MIEC

SPECIAL REPORT

# MIEC Claims Alert

Number 25A
Revised November 2015

## The use of nonphysician clinicians in a medical practice

### INSIDE



**Special Report Claims Alert**
A publication of the Loss Prevention Department, Medical Insurance Exchange of California, 6250 Claremont Ave, Oakland, CA 94618. Articles do not constitute legal advice.


*Physicians work with nonphysician clinicians (NPCs) in a variety of medical settings. Variously called "physician extenders," "midlevel practitioners," or "allied health professionals," nonphysician clinicians provide support services in hospitals, group practices, clinics and offices of solo practice physicians. Nonphysician clinicians include physician assistants (PAs), an allied health profession all fifty states recognize and most license; and four classifications of advanced practice nurses (APNs): nurse practitioners (NPs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). As acceptance of nonphysician clinicians increases among third-party payers and the public, physicians may want to explore the benefits of employing NPCs, as well as the impact NPCs have on the role of physicians.*

### NPC scope of services vary

The medical and support services nonphysician clinicians are permitted to provide vary among the states. Some states certify physician assistants and nurse practitioners; others use the term "physician assistant" interchangeably with "medical assistant" to describe any support personnel, licensed or unlicensed, who assist doctors in an office or hospital setting.

**Physician Assistants:** PAs who have completed training in a two- or three-year accredited program can be certified by the National Commission on Certification of Physician Assistants (NCCPA). According to the American Association of Physician Assistants (AAPA), some 83,466 PAs now practice in the United States;[1] 43% work in primary care practices and sub-specialties, while 25% are employed in surgical practices with orthopedics having the greatest distribution of PAs followed by cardiovascular/ cardiothoracic, neurology and urology specialties. Forty-seven percent (47%) of PAs provide services in a hospital-type setting, 38% work in single or multi-specialty group practices, and 15% work in solo practice offices. The AAPA defines PAs as "health professionals who practice medicine with physician supervision. They deliver a broad range of medical and surgical services to diverse populations in rural and urban settings. PAs conduct physical exams, diagnose and treat illnesses, order and interpret

1 "Physician Assistant Census Report: Results from the 2010 AAPA Census." American Academy of Physician Assistants, Alexandria, VA.

tests, counsel on preventive health care, assist in surgery, and in virtually all states, can write prescriptions."[2]

**Advanced Practice Nurses:** APNs are registered nurses who have had additional training and certification. Nurse practitioners usually complete a master's degree program. CNMs undergo specialized training in a certificate or master's program. CNSs complete an advanced training program in one medical specialty, such as oncology, pediatrics, obstetrics or neonatology. CRNAs are required to have specialized training and be certified by a national organization.

The US Department of Health and Human Services (DHHS), Health Resources and Services Administration, reported in 2010 that there were over 3.1 million registered nurses in the United States, of which 270,903 (8.7%) were advanced practice nurses.[3]

## Benefits of using NPCs

Physicians who support the use of NPCs cite several benefits to themselves and to patients. Among them:

- **Immediate patient access to health care:** Many groups offer patients the option of seeing an NPC immediately for primary care visits instead of waiting for an appointment with the doctor. Patients are often pleased with the convenience of this option, and may perceive the practice that provides this service as being more responsive to their needs.
- **Physician time is available for difficult cases:** NPCs can perform a variety of time consuming, but important tasks, and free physicians to provide services NPCs cannot. Among the services NPCs provide in physician offices, urgent care centers and emergency departments include: physical exams, blood pressure checks, prenatal visits, post-operative wound checks, immunizations, and treatment of minor complaints, such as colds, flu, respiratory infections and minor skin problems.
- **Lower overhead:** In the 2010 American Academy of Physician Assistants (AAPA) Census Report, 83% of the 19,830 respondents reported that they are employed full-time (i.e., 32+ hours per week). The median annual salary for PAs is $90,000.

  According to the DHHS 2008 Sample Survey published in 2010, the average salary for nurse practitioners is $73,776, $74,918 for nurse specialists, and $69,222 for nurse midwives. Nurse anesthetists are the highest paid advance practice nurses averaging $135,776 per year.
- **Increased patient satisfaction:** Current studies indicate high patient satisfaction with care delivered by nonphysician clinicians. "The success of NPs in keeping patients healthy and happy has not escaped the attention of health care administrators and patients."[4]
- **Education of patients:** According to the American College of Nurse Practitioners, NP training focuses on health maintenance, disease prevention, counseling and patient education. Studies indicate that patients educated about their medical conditions and treatment are less likely to suffer an injury. Midlevel practitioners report that their status as "nonphysician" smooths the way for patient education, as many patients feel more comfortable asking questions of NPCs than of physicians.
- **Defensible documentation:** Liability specialists who conduct office surveys find that nurse practitioners and physician assistants tend to keep detailed and complete medical records. Most NPCs have had the importance of documentation stressed in their training and know their performance reviews are based, in part, on the supervising physician's review of medical records."

## NPC claims data

Data about the frequency and severity of NP and PA claims is not readily attainable. The Physician Insurers Association of American's (PIAA) Data Sharing Project reports a low number of claims involving nonphysician clinicians. Between January 1985 and December 31, 2010, the PIAA collected and reviewed 256,225 claims in which 173,465 "associated personnel occurrences" were reported. Claims involving advanced practice nurses and physician assistants account for 4,558 (2.6%) of the total reported "associated personnel occurrences." The Data Sharing Project also separated "associated issues" (e.g., medical records, informed consent, breach of confidentiality) from the allegations of medical

2 News Release: "PAs Work Predominantly in Primary Care," American Academy of Physician Assistants, October 31, 1997.

3 Data as of September 2010. US Department of Health and Human Services, Health Resources and Services Administration. "The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses."

4 Francisco Trilla, MD, Angela Patterson, RNCS, "Physicians and Nurse Practitioners in Collaborative Practice," Forum, Winter 1998, 18(5).

negligence; 157,142 associated issues were reported. Physicians' vicarious liability (liability for the actions of employees) accounted for 6,289 (4.0%) of the "associated issues." Published reports about malpractice claims that involve nonphysician clinicians indicate that, although infrequent, jury awards and settlements for NPC errors tend to be high. In some cases, NPCs who provide medical treatment ordinarily provided by a physician have been held to the same standards of care applied to physicians. Allegations of inadequate physician supervision of NPCs also have been issues in claims.

Overall, national and state malpractice data do not indicate significant increased liability risk for physicians who employ or supervise NPCs. However, the severity of awards in published cases serves as a reminder to physicians of the need to properly monitor and supervise midlevel practitioners for whom they are responsible.

## Preventing NPC liabilities

Some of the leading reasons NPCs are named defendants in litigation include: they rendered a service beyond their capabilities; took an inadequate history; failed to consult with their supervising physician and, as a result, failed to diagnose a condition; neglected to refer a patient; failed to follow established protocols; and improperly ordered or monitored medications.

The liability risks for physicians who employ NPCs can be minimized by developing and implementing reasonable protocols, guidelines, and policies for the hiring, supervising and reviewing of NPCs.

**Of note:** Based on MIEC's claims history and loss prevention experience, we strongly recommend that policyholders maintain a well-developed physician-patient relationship with patients. NPCs are certainly a vital part of that relationship; however, they should not be the primary clinician managing the overall health of the relationship or the patient. The relationship is tested and liability potentially increases when your patients feel abandoned after suffering an unexpected outcome such as an adverse medication reaction, an intraoperative complication that leaves them disabled or in chronic pain, a hospital readmission, and more. You avoid patient perception of abandonment when you address the issues rather than having your NPC serve as your representative.

Claims experience also reveals that surgeons reduce their risk and preserve their patients' confidence and trust when the treating surgeons, rather than their PAs, see patients for the first post-operative visits. This gives the physicians an opportunity to evaluate the patients. More importantly it communicates to patients care and concern, and allows them to ask any questions they may have as to outcome of the operation, recovery, and more.

## How to reach MIEC:

Phone:
Oakland: 510/428-9411
Honolulu: 808/545-7231
Boise: 208/344-6378
Alaska: 907/868-2500
Outside of area: 800/227-4527

Fax:
Loss Prevention: 510/420-7066
Oakland: 510/654-4634
Honolulu: 808/531-5224
Boise: 208/344-7903
Alaska: 907/868-2805

Email:
Lossprevention@miec.com
Underwriting@miec.com
Claims@miec.com

**MIEC on the Internet:**
**www.miec.com**

# MIEC Recommends

- Check an applicant's credentials carefully before hiring; verify an NPC's credentials and prior experience as thoroughly as you would a physician's. Ensure that their specialty mirrors yours in order for you to supervise them.

- Review state laws on licensure, scope of practice, and supervision of NPCs.

- Together with the NPC, prepare written guidelines that specify the NPC's role in examining, assessing, diagnosing, and treating patients; written guidelines should define the supervising physician's role and identify cases that need prompt referral to the physician; periodically review and update the guidelines.

- Establish an "open door" policy with NPCs to discuss their questions or concerns about treatment of patients; frequently communicate with midlevel practitioners to stay informed about their medical management of patients.

- Ensure that other staff members know the NPC's responsibilities and limitations.

- Introduce the NPC to patients and identify his or her specialty; promote the NPC's skills to patients, but assure patients that they can be seen by a physician when they or the doctor feel it necessary; stress that the NPC works collaboratively with the doctor, who ultimately is responsible for treatment decisions; schedule patients to be evaluated periodically by a physician, which underscores the doctor's supervisory role.

- Establish criteria for ongoing, periodic review of the NPC's documentation as mandated by the laws in your state. If your state laws are silent about periodic records review requirements, do not be reluctant to establish a criteria anyway *[For more information about defensible record-keeping, see MIEC's handbook,* ***"Medical Documentation for Patient Safety and Physician Defensibility"****]*.

- Ask patients for feedback about their level of satisfaction with treatment by NPCs.

- Inform MIEC if you employ NPCs; unlike some unlicensed office staff who may not have to be named on your policy, coverage of NPCs requires an Underwriter's approval; if the NPC is not an employee, require that he or she has liability insurance with limits equal to your own.

- If the NPC is expected to see your hospitalized patients, get approval from the hospital or ask the NPC to apply for privileges from the hospital's medical staff.

- Introduce the NPC to your on-call colleagues and give them a copy of the written guidelines the NPC follows; if you are off-call, make certain that state law permits you to delegate supervision of the NPC to another physician.

*Figure A*

# State Specific Charts

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Physician Assistant Qualifications** | Graduate accredited PA program; current NCCPA certificate. **[12 AAC 40.400]** | Graduate California-approved PA program; current NCCPA certificate. **[B&P Code §3519 and CCR Title 16, Division 13.8, Article 1, §1399.507]** | Graduate a board approved PA program; current NCCPA certificate; current NCCPA certificate required for biennial renewal. **[HAR §16-85-46(a)(1)-(11) and HAR §16-85-47(a)]** | Graduate accredited PA program; bachelor's degree; NCCPA exam. **[IDAPA 22.01.03. Subsection 021.01-06]** |
| **MD Supervision of Physician Assistant** | **Collaborative Plan as defined in 12 AAC 40.410(a)-(j):**<br>✓ PA may not practice without at least one collaborative relationship that is documented by a plan on a form provided by the medical board. Must include: Name, license number and specialty of primary supervising physician and at least one alternate collaborative physician.<br>✓ Collaborative plan must be filed with the medical board within 14 days after the effective date of the plan or any change to the plan. Copy of the plan must be kept in the place of employment and must be available for inspection by the public.<br>✓ Any change to the plan automatically suspends a licensed PA's authority to practice under the plan, unless the change is to replace the primary collaborating physician with an existing alternate collaborating physician. Changes must be reported to the board.<br>✓ The collaborating physician must hold a current, active and unrestricted license to practice medicine in AK and must be in an "active" (at least 200 hours each year of direct patient contact) practice. | **Supervision required as defined in CCR Title 16, Division 13.8, Article 1, §1399.545:**<br>✓ A supervising MD shall be available in person or by electronic communication at all times when the PA is caring for patients.<br>✓ A supervising MD shall delegate to a PA only those tasks and procedures consistent with the MD's specialty or usual and customary practice and with the patient's health and condition.<br>✓ A supervising MD shall observe or review evidence of the PA's performance of all tasks and procedures to be delegated to the PA until MD is assured of competency.<br>✓ The PA and supervising MD will establish written transport and back-up procedures for the immediate care of patients in need of emergency care beyond the PA's scope of practice for times when a supervising MD is not on the premises.<br>✓ A PA and his/her supervising MD will establish written guidelines for the adequate supervision of the PA which will include one or more of the following mechanisms:<br>1) Examination of the patient by a supervising MD the same day as care is given by the PA; | **Degree of supervision as defined in HAR §16-85-49(a)(1)-(7):**<br>The supervising physician shall:<br>✓ Possess a current unrestricted HI license to practice medicine and surgery.<br>✓ Submit a statement that the supervising MD will direct and exercise supervision over any subordinate PA in accordance with HAR subchapter and recognizes that the supervising MD retains full professional and legal responsibility for the performance of the PA and care and treatment of the patient.<br>✓ Permit the PA to be utilized in any setting authorized by the supervising MD including, but not limited to, clinics, hospitals, ambulatory centers, patient homes, nursing homes, other lodging and other institutional settings.<br>✓ Provide adequate means for direct communication between the PA and supervising MD; physical presence of the supervising MD is not required and the direct communication may occur through the use of technology (two-way radio, telephone, fax, modem or other telecommunication device). | **Supervision required as defined in IDAPA 22.01.04, Subsection 020.01 to 06:**<br>Supervising physicians must register with Idaho's Board of Medicine and generally may supervise no more than three (3) PAs at a time. The Board may authorize a physician to supervise a total of six (6) PAs contemporaneously if necessary to provide adequate medical care and upon prior petition documenting adequate safeguards to protect the public health and safety. **[IDAPA 22.01.04, Subsection 010.15]**<br>According to **IDAPA 22.01.04**, Subsection 020.01 to 06, the supervising MD must:<br>✓ Accept full responsibility for the medical acts and patient services provided by PA and graduate PAs and for the supervision of such acts which include:<br>✓ Conduct onsite visit at least monthly to personally observe the quality of care provided;<br>✓ Periodic review of a sample of records to evaluate medical services provided. When applicable, review shall include an evaluation of adherence to the delegation of services agreement between the MD and PA; and |

5 Information provided in the grid was obtained from the Boards of Medicine and Boards of Nursing in Alaska, California, Hawaii, and Idaho. Physicians who employ or plan to enter into a collaborative arrangement with an NPC should obtain their state's current regulations. A copy of the regulations governing physician assistants (PA) and advanced practice nurses are available from the medical board or nursing board in each state. In California, physicians may obtain data about PAs from the Board of Physician Assistants.

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Physician Assistant** | ✓ The collaborating physician is responsible for ensuring that the PA complies with state and federal inventory and record keeping requirements.<br>**Remote practice location:**<br>(a) To qualify to practice in a remote practice location, a physician assistant with less than two years of full-time clinical experience must work 160 hours in direct patient care under the direct and immediate supervision of the collaborating physician or alternate collaborating physician. The first 40 hours must be completed before the physician assistant begins practice in the remote practice location, and the remaining 120 hours must be completed within 90 days after the date the physician assistant starts practice in the remote practice location.<br>(b) A PA with less than two years of full-time clinical experience who practices in a remote practice location and who has a change of collaborating physician must work 40 hours under the direct and immediate supervision of the new collaborating physician within 60 days after the effective date of the new collaborative plan unless the change is only to replace the primary collaborating physician with an existing alternate collaborating physician.<br>(c) A PA with two or more years of full-time clinical experience who applies for authorization to practice in a remote practice location shall submit with the collaborative plan | 2) Countersignature and dating of all the PA's medical records written within 30 days of care given by the PA; and<br>3) The supervising MD may adopt protocols to govern the performance of a PA for some or all tasks. The minimum content for a protocol is outlined in CCR Title 16, Division 13.8, Article 1, §1399.545 (e)(3) and in B&P Code §3502(c).<br>**PLEASE NOTE**: The supervising MD shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the PA functioning under these protocols, within 30 days of the patient visit. The MD shall select for review those cases which by diagnosis, problem, treatment or procedure represent the most significant risk to the patient.<br>✓ The supervising MD has continuing responsibility to follow the progress of the patient and to ensure that the PA does not function autonomously. **The supervising MD shall be responsible for all medical services provided by a PA under his/her supervision. [CCR, Title 16, Division 13.8, Article 1, §1399.545(f)]**<br>✓ Each time the PA provides care for a patient and enters his/her name, signature, initials, or computer code on a patient's record, chart or written order, the PA shall also enter the name of the supervising MD who is responsible for the patient. When the PA transmits an oral order, he/she shall also state the name of the supervising MD | ✓ Personally review the records of each patient seen by the PA within seven (7) working days.<br>✓ Designate an alternate supervising MD in the physician's absence.<br>✓ Supervise no more than four (4) PAs at any one time.<br>✓ Be registered under section 329-33, HRS, when supervising and delegating to the physician assistant the authority to prescribe, dispense and administer Schedule II-V medications.<br>✓ The supervising MD or MDs and the PA will notify the Board within 10 days of severance of supervision or employment of the PA. **[HAR §16-85-49(b)]**<br>"Supervision" is defined: Overseeing the activities of, and accepting responsibility for, the medical services rendered by a PA. Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising MD at the time and place the services are rendered. **[HAR §16-18.44.5]**<br>**See PA prescribing medications section below.** | ✓ Hold regularly scheduled conferences.<br>✓ Report to the Board all patient complaints received against the PA or graduate PA which relate to quality and nature of medical care or patient services rendered.<br>✓ Must always be available either in person or by phone to supervise, direct and counsel PA.<br>✓ Outline the scope and nature of the supervision in a delegation of services agreement, as set forth in IDAPA 22.01.03, "Rules for the Licensure of PA," subsection 030.04.<br>✓ Disclose to patients the fact that the PA is not an MD. This can be accomplished with nametags, correspondence, oral statements, office signs or other procedures.<br>✓ Shall not utilize or authorize the PA to use any pre-signed prescriptions. **[IDAPA 22.01.04, Subsection 020.03]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Physician Assistant** | (1) a detailed curriculum vitae documenting that the physician assistant's previous experience as a PA is sufficient to meet the requirements of the location assignment; and<br>(2) a written recommendation and approval from the collaborating physician.<br>(d) In this section, "remote practice location" means a location in which a physician assistant practices that is 30 or more miles by road from the collaborating physician's primary office. **[ 12 AAC 40.415]**<br>**Performance and Assessment of Practice:**<br>✓ PA may perform medical diagnosis and treatment only if licensed by the board and only within the scope of practice of the collaborating physician.<br>✓ Collaborating physician must establish a periodic quality of practice assessment of the PA's medical care and clinic management.<br>Plans in effect less than 2 years must include at least one direct personal visit from the supervising physician per quarter for at least four hours.<br>Plans in effect 2 years or more must include at lease two direct personal contact visits with primary or alternate collaborating physician per year lasting at least four hours and must be four months apart.<br>A PA who practices under a plan for a continuous period of less than 3 months per year must have at least one direct personal contact visit with the collaborating physician annually. | responsible for the patient. **[CCR, Title 16, Division 13.8, Article 1, §1399.546**]<br>✓ **The Delegation of Service Agreement** is outlined in **Title 16, Division 13.8, Article 1, §§1399.540 and 1399.541.**<br>✓ No MD and surgeon shall supervise more than four (4) PAs at any one time, except as provided in section 3502.5 (during a state of emergency). The board may restrict an MD and surgeon to supervising specific types of PAs, including, but not limited to, restricting a physician and surgeon from supervising PAs outside of the field of specialty of the physician and surgeon. **[B&P §3516 (b)(c)]** | | |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Physician Assistant** | ✓ Plans must include at least monthly telephone, radio, electronic or direct personal contact between the PA and collaborating physician. Contact must be documented.<br>✓ Collaborating MD shall maintain records of performance assessments for at least seven years after the date of the evaluation **[12 AAC 40.430(a)-(q)]** | | | |
| **Physician Assistant Prescribing Medications** | Prescriptive authority for non-controlled substances and Schedule II-V drugs with physician authorization stated in the PA's current collaboration plan. Prescriptions written and signed by PA must include MD's and PA's name and DEA numbers on the prescription forms. PA may order, administer and dispense Schedule II-V drugs with the specific approval of the collaborating physician. **[12 AAC 40.450(a)-(j)]** | Each supervising physician and surgeon who delegates the authority to issue a drug order to a PA shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the supervising MD's type of practice. When issuing a drug order, the PA is acting on behalf of and as an agent for a supervising physician and surgeon. **[B&P Code §3502.1(a)(2)]**<br>✓ A drug order for any patient cared for by a PA shall either be based on written protocols or shall be approved by the supervising MD and surgeon before it is filled or carried out. **[B&P Code §3502.1(c)]** | ✓ By authorization of the supervising physician, PAs have prescriptive authority for all legend and Schedule III-V drugs. PAs who prescribe Schedule II-V medications must be registered with the DEA.<br>✓ Effective April 16, 2015, Hawaii Administrative Rules Chapter 16-85 were amended to allow PAs to prescribe Schedule II controlled substances in all practice settings under the supervision of a Hawaii-licensed physician. Prior to prescribing Schedule II drugs, PAs must update their Controlled Substance Registration issued by the Department of Public Safety, Narcotics Enforcement Division (NED) by downloading the new PA's Registration Form online at http://dps.hawaii.gov/about/divisions/law-enforcement-division/ned. PAs may need to update their federal DEA license to include Schedule II drugs before submitting their updated registration to NED.<br>✓ Each prescription written by the PA shall include the printed, stamped, typed or hand-printed name, address, and phone number of the supervising MD and PA. | ✓ A PA may apply to the Idaho Board of Medicine for approval to prescribe Schedule III-V and non-controlled substances. The application must include documentation that he/she has completed a pharmacology course (at least 30 hours), frequency with which the supervising MD will review prescriptions written, and a signed statement from the supervising MD certifying that the PA is qualified to prescribe the drugs for which the PA is seeking approval.<br>✓ To be authorized to prescribe Schedule III-V drugs, the PA must register with DEA and Idaho Board of Pharmacy. [IDAPA 22.01.03, Subsection 042.02]<br>✓ A PA may issue written or oral prescriptions for legend drugs and controlled drugs, Schedule III-V in accordance with approval and authorization granted by the Board of Medicine, the current delegation of services agreements and shall be consistent with the regular prescriptive practice of the supervising MD.<br>**[IDAPA 22.01.03, Subsection 042.01]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Physician Assistant Prescribing Medications** | | ✓ PA shall administer or provide a drug or issue a drug order only for drugs listed in the formulary. This includes handing to the patient a properly labeled prescription drug pre-packaged by a physician, surgeon, manufacturer as defined in Pharmacy Law, or a pharmacist. **[B&P Code §3502.1(c)(1)]**<br><br>✓ PA may not administer, provide or issue a drug order to a specific patient for Schedule II-V controlled substances without advance approval by a supervising MD and surgeon unless the PA has completed a controlled substances educational course that is approved by the committee. The course must be completed before the PA is issued a DEA registration number. **[B& P Code §3502.1(c)(2)]**<br><br>✓ A drug order issued by a PA shall be subject to a reasonable quantitative limitation consistent with what is customary in the supervising MD and surgeon's practice. **[B&P Code §3502.1(c)(3)]**<br><br>✓ Drug orders must have the printed name, address, and phone number of the super-vising MD, and the printed or stamped name, license and DEA numbers, and signature of the PA. **[B&P Code §3502.1(d)]**<br><br>✓ The supervising MD and surgeon shall review, countersign and date within seven (7) days any medical record of any patient cared for by a PA for whom the PA issued or carried out a Schedule II drug order. **[B&P Code §3502.1(e)]** | When prescribing Schedule II-V medications, the written prescription order shall include the DEA registration number of the supervising physician. PA shall sign the prescription next to his/her printed name.<br><br>✓ A PA may request, receive, and sign for professional samples and may distribute professional samples to patients, provided that the samples are not controlled substances.<br><br>✓ PAs employed or extended privileges by a hospital or extended care facility may write orders for Schedule II-V medications for inpatients under the care of the supervising MD. The Board of Medical Examiners shall notify the Pharmacy Board in writing, at least annually or more frequently if required by changes, of each PA authorized to prescribe.<br><br>✓ All dispensing activities shall comply with appropriate state and federal regulations, **[HAR §16-85-49(a)(8)(A)-(G)]** | ✓ Prescription forms used by PA must be printed with the name, address, and telephone number of the PA and of the supervising MD. [IDAPA 22.01.03, Subsection 042.03]<br><br>✓ Shall maintain accurate records, accounting for all prescriptions written and medications delivered.<br><br>**[IDAPA 22.01.03, Subsection 042.04]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Nurse Practitioner Qualifications** | Advanced Nurse Practitioner (ANP) is a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the AK Board of Nursing. **[AS §08.68.850(1)]**<br><br>ANP educational requirements are outlined in **12 AAC 44.400**.<br><br>ANP may practice independently in the practice areas of:<br><br>(1) acute care/emergency;<br>(2) adult;<br>(3) family;<br>(4) geriatric;<br>(5) neonatal;<br>(6) pediatric;<br>(7) women's health;<br>(8) family psychiatric mental health; and<br>(9) adult psychiatric mental health. **[12 AAC 44.380]** | A registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Section 1484. **[CCR Title 16, Div. 14, Art. 7 §1480(a)]**<br><br>Beginning January 1, 2008, first time NP applicants must also have a master's degree in nursing or a clinical field related to nursing or a graduate degree in nursing, and must successfully complete a NP program approved by the Board. **[B&P §2835.5(d)(1)-(3)]** | Generally defined in HI as an "Advanced Practice Registered Nurse (APRN):"<br><br>A person recognized as an APRN **prior to 10/1/09** with a master's degree in nursing or a current certificate for specialized and advanced nurse practice from a national certifying body will be eligible to renew that recognition provided that all nurse licenses, recognitions, and prescriptive authorities or similar designations held by the person in any jurisdiction are unencumbered. **[HRS §457-8.5(b)]**<br><br>**Effective 10/1/09**, the board grants a nurse recognition as an APRN who: (1) has a current, unencumbered license as an RN in HI, and in all other states in which the RN has a current and active license; (2) unencumbered recognition as an APRN in all other states in which the RN has current recognition; (3) completed accredited graduate-level education leading to a master's degree as a CRNA, nurse midwife, clinical nurse specialist or NP; (4) current, unencumbered certificated of having passed a national certification examination; (5) maintained competencies; (6) acquired advanced clinical knowledge and skills; (7) demonstrated a greater breadth of knowledge; (8) experience; and (9) paid the appropriate fees. **[HRS §457-8.5(a)]**<br><br>Each hospital in the State licensed under HRS §321-14.5 shall allow APRN recognized pursuant to HRS §457-8.5 and qualified APRN granted prescriptive authority pursuant to §457-8.6 to **practice at the hospital within the full scope** | Generally defined in ID as "Advanced Practice Professional Nurse (APPN):" Licensed professional RN who graduated from a nationally accredited NP program, passed a qualifying examination recognized by the Board, and has current certification from a national organization recognized by the Board. **[IDAPA 23.01.01, Subsection 271.11]**<br><br>In addition to the core standards of APPN, NPs shall practice in accord with standards established by the American Nurses Credentialing Center, the American Academy of NP, the National Association of Pediatric Nurse Associates and Practitioners or the Association of Women's health OB and Neonatal Nurses. NP who meet qualifying requirements and are licensed by the Board may perform comprehensive health assessments, diagnosis, health promotion and the direct management of acute and chronic illness and disease as defined by the NP's scope of practice. **[IDAPA 23.01.01, Subsection 280.05]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Nurse Practitioner Qualifications** | | | **of practice authorized under chapter 457, including practice as a primary care provider.**<br><br>**Scope of practice for an NP is outlined in HAR §16-89-81 (c)(1) (A)-(H).** | |
| **MD Supervision of Nurse Practitioner** | **There are no requirements for MD collaboration or supervision.** | NPs certified by the Board of Registered Nursing (BRN) use standardized procedures when performing medical functions. These are developed in collaboration by the physicians, NPs, and administration of the organized healthcare system through which the NP delivers care. The standardized procedures address the issue of physician supervision. **[CCR Title 16, Div. 14, Art. 7 §1474]**<br><br>**Authorized standardized procedures:** (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following: | **There are no MD supervision requirements.**<br><br>According to **HAR §16-89-81(b)(6)**, an APRN shall establish collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of an APRN shall be referred to an appropriate health care provider.<br><br>A collaborative agreement is required if the APRN is applying to the board to prescribe controlled substances. An agreement is NOT required if the APRN only plans to prescribe non-controlled drugs.<br><br>**See Nurse Practitioner Prescribing Medications below.** | APPN's scope of practice is authorized by the Board of Nursing. An APPN shall consult and collaborate with other members of the healthcare team and make appropriate referrals, but is not supervised by a physician. **[IDAPA 23.01.01, Subsection 280.02 (a)-(c)]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Nurse Practitioner** | | (1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.<br>(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.<br>(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.<br>(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment **[B&P Code §2835.7]** | | |
| **Nurse Practitioner Prescribing Medications** | Alaska's Board of Nursing will, in its discretion, authorize an advanced nurse practitioner (ANP) to prescribe/dispense legend drugs in accordance with applicable state and federal laws. A nurse who applies for authorization to prescribe and dispense must: (1) be an ANP in Alaska; (2) have completed 15 hrs. of pharmacology education and clinical management of drug therapy within a 2-yr period immediately before date of application; and, (3) submit a completed notarized application. Prescriptions must contain the prescriber's ID number assigned by the Board | NPs certified by the BRN, and who possess a BRN-issued furnishing number can furnish or order drugs and devices based upon standardized procedures developed by the NP, supervising MD, and facility administrator.<br>Furnishing Schedule II-V controlled substances requires that the NP must possess a DEA number and use standardized procedures. Furnishing of Schedule II and III controlled substances must be according to a patient-specific protocol approved by a supervising physician. Furnishing numbers are | Only an APRN granted prescriptive authority by the board shall be able to practice as an APRN with prescriptive authority. **[HAR §16-89-117]**<br>APRN shall be considered qualified if they met the requirements of **HRS §457-8.5(a)**, and have met the advanced pharmacology requirements for initial prescriptive authority pursuant to rules of the board. Only qualified APRN authorized to diagnose, prescribe, and institute therapy or referrals of patient to health care agencies, health care providers, and community resources, and only as | APPN who applies for authorization to prescribe medications must have a current APPN Idaho license, provide evidence of completion of 30 hours of post-basic education in pharmacothera-peutics, and write prescriptions in compliance with applicable state and federal laws and signing the prescription with the abbreviation for the applicable category of advanced nursing practice, the identification number assigned by the Board and, where applicable, the Idaho controlled substance registration number and federal DEA registration. |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Nurse Practitioner Prescribing Medications** | of Nursing, and signature followed by the letters "ANP." **[12 AAC 44.440]**<br><br>In addition to the legend drug prescriptive and dispensing authority in 12 AAC 44.440, the Board with authorize an ANP to prescribe and dispense Schedule II-V controlled drugs if the ANP: submits a completed application that includes the ANP's name, address, phone number, ANP license number, date of birth, prescribing experience for 5* years immediately before the date of the application, notarized signature certifying that the information is correct. **[12 AAC 44.445(1) (A-E)]**<br><br>Verification of the equivalent of one year of experience prescribing legend drugs within the 5 years immediately preceding the date of the application does not apply to an applicant who is authorized to practice as an adult or family psychiatric mental health nurse practitioner and pays the application fee established by 12 AAC 02.280. **[12 AAC 44.445 (2)-(3)]**<br><br>For dispensing standards, see **12 AAC 44.447**.<br><br>* *According to the Board of Nursing, the 5 year requirement applies to NPs with prescribing experience outside of the state of Alaska. (5/21/12)* | issued to those BRN-certified NPs who have completed at least 6 months of physician supervised experience and a pharmacy course that covers the drugs and devices to be furnished. **[B&P Code §2836.1(a)-(i)]**<br><br>✓ Physician supervision includes: (a) collaboration on the development of a standardized procedure or protocol; (b) approval of the procedure or protocol. The MD is not required to be physically present, but must be telephonically available at the time of the patient examination by the NP. **[B&P Code §2836.1(d)]**<br><br>✓ For the purposes of this section, MDs may supervise no more than four NPs at one time. **[B&P Code §2836.1(e)]** | appropriate, to the practice specialty in which the APRN is qualified, may: (1) prescribe and administer over the counter, legend and controlled drugs…, and request receive, and dispense manufacturers' prepackaged samples of over the counter and non-controlled legend drugs to patients under their care. The APRN shall not request, receive, or sign for professional controlled substance samples; (2) prescribe, order and dispense medical devices and equipment; and (3) plan and initiate a therapeutic regimen. **[HRS §457-8.6(d)(1)-(3)]**<br><br>**Eligibility requirements include:** In addition to qualifications as an APRN, the applicant must provide proof of successful completion of at least 30 contact hours, as part of the Master's Degree program, of advanced pharmacology education, included advanced pharmacotherapeutics integrated into the curriculum within a 3-year time period immediately preceding the date of application.<br><br>If completed more than the 3-year time period, the APRN must provide evidence of at least 30 contact hours of advanced pharmacology and pharmaco-therapeutics from an accredited, board recognized college or university of at least 30 contact hours of continuing education (CE). Also evidence of CE in controlled substances, current state oral code number, current DEA number to prescribe controlled substances, current HI Narcotics Enforcement Division registration number and paid fee. **[HAR §16-89-119(a)(1)-(10)]** | **[IDAPA 23.01.01, Subsection 315.01(a)-(d).]**<br><br>Properly licensed APPN may prescribe, deliver, distribute and dispense pharmacologic and non-pharmacologic agents to a client in compliance with Board rules and applicable federal and state law. Pharmacologic agents include legend and Schedule II-V controlled substances. **[IDAPA 23.01.01, Subsection 271.13]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Nurse Practitioner Prescribing Medications** | | | If the APRN is applying to prescribe controlled substances, the applicant must submit proof of a collaborative agreement with a licensed physician practicing medicine or surgery in HI in the same or related specialty area as the APRN. **[HAR §16-89-119(a)(11)]**<br><br>**See HAR §16-89-121(a)-(h) re: the collaborative agreement.** An APRN who intends to prescribe controlled substances shall have a collaborative agreement with at least one licensed MD and the agreement shall be filed with and approved by the Board.<br><br>**See HAR §16-89-122 re: the exclusionary formulary for prescriptive authority.** | |
| **Certified Nurse Midwife Qualification** | Under AK's nursing regulations, CNMs are Advanced Nurse Practitioners. See Nurse Practitioner description above.<br><br>Alaska has a well-defined Certified Direct-Entry Midwife program. **AS 08.65 and 12 AAC 14** are the defining statutes and regulations. Direct-Entry Midwives are not nurses. | Licensed RN; graduate of a BRN-approved program in nurse-midwifery or meet equivalency requirements. **(CCR Title 16, Div.14, Art. 6, §1460)** | See APRN description above.<br><br>**Scope of practice for CNM is outlined in HAR §16-89-81 (c)(3)(A)-(C).** | Licensed professional RN who has graduated from a nationally accredited nurse-midwifery program and passed a qualifying exam and is currently certified as a nurse mid-wife by a national organization recognized by the board. **[IDAPA 23.01.01, Subsection 271.05]**<br><br>In addition to the core standards for APPN, certified nurse-midwives shall practice in accord with standards established by the American College of Nurse Midwives Certifying Council or the American College of Nurse Midwives. Certified nurse midwives who meet qualifying requirements and are licensed by the Board, may manage women's health care focusing on pregnancy, childbirth, the postpartum period, care of the newborn, reproductive and gyn needs of well women. **[IDAPA 23.01.01, Subsection 280.03]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Certified Nurse Midwife** | No MD supervision or collaboration is required. According to the AK Board of Nursing, "consultation and referral are expected." | ✓ Nurse-midwives (NMW) practice under the supervision of a physician and provide care during normal prenatal, intrapartum, and postnatal and immediate care of the infant. NMWs must be able to obtain MD assistance and consultation when indicated. Complicated cases must be referred to a physician immediately. A NMW cannot utilize artificial, forcible or mechanical means while assisting at childbirth. **[B&P Code §2746.5(a)(b)]**<br>✓ Physician supervision includes: (a) collaboration on the development of a standardized procedure or protocol; (b) approval of the procedure or protocol. The MD is not required to be physically present, but must be telephonically available at the time of the patient examination by the NMW. **[B&P Code §2746.5(c) and §2746.51(a)(4)(A)-(C)]**<br>✓ A physician or surgeon may not supervise any more than four (4) NMWs at any given time. **[B&P §2746.51(a)(4)]**<br>✓ NMWs can perform and repair episiotomies as well as first and second-degree lacerations of the perineum in a licensed acute care hospital and licensed alternate birth center **ONLY,** if all conditions defined in **B&P Code §2746.52** are met. | See APRN description above. | See APPN description above. |
| **Certified Nurse Midwife Prescribing Medications** | See AK Nurse Practitioner prescribing medications requirements described above. | NMWs with a BRN-issued furnishing number can furnish drugs or devices based on a standardized procedure developed and approved by the supervising MD, NMW and facility administrator if they are incidental to provision of family planning services, routine health or | See APRN description above. | See APPN description above.<br>Nurse midwives may prescribe and dispense pharmacologic and non-pharmacologic agents. **[IDAPA 23.01.01, Subsection 280.03]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **Certified Nurse Midwife Prescribing Medications** | | perinatal care, and care rendered consistent with the NMW's educational qualifications in an acute care hospital, clinic, physician's office, student health clinic, and birth center. NMWs may furnish Schedule II-V controlled substances according to standardized procedures. Furnishing Schedule II or III controlled substances also requires a DEA number and patient-specific protocol approved by a supervising MD. **(B&P Code §2746.51)** | | |
| **Certified Registered Nurse Anesthetist Qualifications** | A Registered Nurse Anesthetist (RNA) is a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to select and administer anesthetic and give anesthesia care under regulations adopted by the board. **[AS 08.68.850 (7)]** | A person who is a BRN-licensed RN with certification and re-certification by the Council on Certification of Nurse Anesthetists, and BRN certification as a Nurse Anesthetist. **[B&P Code §2826(a)]** | See APRN description above.<br>**Scope of practice for CRNA is outlined in HAR §16-89-81 (c)(2)(A)-(L).** | Licensed RN who graduated from a nationally accredited nurse anesthesia program, passed a qualifying exam recognized by the Board and has current initial certification or current recertification as a nurse anesthetist from a national organization recognized by the Board. [**IDAPA 21.01.01**, **Subsection 271.15]**<br>In addition to the core standards, APPNs in the category of registered nurse anesthetist (RNA) shall practice in accord with standards established by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. [**IDAPA 23.01.01, Subsection 280.06]** |
| **MD Supervision of Certified Registered Nurse Anesthetist** | A Registered Nurse Anesthetist in AK is authorized with the scope of his or her educational preparation to perform procedures outlined by the *American Association Nurse Anesthetist Guidelines for the Practice of Certified Registered Nurse Anesthetist.* The RNA is authorized to administer anesthesia (1) in collaboration with the director of the anesthesia service or a qualified designee of the director; or (2) in collaboration with the primary | **B&P Code §§2725 and 2827** provide for a CRNA to administer general and regional anesthetics according to the order of a physician, dentist or podiatrist.<br>**OF NOTE:** In 2009 former Governor Arnold Schwarzenegger decided to exempt California from federal rules requiring physician supervision of nurse anesthetists in Medicare participating hospitals. The California Medical Association (CMA) and the California Society | A physician must oversee anesthesia at a departmental level in hospitals and supervise or direct each service in an ambulatory surgical center. **(Source: ASA "The Scope of Practice of Nurse Anesthetists, 2004")** The level of supervision or method for implementation varies depending on the facility in which anesthesia is administered.<br>Nothing in this chapter shall require a CNA to have prescriptive | In collaboration with an MD, dentist, or podiatrist, an RNA may provide anesthesia care services in¬cluding selecting, ordering and ad¬min¬istering medi¬cations as defined by standards approved by the Board. The scope of practice for authorized RNAs may include the prescribing and dispensing of pharmacologic agents. **[IDAPA 23.01.01, Subsection 280.06]** |

| NPC[5] | Alaska | California | Hawaii | Idaho |
|---|---|---|---|---|
| **MD Supervision of Certified Registered Nurse Anesthetist** | physician or qualified physician designee of the primary physician or of the dentist responsible for the patient's immediate care.<br><br>"Collaboration" is defined as a process which involves two or more parties working together, each contributing his or her respective area of expertise to provide more comprehensive care than one alone can offer. **[12 AAC 44.510(a)-(c)]**<br><br>The board will, in its discretion, authorize a RNA to prescribe legend drugs and Schedule II-V controlled substances in accordance with applicable state and federal laws. **[12 AAC 44.525 (a)]** | of Anesthesiologists (CSA) filed a lawsuit challenging Schwarzenegger's decision because they believed it is inconsistent with California law, which requires that a physician always needs to retain responsibility and control over the medical care of his or her patient. On October 8, 2010, San Francisco County Superior Court Judge Peter Busch ruled that there is no state statute that mandates physician supervision of nurses administering anesthesia. The CMA and CSA appealed the judge's ruling. On March 15, 2012, the First District Court of Appeal in San Francisco upheld the lower court's decision.<br><br>According to the CMA, "Despite the recent court ruling and Schwarzenegger's opt-out decision, hospitals in California still have the authority to require physician supervision of nurse anesthetists at their facilities. Furthermore, medical staffs at hospitals may also be able to implement a supervision requirement within the scope of their self-governance rights over the professional work in a hospital." | authority in order to provide anesthesia care. **[HAR §16-89-119 (e)]** | |