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***Special Report***

**MIEC Claims Alert**

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# The use of nonphysician clinicians in a medical practice


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*Physicians work with nonphysician clinicians in a variety of medical settings. Variously called "physician extenders," "midlevel practitioners," or "allied health professionals," nonphysician clinicians (NPCs) 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 mid-wives (CNMs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). As acceptance of nonphysician clinicians increases among managed care organizations 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.*

## NPCs' 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 55,000 PAs now practice in the United States[1]; 41% work in primary care practices, and 25% are employed in surgery practices. Twenty-two percent (22%) of PAs provide services in a hospital setting, 43% work in single or multi-specialty group practices, 14% work in solo practice offices, and about 10% work in rural or inner city health clinics. 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 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, Division of Nursing, reported in 2000 that there were over 2.7 million registered nurses in the United States, of which 196,279 (7.3%) were advanced practice nurses.[3] The Health Resources and Services Administration Sample Survey reported 102,829 nurse practitioners in the United States in the year 2000, an increase of more than 44% over 1996 data. By 2004, there were an estimated 115,000 nurse practitioners in California alone (American College of Nurse Practitioners).

## Managed care demands high quality for low cost

Managed care organizations (MCOs) encourage the use of NPCs to provide primary care, in part to reduce costs. Current literature suggests that the managerial role of physicians will expand as NPCs become permanent members of the health care team. In his article, "The Industrialization of Health Care," J.D. Kleinke argues that the industrialization of any business involves the compulsion to push production to the lowest possible cost by replacing, whenever possible, labor with technology and by increasing the division and specialization of labor. "Each of these replacements is applicable to the industrialization of health care and each has major ramifications for the future of the medical professions." [4] Kleinke says the increased use of PAs and APNs will significantly impact the future roles and training needs of physicians: "The existence of an increasing number of PAs and APNs, whose role is designed to leverage a physician's talent, time, and resources, will necessitate a shifting of the primary role of physician from pure clinician to manager of a hierarchy of clinicians. Physicians will be spending less time with less complex cases and devoting a greater share of direct clinical time to those cases that PAs and APNs need to refer up the hierarchy . . . a successful general practitioner will be a manager of a large number of PAs and APNs; a successful obstetrician is a manager of high-risk pregnancies and an effective deployer of nurse midwives; a successful anesthesiologist is a manager of a group of certified registered nurse anesthetists (CRNAs)."

## Nonphysician clinicians seek more autonomy

The scope of nonphysician clinicians'' services continues to be debated by medical and nursing organizations. Some nurse practitioner groups claim NPCs can safely perform 60% or more of the nonsurgical tasks physicians now manage. In 1997, Certified Nurse Midwives attended the birth of 14.12% of the babies born in Alaska that year (American College of Nurse Midwives).

Certified registered nurse anesthetists administer anesthesia to about 65% of the 26 million patients who are anesthetized in the United States every year (Hawaii Association of Nurse Anesthetists).

In some states, NPCs are seeking expanded prescriptive authority, hospital admitting privileges, expanded scope of treatment, reimbursement from insurance companies or public payers, and less physician supervision. However, in the past five years supervision requirements for many NPCs have become more stringent. APNs currently have independent prescriptive authority for legend drugs and controlled substances in 10 states, down from 21 states in 1999.[5] Several states permit APNs only to "furnish" drugs physicians have pre-selected from a formulary that specifies when each drug can be dispensed, or to "dispense" drugs that have been pre-packaged for specific purposes.

According to the American College of Nurse Practitioners, NPs can now practice independently in 20 states (including Alaska, Hawaii, and Idaho) and the District of Columbia, five fewer states than in 1999. Twenty-four (24) states, including California, require formalized physician involvement that must be documented in writing, and six states require physician involvement, but not a documented relationship. "Physician involvement" can mean collaboration, supervision, authorization, and/or delegation to direction of activities (ibid).

The Balanced Budget Act of 1997, effective January 1, 1998, allows nurse practitioners and clinical nurse specialists working in collaboration with physicians to obtain direct Medicare reimbursement for patient care in both rural and urban settings; however, many NPs in private practice have difficulty being accepted as primary care providers on private insurance panels. Although NPs in independent

practice earn significantly more than their employed colleagues (an average of $94,313 annually), only 1% of survey respondents own their own practice, the same number as in 2001.[6]

Federal regulations for accreditation of hospital facilities under the Medicare and Medicaid programs require that a nurse anesthetist be under the supervision of the operating practitioner or an anesthesiologist who is immediately available if needed (42 C.F.R. 482.52). A similar requirement is contained in the regulations relating to ambulatory surgical centers (ASCs) (42 C.F.R. 416.42) and critical access hospitals (CAHs) (42 C.F.R. 485.639). The requirement was reinforced on November 13, 2001, when CMS issued a regulation maintaining the requirement of physician supervision of nurse anesthetists in Medicare-approved hospitals, ASCs and CAHs. However, the regulation provides governors with an opportunity to "opt out" of the federal supervision requirement, *to the extent consistent with state law*, if the governor determines it to be in the best interest of the state. Gubernatorial action has no impact on hospital and ASC bylaws requiring physician participation in anesthesia care. To date, 14 states, including Alaska and Idaho, have filed "opt out" letters with CMS.

Although liability insurers believe physician supervision of NPCs is an essential safeguard, NPCs claim less supervision is not a hazard. They note that in some communities, PAs, NPs and nurse anesthetists are "supervised" only nominally by a physician, if at all. Some states, such as California, do not require a supervising physician to be physically present, but to be telephonically or electronically available when a supervised NPC calls. NPCs say minimal "supervision" is widespread, and supports their claim that reduced physician oversight does not adversely affect the NPCs' quality of care. MIEC is appreciative of the high quality of care provided by NPCs. However, insofar as any supervisory or collaborative relationship exists between a physician and an NPC, it is to the physician's advantage to provide adequate supervision in close, collaborative relationships with NPCs.

## NPCs have low claims history

Data about the frequency and severity of NP and PA claims is not readily attainable. The Physician Insurers Association of American (PIAA)'s Data Sharing Project reports a low number of claims involving nonphysician clinicians. Between January 1985 and December 31, 2003, the PIAA collected and reviewed 186,281 claims in which 150,982 "associated personnel occurrences" were reported. Claims involving advanced practice nurses, and physician assistants account for 3,615 (2.4%) 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 negligence; 116,639 associated issues were reported. Physicians' vicarious liability (liability for the actions of employees) accounted for 4,841 (4.2%) 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.

## 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 are 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:** The 2005 American Academy of Physician Assistants (AAPA) Census Report shows that 80% of the 22,502 respondents reported receiving their base pay in the form of a salary. The mean annual salary by state of full-time PAs who are not self-employed is: $90,276 (Alaska); $90,447 (California); $80,091 (Hawaii); and $78,049 (Idaho).

  According to the 2003 National Salary Survey of Nurse Practitioners, the average overall salary for nurse practitioners increased from $52,532 in 1997 to $69,203 in 2003, with the Western and Pacific regions experiencing the highest salaries. The reported average earnings by state include: $77,273 (Alaska); $76,710 (California); $66,658 (Hawaii); and $66,483 (Idaho).

  Although earnings continue to rise, hiring NPCs may be a prudent way to supplement patient care without unduly increasing overhead expenses. Some NPCs are paid through a straight salary arrangement, particularly if there is a finite set of patients available to the practice. Others receive a base salary with bonuses linked to productivity benchmarks. Such bonus incentives can encourage NPCs to pay attention to accurate coding and likely foster a more positive reaction to situations such as patients coming in five minutes before the office closes. Experts recommend that incentives be based on realistic and attainable goals to maximize their motivational impetus. It is also suggested that incentive arrangements include a quality assurance program in which NPC records are monitored to ensure that quality doesn't suffer as a result of the incentives and that unnecessary tests aren't being ordered to meet a financial benchmark. A practice management consultant can help determine which payment option makes the most sense.[7]

- **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." [8]

- **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 condition 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.


- **lower overhead:** The 2005 American Academy of Physician Assistants (AAPA) Census Report shows that 80% of the 22,502 respondents reported receiving their base pay in the form of a salary. The mean annual salary by state of full-time PAs who are not self-employed is: $90,276 (Alaska); $90,447 (California); $80,091 (Hawaii); and $78,049 (Idaho).


## Preventing NPC Liabilities

The leading reasons NPCs are involved in litigation are that 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. Review "MIEC Recommendations for Working with Nonphysician Clinicians" on the following page for additional guidance.

## MIEC's Recommendations for Working with Nonphysician Clinicians

- Check an applicant's credentials carefully before hiring; verify an NPC's credentials and prior experience as thoroughly as you would a physician's;
- 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 [For more information about defensible record-keeping, see MIEC's handbook, **"Medical Documentation for Patient Safety and Physician Defensibility"**];
- Ask patients for comments about their satisfaction with treatment by an NPC;
- Inform MIEC if you employ an NPC; 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; and
- 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.

## How to reach MIEC

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## State-specific regulations for NPC's[9]

| NPC's[9] | ALASKA | CALIFORNIA | HAWAII | IDAHO |
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| **Physician Assistant Qualifications** | Graduate accredited PA program; current NCCPA certificate | Graduate California-approved PA program; current NCCPA certificate | Graduate accredited PA program; current NCCPA certificate; current NCCPA certificate required for biennial renewal. | Graduate accredited PA program; bachelor's degree; NCCPA exam. |
| **MD Supervision of Physician Assistant** | Periodic direct, personal contact and at least monthly telephone or radio review of patient care and records. PAs in locations 30 or more miles from MD's primary office, and who have less than two years of experience must work 160 hours under MD's direct and immediate supervision, with the first 40 hours being completed before the PA begins the remote practice, and the remaining 120 hours being completed within 90 days of starting the remote practice. Periodic assessment must include at least one direct personal visit from the supervising physician per quarter for at least four hours. | MD must be available in person or electronically at all times PA is caring for patients. Written guidelines for supervision must include one or more: same-day exam of patient by MD; co-sign and date all medical records within 30 days; or co-sign and date within 30 days at least 10% of records of patients treated according to written protocols.<br><br>**Generally, an MD cannot supervise more than two PAs at a time. MDs in designated undeserved areas may supervise up to four PAs at a time.** | Physical presence of MD or availability of MD by telecommunication. MD must review PA's records within seven working days. | Supervising MD must conduct onsite visit at least monthly to personally observe the quality of care provided. Must be available by phone or in person; hold regularly scheduled conferences; review sampling of charts.<br><br>**Supervising physicians must register with Idaho's Board of Medicine and generally may supervise no more than three PAs at a time.** The Board may authorize a physician to supervise a total of six PAs contemporaneously if necessary to provide adequate medical care and upon prior petition documenting adequate safeguards to protect the public health and safety. |
| **Physician Assistant Prescribing** | Prescriptive authority for non-controlled sub-stances and Schedule III-V | PA may administer or furnish meds to patients based upon protocol or | PAs have prescriptive authority for all legend and Schedule III-V | A PA may apply to the Idaho Board of Medicine for approval to prescribe Schedule II-V and non- |

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| | drugs with physician authorization stated in the PA's current collator-ration plan. Prescription 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 drugs with the specific approval of the collator-rating physician. | upon patient-specific order. Prescriptions for controlled substances may not be transmitted without patient-specific order from MD. Drug order must have printed name, address, and phone number of physician, and printed or stamped name, license # and DEA # of PA. Medical records containing prescription must be cosigned and dated by supervising MD within seven days for Schedule II drugs only. | drugs delegated by a supervising MD.<br><br>Drug orders for controlled substances must have the DEA number of the PA and MD. PAs employed or extended privileges by a hospital or extended care facility may write orders for drugs as allowed by facility policy. | controlled substances. The application must include documentation that he/she has completed a pharmacology course (at least 30 hours). PA must register with DEA and Idaho Board of Pharmacy. |
| **Nurse Practitioner Qualifications** | Advanced Nurse Practitioner 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 §8, 68.410(1)] | Licensed RN with additional skills and education, which includes completion of a BRN-approved program or equivalency. [B&P Code §1480(a)]<br><br>Beginning January 1, 2008, NPs must also have a master's degree in nursing or a clinical field related to nursing or a graduate degree in nursing. | Generally defined in HI as an "Advanced Practice Registered Nurse (APRN):" Licensed RN with a master's degree in nursing or a current certificate for specialized and advanced nurse practice from a national certifying body. | 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. |
| **MD** | There are no | NPs certified by | APRNs with | APPN's scope of |

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| **Supervision of Nurse Practitioner** | requirements for MD collaboration or supervision. | the Board of Registered Nursing use standardized procedures when performing medical functions. These are developed 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>MDs may supervise no more than four NPs who furnish drugs (There is no limit to how many NPs an MD may supervise when the NPs do not furnish drugs.) (B&P Code §2836.1) | prescriptive authority for non-controlled substances must develop a collegial working relationship with a physician based upon a written policy that is filed with the Department of Commerce and Consumer Affairs. (HAR §16-89C)<br><br>PENDING: If ratified, proposed law would permit APRNs to have prescriptive authority of **controlled substances** as well, with more specific requirements for the supervising physician, who would be available physically or through other means to communicate with the APRN, and must review within seven days the records of each patient seen by the APRN. A physician may supervise no more than two APRNs at any one time. | 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 commencing at 280.02 (a) and (b)]. |
| **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 | NPs certified by the Board of Registered Nursing (BRN), and who possess a BRN-issued furnishing number can furnish or order drugs and devices. Furnishing Schedule II-V | APRNs may prescribe non-controlled substances when in a collegial working relationship with a physician. APRNs may not prescribe drugs or pharmaceuticals excluded in their collegial relationship | APPN who applies for authorization to prescribe medications must complete 30 hours of post-basic education in pharmacotherapeutics, complete an application, and pay a $50 fee. Prescriptions by an APPN must be signed by the prescriber with the |

| | 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 of Nursing, and signature followed by the letters "ANP". For Sch. II-V controlled drugs, ANP must apply and verify the equivalent of one year prescribing legend drugs within the five years immediately before his/her application is submitted. | controlled substances requires possessing a DEA number and using standardized procedures. Furnishing of Schedule II and III controlled substances must be according to a patient-specific protocol determined by a supervising physician. Furnishing numbers are 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) | agreement filed with the Department of Commerce and Consumer Affairs.<br><br>PENDING: The HI Board of Medical Examiners has amended the APRN exclusionary formulary to allow APRNs to prescribe **controlled substances** under physician **supervision** (see physician supervision above). However, the final rules have not been ratified at the time of this publication; therefore, APRNs may not at this time prescribe controlled substances.<br><br>The amended Exclusionary Formulary, if ratified, provides that APRNs may not prescribe: general anesthetics; investigational drugs; narcotics and sedatives for treatment of chronic pain and fatigue; stimulants and hormones for treatment of obesity; human growth hormones, anabolic steroids or hormones for performance enhancement or decreasing the impact of aging; and all other drugs or pharmaceuticals excluded in the supervisory relationship | 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 number. (IDAPA 23.01.01 commencing at 280) |
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| | | | agreement. | |
| **Certified Nurse Midwife Qualification** | Under AK's nursing regulations, CNMs are Advanced Nurse Practitioners. To become certified, the nurse-midwife must complete a course of study in an accredited educational program and pass an examination administered by the American College of Nurse Midwives. State requirements for nurse-midwifery must also be met. | 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.** | 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 midwife by a national organization recognized by the board. |
| **MD Supervision of Certified Nurse Midwife** | No MD supervision. To be in compliance with national standards, a CNM must have written practice guidelines that include the parameters for the service/practice of nurse-midwifery management, and MD management, consultation and referral. In urban areas, CNMs must have a physician sponsor in order to be given hospital privileges. | Nurse-midwives practice under the supervision of a physician and provide care during normal prenatal, intrapartum, and postnatal and immediate care of the infant. [B&P Code §2746.5(a)] NMWs must be able to obtain MD assistance and consultation when indicated. NMWs can perform episiotomies (B&P Code §2746.52), but can not utilize artificial, forcible or mechanical means while assisting at childbirth. [B&P Code §2746.5(b)] NMWs must refer all complications to a physician immediately. | **See APRN description above.** | **See APPN description above.** |

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| **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 perinatal care, and care rendered to essentially healthy persons in certain facilities. CNMs may furnish Schedule II-V con-trolled substances according to standardized procedures. Furnishing Schedule II or III controlled substances also requires a DEA number and patient-specific protocol approved by treating or supervising MD. Schedule II controlled substances can be furnished only in an acute care general hospital. (B&P Code §2746.51) | **See APRN description above.** | **See APPN description above.**<br><br>Nurse midwives may prescribe and dispense pharmacologic and non-pharmacologic agents. |
| **Certified Registered Nurse Anesthetist Qualifications** | Licensed RN who graduated from nation-ally accredited nurse anesthesia | A person who is a BRN-licensed RN with certification and re-certification | Licensed RN with a Master's Degree in anesthesia, or certified by a nationally | Licensed RN who graduated from, passed a qualifying exam administered by, and is currently |

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| | program and passed a qualifying exam administered by a nation-ally recognized certifying agency for nurse anesthetists. [Professional Regulations, Board of Nursing, Ch.44, art.5, §12 AAC 44.500(2)] | by the Council on Certification of Nurse Anesthetists, and BRN certification as a Nurse Anesthetist. [B&P Code §2826(a)] | accredited CRNA program. [HRS 457, §457-8.5(3)] and HAR §16-89-83(3)] | certified by a nationally accredited nurse anesthesia program recognized by the Idaho Board of Nursing. [Idaho Statutes, Title 54, Chap. 14, §54-1402(1)(d) and IDAPA 23.01.01, §271.14] |
| **MD Supervision of Certified Registered Nurse Anesthetist** | A registered nurse anesthetist (RNA) must submit to the AK Board of Nursing written practice guidelines that include the location of practice; name of collaborating anesthesiologist, MD or dentist; and a communication, post-anesthesia transfer, and QA plan. RNA may prescribe legend drugs and Sch. II-V controlled substances. | 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. In the hospital setting, CRNAs must be supervised by a physician (not necessarily an anesthesiologist). This may occur at a departmental level, and the hospital may define or narrow a CRNA's scope of practice. (Source: ASA) | 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 level of supervision or method for implementation varies depending on the facility in which anesthesia is administered. | In collaboration with an MD, dentist, or podiatrist, an RNA may provide anesthesia care services as defined by the rules of the Board, including selecting, ordering and administering medications appropriate for rendering anesthesia care services. (Source: ASA) |

## Endnotes:

1. Data as of January 2005. American Academy of Physician Assistants, Alexandria, VA.

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

3. Data as of March 2000. US Department of Health and Human Services, Division of Nursing.

4. CJ.D. Kleinke, "The Industrialization of Health Care," from Pulse in *the Journal of the American Medical Association*, November 5, 1997, pp. 1456-1457.

5. The Pearson Report: A National Overview of Nurse Practitioner Legislation and Healthcare Issues, Linda J. Pearson, The American Journal for Nurse Practitioners, Vol. 9 No. 1, January 2005.

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6. 2003 National Salary Survey of Nurse Practitioners, Advance News Magazines for Nurse Practitioners.

7. American Medical News, Volume 48, Number 40, “Extenders Can Get Paid in Different Ways,” by Mike Norbut.

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

9. Information provided in the grid was obtained from the Boards of Medicine and Boards of Nursing in Alaska, California, Hawaii, Idaho and Nevada. 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.

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