the MMA strongly encourages physicians to utilize written agreements.

8. Does the law allow an APRN to collaborate with a retired physician?

The law requires an APRN to have a collaborative management plan/agreement with at least one or more physicians licensed under chapter 147. Except in the case of a certified registered nurse anesthetist (CRNA), any physician who maintains an active Minnesota license could agree to collaborate with an APRN to manage the care of patients provided the physician has experience in managing patients with the same or similar types of medical problems as those being managed by the APRN.

A retired physician would be prohibited from developing a collaborative management plan/agreement with a CRNA because the law requires the CRNA’s collaborative management plan/agreement to be with a physician, podiatrist, and/or dentist who provides anesthesia services at the same hospital, clinic, or health care setting as the CRNA.

9. Does the law allow an APRN to develop a collaborative plan/agreement with providers other than physicians?

All APRNs, except CRNAs, are required by law to have a collaborative management plan/agreement solely with a physician.

The statute differs in respect to CRNAs as it specifies that, in addition to collaborating with physicians, CRNAs may also provide anesthesia services in collaboration with podiatrists or dentists who provide anesthesia services at the same hospital, clinic, or health care setting as the CRNA.

10. Can an APRN develop a collaborative management plan/agreement with more than one physician?

The law does permit an APRN to develop a collaborative management plan/agreement with more than one physician. In the case of a CRNA, a collaborative management plan/agreement can be developed with physicians, podiatrists, or dentists. It would not be unusual for an APRN who practices in a clinic or health system to have a collaborative plan/agreement with several physicians who clinically manage the same type of patients. For instance, a clinical nurse specialist or nurse practitioner could develop a collaborative plan/agreement with one, several, or all of the physicians in a clinic provided each physician has agreed to individual collaborative practice parameters with the APRN.

Conversely, the law does not permit an APRN to have a single prescribing agreement with several physicians. The statute requires that a specific prescribing agreement exist only between an individual physician and an individual APRN.
11. What criteria are required before a collaborative management plan/agreement can be developed?

In order for a valid collaborative management plan/agreement to exist between an APRN and a collaborating physician, the law requires that the following criteria be met:

1. the APRN must have experience in providing care to patients with the same or similar medical problems as the physician with whom the APRN is collaborating;
2. the APRN must practice within a health care system that provides for consultation, collaborative management, and referral;
3. a physician with a medical background and experience similar to the APRN's must agree to collaborate; and
4. the physician must possess an active Minnesota license.

12. What other issues should a physician consider prior to entering into a collaborative plan/agreement with an APRN?

It is important to note that, with the exception of a clinical nurse specialist, the law contains no specific requirements regarding the APRN’s clinical experience, including prescribing experience, prior to establishing a collaborative plan/agreement with a physician. Clinical nurse specialists are required to have no less than 30 hours of formal study in prescribing and the therapeutic management of the clinical type of patients in the nurse’s practice.

Physicians might wish to review an APRN’s clinical experience, prescribing experience, and experience in managing patients prior to entering into a collaborative management plan/agreement and/or a prescribing agreement with an APRN. Physicians might also want to determine if there is an employment agreement or contract that outlines how the physician and APRN will collaborate. Another consideration might be the delineation of the method by which the APRN can contact the physician, or how often APRN/physician consultation will routinely occur.

13. How does a certified registered nurse anesthetist’s (CRNA) collaborating plan/agreement differ from the collaborating plan/agreement of other APRNs?

A CRNA must provide anesthesia services in collaboration with physicians (including surgeons), podiatrists, or dentists. The anesthesia services must be provided within the context of collaborative management at the same hospital, clinic, or health care setting as the collaborating physician, podiatrist licensed under chapter 153, or dentist licensed under chapter 150A. A CRNA is allowed to recommend and administer a drug or therapeutic device perioperatively. Under the law, this does not constitute the act of prescribing.

A CRNA’s practice often includes dealing with critical and life threatening patient problems such as acute respiratory, airway, or cardiac difficulties. These types of medical problems must be appropriately treated within a very short time frame to prevent death or severe complications. Therefore, although not required by law, the physician who agrees to collaborate with a CRNA might wish to consider including in the collaborating plan/agreement a stipulation that the physician will be readily available in person or by telephone for consultation when the CRNA is providing anesthesia care and related services.

14. Does the law require that a collaborating physician be on-site or supervise the APRN at all times?

No, the law does not require that the collaborating physician be present or on-site at all times, nor does the law specify that an APRN be supervised by a physician. Because the law does not have these requirements, it is important that the collaborative management plan/agreement consider issues such as how physician collaboration will occur, how often, and under what circumstances.

15. Does the law require that a collaborative management plan/agreement be in writing?

The law does not require that a collaborative management plan/agreement be in writing. In fact, the Minnesota Nurses Association has informed their members that “the mutually agreed upon plan could be as simple as a handshake, or as complex as a written contract.”

It is important for physicians to note that medical malpractice law may hold the physician liable for the APRN’s negligence. The extent of that liability may depend upon the agreement that exists between the physician and APRN. Without a comprehensive, written plan/agreement in place that clearly defines each party’s responsibilities and duties in the relationship, defense of a malpractice claim could be compromised. Contract language advice from an attorney and malpractice coverage information from the collaborating physician’s professional liability carrier is recommended.

16. Does Minnesota law allow an APRN to become an independent provider, contractor, or manager of their own business?

An APRN could be an independent contractor or own a business providing the APRN practices within his/her scope of practice as defined in state law. According to Minnesota law, APRNs have a defined scope of nursing practice that must take place within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient, and the APRN must have a collaborative management plan/agreement with a physician.

An APRN’s practice includes functioning as a direct care provider, case manager, consultant, educator, and researcher and also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers. Within the context of collaborative management, an APRN may autonomously perform these functions including the provision of nonpharmacologic treatment to patients.
17. Is reimbursement for APRN services dependent upon the existence of a collaborative plan/agreement with a physician?
Each payer, i.e., a health plan, insurance company, Medicare, or Medicaid, has rules that determine if services provided by an APRN will be reimbursed. As a general rule, the presence or absence of a collaborative plan/agreement is not pertinent to whether an APRN provided service will receive reimbursement from a specific payer.

18. What are a physician’s liabilities in regard to a collaborative management plan/agreement?
A physician always has potential liability when practicing medicine, or when delegating a portion or portions of their legal scope of practice to another individual, such as an APRN. Therefore, it is of the utmost importance that, prior to entering into a collaborative plan/agreement or a prescribing agreement with an APRN, the physician is aware of the potential liabilities.

Physicians are encouraged to discuss potential liabilities with their malpractice insurer.

Section II: Physician Delegation of Prescribing Authority to Advanced Practice Registered Nurses

19. What types of APRNs are permitted under Minnesota law to receive delegated prescribing authority from a physician?
A new law regulating APRNs was passed during the 1999 Minnesota legislative session. The law specifies the following groups of nurses as APRNs who can enter into a prescribing agreement with physicians:

- Clinical Nurse Specialist in Psychiatric and Mental Health Nursing;
- Clinical Nurse Specialist, other than Psychiatric and Mental Health Nursing;
- Certified Nurse Midwife;
- Certified Registered Nurse Anesthetist; and
- Certified Registered Nurse Practitioner

It is important to note that registered nurses who are not APRNs are not allowed to prescribe or enter into a prescribing agreement with a physician. Prescribing would be considered by state law and the Minnesota Board of Nursing, the state agency that regulates nurses, to be outside the registered nurse’s scope of practice, and therefore a physician cannot delegate prescribing authority to a registered nurse who is not an APRN.

20. How does the 1999 law regulating APRNs change pre-1999 prescribing agreements?
The 1999 law did not change the prescribing authority for certified nurse midwives and certified nurse practitioners. New delegated prescribing authority was authorized in the law for clinical nurse specialists, other than those in psychiatric and mental health nursing, and certified registered nurse anesthetists (CRNA). In addition, clinical nurse specialists in psychiatric and mental health nursing may now be delegated prescribing authority by other physicians, rather than solely by a psychiatrist, as was the case in pre-1999 law.

21. What is the definition of “prescribing” according to Minnesota law?
According to statute, “prescribing” means the act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device in accordance with the provisions of section 148.235. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the federal Food and Drug Administration to meet the labeling requirements for prescription drugs and devices. Prescribing also does not include recommending or administering a drug or therapeutic device perioperatively by a certified registered nurse anesthetist. “Prescription” means a written direction or an oral direction reduced to writing provided to or for an individual patient for the preparation or use of a drug or therapeutic device.

22. Can an APRN prescribe according to his/her nursing scope of practice?
Nurses certified in advanced practice have had prescribing experience as part of their educational curriculum. The type of experience each APRN receives can differ widely from one nursing specialty to another, but as a general rule, certified advanced practice nurses are permitted by their scope of practice to prescribe. This alone, however, does not mean APRNs may legally prescribe. The act of prescribing must be granted to individuals by state law.

It is important to note that state law supersedes an APRN’s professionally designated scope of practice. In Minnesota, as in most other states, state law requires that an APRN prescribe only when he or she has been delegated by a physician the authority to prescribe.
23. Is a certified nurse midwife (CNM) required to have a written prescribing agreement with a physician?

According to the law, a certified nurse midwife does not need to have a written prescribing agreement with a physician. They may prescribe and administer drugs and therapeutic devices within their practice as a CNM.

24. What criteria should a physician consider prior to entering into a prescribing agreement with an APRN?

With the exception of requirements for clinical nurse specialists, the law contains no specific requirements regarding an APRN’s clinical experience, including prescribing experience, prior to developing a prescribing agreement with a physician. The law requires certified clinical nurse specialists to have no less than 30 hours of formal study in prescribing and the therapeutic management of the clinical type of patients in the nurse’s practice.

A physician might want to consider reviewing the APRN’s clinical experience, prescribing experience, and experience in managing patients prior to entering into a prescribing agreement (and/or collaborative management plan) with an APRN.

25. Can an APRN practice without being supervised by or having a prescribing agreement with a physician?

The law permits an APRN to practice within their scope of nursing without a prescribing agreement, and APRNs are not required by law to be supervised by a physician. However, APRNs who do not have a prescribing agreement with a physician may not prescribe.

An APRN’s scope of practice is regulated by state law and depends upon several factors including the type of certification that has been granted to the APRN by a national nurse certification organization. Minnesota law requires that an APRN’s practice occur within a system that provides for consultation, collaborative management, and referral.

26. How is prescribing authority delegated?

Prescribing authority may only be delegated by an individual who is authorized by law to prescribe. Minnesota statute 151.01, subd 23, delineates a “practitioner” legally authorized to prescribe as a licensed doctor of medicine, licensed doctor of osteopathy duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, physician assistant, or an advanced practice [registered] nurse authorized to prescribe based on MN statute 148.235. This statute requires an APRN to have a written prescribing agreement with a physician who has delegated prescribing authority to the APRN.

A physician may only delegate prescribing authority after a written prescribing agreement has been developed, agreed to, and signed by both a collaborating physician and an APRN. The prescribing agreement must meet specific criteria (see Question 31 below) as defined in the MNA/MMA Memorandum of Understanding (MOU).

27. Does the law allow an APRN to have a prescribing agreement with a provider who is not a physician?

The law requires APRNs to have a prescribing agreement with a physician. No other type of provider may enter into a prescribing agreement with an APRN. CRNAs may provide anesthesia in collaboration with physicians, including surgeons, podiatrists, or dentists, but a CRNA’s written prescribing agreement must be with a physician.

28. What factors should physicians consider before delegating prescribing authority?

Before an APRN may legally prescribe, he or she must have a written prescribing agreement with a physician who has agreed to collaborate with the APRN for the purpose of prescribing. The prescribing agreement must meet the standards specified in the official Memorandum of Understanding that has been agreed to by the Minnesota Nurses Association (MNA) and the Minnesota Medical Association (MMA). For clinical nurse specialists in psychiatric and mental health nursing, the agreement must meet the standards specified in the Memorandum of Understanding between the Minnesota Nurses Association and the Minnesota Psychiatric Society.

A physician might want to consider the following APRN specific information prior to entering into a prescribing agreement: specific nursing specialty, type of certification, clinical experience, prescribing experience, patient population covered by the prescribing agreement, the drug classifications that may be prescribed, any restrictions to prescribing, and the schedule of physician review.

29. What if a physician, other than a psychiatrist, wishes to delegate prescribing authority to a certified clinical nurse specialist in psychiatric and mental health nursing?

It is important to remember that delegated prescribing authority for clinical nurse specialists in psychiatric and mental health nursing extends only to those drugs used to treat psychiatric and behavioral disorders and the side effects of those drugs within the scope of the written prescribing agreement and within the nurse’s scope of practice. For instance, a clinical nurse specialist in psychiatric and mental health nursing could not be delegated by a psychiatrist or other physician the authority to prescribe an antibiotic, even though the patient being cared for is a psychiatric patient.

Therefore, an agreement between a physician and a clinical nurse specialist in psychiatric and mental health nursing might designate that the APRN’s prescribing authority extends only to those drugs used to treat psychiatric or behavioral disorders and the side effects of those drugs.
30. If a physician delegates the authority to prescribe drugs that treat psychiatric or mental health disorders to an APRN other than a clinical nurse specialist in psychiatric and mental health nursing, what should the physician consider prior to signing a prescribing agreement?

As with any prescribing agreement, physicians need to determine the APRN’s experience with prescribing drugs used to treat various diseases and conditions prior to delegating prescribing authority for any drug or class of drugs. For instance, a physician would probably not delegate the authority to prescribe antidepresants to an APRN who had little or no prior experience in managing psychiatric patients or prescribing psychotrophic drugs. Likewise, a physician, such as a pediatrician, would probably not delegate the authority to prescribe drugs used to treat adult disorders to a pediatric nurse practitioner.

31. What is the minimum amount of information that must be contained in a prescribing agreement between an APRN and a physician?

The minimum amount of information required in a prescribing agreement includes the APRN’s and collaborating physician’s name, address, phone numbers, medical and nursing specialty, statements about the APRN’s practice and experience, specific categories of drugs and therapeutic devices that may be prescribed, any restrictions to prescribing, and the frequency of review of the APRN’s prescribing practice.

32. If a physician delegates prescribing authority to several APRNs, should each written prescribing agreement be worded the same way, or can each prescribing agreement differ?

Prescribing agreements may differ widely depending on various factors such as the length of time a physician has worked with a particular APRN, the APRN’s clinical experience, and the type of patients that are managed by the APRN. For instance, a physician might have a very restrictive prescribing agreement with an APRN with whom the physician is unfamiliar. Correspondingly, a physician might have a more permissive agreement with an APRN with whom the physician has worked for a considerable length of time, has established a trusting working relationship, and where the APRN has, through past experience working with the physician, demonstrated his or her ability to prescribe appropriately.

33. What if a physician determines it is necessary to specify more information in the prescribing agreement than is required by law?

The law requires that, at a minimum, specific informational items be included in a prescribing agreement. The law does not prohibit a prescribing agreement from having more information than that which is minimally required; therefore, a physician may wish to include information or designate specific protocols that may be over and above what is required by law.

34. How often should a prescribing agreement be reviewed, updated, and signed?

This would depend on several factors. The 1999 statute requires that, at a minimum, a prescribing agreement be reviewed, updated, and signed at least annually by the collaborating physician and APRN. However, other circumstances might indicate that more frequent review is necessary such as a change in the type of patients that are being managed by the APRN or collaborating physician, the presence or absence of an APRN’s DEA number, or the APRN’s request to begin prescribing a drug or class of drug that was not originally included in the prescribing agreement.

In addition, if in the future, a new Memorandum of Understanding (MOU) is developed by the Minnesota Nurses Association and the Minnesota Medical Association or the Minnesota Nurses Association and the Minnesota Psychiatric Society that changes the standards or requires additional standards to be included in prescribing agreements, every future agreement would need to comply with the new requirements. Therefore, it is important to determine prior to developing or revising an MOU if the 1999 MOU has been revised.

35. How does a certified registered nurse anesthetist's (CRNA) prescribing agreement differ from a prescribing agreement of other APRNs?

To have delegated prescribing authority, a CRNA must have a written agreement with a collaborating physician, licensed under chapter 147, who practices at the same hospital, clinic, or health care setting. The written prescribing agreement with the collaborating physician must define the delegated responsibilities related to the prescription of drugs and therapeutic devices and the CRNA must prescribe and administer drugs and therapeutic devices within both the scope of the written agreement and the scope of practice of a CRNA.

A CRNA’s practice often includes dealing with critical and life-threatening patient problems such as acute respiratory, airway, or cardiac difficulties. These types of medical problems must be appropriately treated within a very short time frame to prevent death or severe complications. Therefore, although not required by law, the physician who agrees to collaborate with or delegate prescribing authority to a CRNA might wish to consider including in the collaborative plan/agreement and the prescribing agreement a stipulation that the physician will be readily available in person or by telephone for consultation when the CRNA is exercising delegated prescribing authority.

A CRNA must provide anesthesia services in collaboration with physicians (including surgeons), podiatrists, or dentists. The anesthesia services must be provided at the same hospital, clinic, or health care setting as the collaborating physician, podiatrist licensed under chapter 153, or dentist licensed under chapter 150A. A CRNA is allowed to recommend and administer a drug or therapeutic device perioperatively. Under the law, this does not constitute the act of prescribing.
36. What if the health plan or health care facility that employs both an APRN and collaborating physician has a designated prescribing agreement form?

Many health plans and health care facilities use a designated form for prescribing agreements between an APRN and physician. If the form contains the minimum amount of information that is required by the MNA/MMA Memorandum of Understanding, it meets the legal requirements for a prescribing agreement.

Most forms that are used by health plans and health care facilities detail the type of collaborative agreement that has been agreed to by an APRN and a physician, including the prescribing authority that has been delegated by the physician. In addition, health plans and health care facilities maintain detailed written agreements to verify to credentialing organizations that the physicians and APRNs they employ have a definitive agreement that specifies numerous aspects of the collaborative arrangements that exist within their facilities.

37. Does the law allow an APRN to have a prescribing agreement with more than one physician?

It would not be unusual for an APRN to have a prescribing agreement with several physicians, but it is important to note that every prescribing agreement must be a distinct agreement made between an individual APRN and an individual physician. For instance, a family practice clinic might employ a nurse practitioner who works with several physicians practicing at the clinic. Each individual APRN/physician prescribing agreement would depend on the type of patients that are managed and would also depend on the professional relationship that exists between the APRN and an individual physician. The APRN’s prescribing agreements could be with one, several, or every physician who practices at the clinic, but each prescribing agreement must be developed, signed, and dated by the individual APRN and individual physician who are entering into the agreement and must cover a specific group of patients.

38. Could an APRN have a prescribing agreement with one physician and a collaborative management plan/agreement with a different physician?

According to the law, an APRN could have distinct agreements with different physicians. For instance, an APRN might have a prescribing agreement with one physician in a particular health care setting and a collaborative plan/agreement with another physician. The physician who signs the prescribing agreement would be solely responsible for jointly determining the scope of the APRN’s prescribing authority. The physician who agrees to develop a collaborative plan/agreement with the APRN would be responsible for jointly determining the scope of collaboration necessary to manage the care being provided to the APRN’s patients. The collaborative plan/agreement may or may not include prescribing parameters. If it does, it would need to meet all the criteria as specified in the MNA/MMA Memorandum of Understanding and it would only apply to prescribing for the patients included in the collaborative plan/agreement.

39. Is an APRN who works in a nursing facility/long term care center allowed to prescribe for a patient or a group of patients without contacting the physician who admitted the patient to the nursing facility?

An APRN is allowed to prescribe as long as there is a written prescribing agreement with a collaborating physician. The agreement must cover a specific patient or group of patients. The law does not specifically stipulate that the collaborating physician must be the physician who admitted the patient to the nursing facility. Often it is the nursing facility’s medical director who has the written prescribing agreement with an APRN. Therefore, it is important that physicians who admit patients to a nursing facility become familiar with the policy and procedure that addresses physician responsibility for the management of ongoing patient care in the nursing facility/long term care center, including the prescribing of drugs and/or therapeutic devices. Most nursing facilities/long term care center have a policy that stipulates that a patient’s medication regimen cannot be changed without contacting the admitting physician unless the admitting physician has signed over ongoing management to a specified physician.
Physicians are encouraged to contact the MMA for a copy of a Model Prescribing Agreement form and the MNA/MMA Memorandum of Understanding.