

# 2014 PEARSON REPORT

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# Components of the 2014 Pearson Report

## Report Outline

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The 2014 Pearson Report contains a state-by-state comprehensive presentation of 67 separate specifics of NP legislation, licensing, scope of practice, prescribing details, reimbursement realities and limitations, and other factors related to NP practice for each of the 51 states (including Washington, DC). It is organized into four sections: (1) General Overview, (2) NP Scope of Practice—Diagnosing and Treating, (3) NP Scope of Practice—Prescribing, and (4) Other Factors Related to NP Practice.

## References

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References within the section “Other Factors Related to NP Practice” include the following:

- **2007 consumer choice ranking of state’s NP regulation:** Reports a groundbreaking study that ranked the regulatory environment for NP practice and consumer healthcare choice for each state by evaluating NPs’ legal capacity, patient access to NP services, and patient access to NP prescriptions. [Source: Lugo, N. R., O’Grady, E. T., Hodnicki, D. R., & Hanson, C. M. (2007, April.) Ranking state NP regulation: Practice environment and consumer healthcare choice. *The American Journal for Nurse Practitioners*, (11)4.] The 2014 Pearson Report has subjectively reranked those states that have (through legislation, regulations, and rules) created more autonomy for NPs since the 2007 ranking.
- **Relevant medical malpractice law applicable to NPs:** This data box presents a state-by-state summary of the highlights of medical malpractice law most relevant to NP practice. [Sources: Input from nurse colleagues; McCullough, Campbell, & Lane, Attorneys at Law. (n.d.). *Summary of medical malpractice law*. Retrieved from <http://www.mcandl.com/states.html>]
- **Recent state malpractice liability tort reform:** This data box presents a summary of each state’s civil justice reforms that are most applicable to NP practice. Information for this cell was provided by NPs within each state. Additionally, data was verified on the ATRA website (American Tort Reform Association; <http://www.atra.org>).

## Maps

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Two maps clearly delineate the following:

- (1) **National Overview of Diagnosing and Treating Aspects of NP Practice:** Provides an overview of diagnosing and treating aspects of NP practice (excluding prescribing), including a summarization of which states have NO requirement for any physician involvement in NP diagnosing and treating (excluding prescribing) practice.
- (2) **National Overview of Prescribing Aspects of NP Practice:** Provides an overview of prescribing aspects of NP practice, including a summarization of which states have NO requirement for any physician involvement in NP prescribing practice.

## NPDB/HIPDB Ratios and Tables

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These compare the ratios of the number of NPs, DOs, and MDs (within each state) to the number of reported filings (for the respective state) from the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). The NPDB reports are composed of the total accumulated malpractice and adverse action filings; the HIPDB reports are composed of total accumulated adverse action reports, including licensure actions and any other negative actions, findings, or adjudicated actions, and civil judgments or criminal conviction reports.

- **The National Practitioner Data Bank (NPDB):** The total accumulated malpractice and adverse actions including medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare and Medicaid exclusion reports compares the filing totals (from 9/1/1990 to 3/30/2013). National legislation related to the Health Care Quality Improvement Act (1986) created the NPDB; it was enacted to help improve the quality of medical care. The NPDB's goal is to encourage state licensing boards, hospitals and other healthcare entities, and professional societies to identify and discipline providers who engage in unprofessional behavior, and to restrict the ability of healthcare providers to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history.

*[Source of this year's data: Research Branch of the Division of Practitioner Data Banks, from the Bureau of Health Professions within the Health Resources and Services Administration/ Department of Health and Human Services.]*

- **The Healthcare Integrity and Protection Data Bank (HIPDB):** Composed of accumulated adverse action reports, including licensure actions and any other negative actions, findings, or adjudicated actions, and civil judgments or criminal conviction reports submitted (from 1/1999 to 3/2013). The Health Insurance Portability and Accountability Act of 1996 created the HIPDB to combat fraud and abuse in health insurance

and healthcare delivery and to promote quality care. The HIPDB is primarily a flagging system whose goal is to alert users to certain final adverse actions taken against healthcare providers, suppliers, and practitioners. [Source of this year's data: Research Branch of the Division of Practitioner Data Banks, from the Bureau of Health Professions within the Health Resources and Services Administration/ Department of Health and Human Services.]

- The number of providers was calculated based upon: (1) the number of NPs reported from every state's BON (as of May 2013) for this 2014 Pearson Report; (2) the number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license to practice medicine. [Source: Federation of State Medical Boards. (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.]
- **Readers note:** When looking at the number of cumulative HIPDB and NPDB reports, it should be recognized that there are multiple factors about the reporting process that may distort the accumulated total numbers for various providers. For example, in some states the National Council of State Boards of Nursing is the agent for HIPDB reporting; they only report twice per year, as opposed to other boards who report within 30 days. Two ProPublica articles critiqued the reporting processes for practitioner databases and they bring up points that are worth considering when looking at the ratios provided. [Source: Ornstein, C., & Weber, T. (2010, March 1). Feds reassign heads of trouble caregivers database. Retrieved from <http://www.propublica.org/feature/feds-reassign-heads-of-troubled-caregivers-database>.] Nonetheless, this author believes that when taken in total, and comparing gross ratio statistics, it is remarkable that NPs consistently have significantly better safety ratios than DOs and MDs across virtually all states year after year.

## 2014 Summary Table: "2014 Pearson Report Summary"

A full summary for each state is presented, all within this one table (including the 2014 updated rank for patient access; whether a doctorate NP may be addressed as "Doctor"; the NP titles used; whether there is any physician-required involvement in diagnosing, treating, or prescribing; the number of NP programs; and the summary of any NP role expansion during the last 2 years of legislative sessions). This table also provides a summary of the number of NPs reported for every state, plus a national total number of NPs.



## THE PEARSON REPORT

**STATE:** ALABAMA

**NP title(s) used in this state:** CRNP (Certified Registered Nurse Practitioner)

**Number of NPs in state:** 2267

**NP specialties legislatively specified?** No.

**How is NP specialty Scope of Practice (SOP) defined by national certification, R&R, state legislation, or other?** The CRNP shall practice in accordance with national standards and functions identified by the appropriate specialty certifying agency as recognized by the BON.

**NP title protection?** Yes. Only RNs who have been issued a certificate of qualification by the BON and who have current approval for collaborative practice from the BON and the BOME may use the title CRNP.

**National certification required for recognition/practice?** Yes. CRNP applicants must have a current certification granted by a national certifying agency recognized by the BON in the clinical specialty that is consistent with educational preparation and appropriate to the area of practice. The BON requires primary source verification from the certifying agency in writing or by electronic communication prior to the expiration date, or NP approval lapses.

**BON sole state authority over NPs?** No. The BON has sole authority to recognize CRNP qualifications, but a joint committee (composed of BOME and BON representatives) regulates practice and grant collaborative approval; the Alabama BME is responsible for authorizing NPs for a Qualified Alabama Controlled Substances Registration Certificate (QACSC).

**MSN required for practice?** Yes. A master's degree or higher degree in advanced practice nursing from an accredited program recognized by the Board is required. Those with degrees obtained prior to 1996 may qualify for exceptions.

**Requirement for APN member on BON?** Yes. Two RN positions are designated as APNs.

**Joint BON/BOM regulation over any aspect of practice?** Yes. Each board (BON and BOME) appoints three members to the Joint Committee, as specified by the statute. The Joint Committee has the authority to recommend to the BON and BOME rules and regulations governing the collaborative relationship between physicians and CRNPs, model practice protocols to be used by CRNPs, and a formulary of legend drugs that CRNPs may prescribe. The Joint Committee approves collaborative practice and specialty requests for increased scope of practice/procedures. In July 2013, the Alabama BOME offered the first CE that is required before applying for the QACSC.

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**Physician involvement required for any aspect of practice?** Yes. The BOM assesses the physician a \$100 fee annually for each NP they are engaged in collaborative practice with (in addition to an application process). BOME requirements for collaborative practice by physicians and CRNPs include: (1) a written standard protocol specific to the specialty practice area of the CRNP and the specialty practice area of the collaborating physician, approved and signed by both the collaborating physician and the CRNP; identifying all sites where the CRNP will practice within the collaboration protocol; identifies the physician's principal practice site; is maintained at each practice site; (2) a formulary of drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and implemented by the CRNP consistent with the rules and appropriate for the collaborative practice setting; (3) a predetermined plan for emergency services; (4) specification of the process by which the CRNP shall refer a patient to a physician other than the collaborating physician; and (5) a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the CRNP, which includes a review of no less than 10% of medical records plus all adverse outcomes. Documentation of the quality assurance review shall be readily retrievable, and identified records selected for review must include a summary of findings, conclusions, and, if indicated, recommendations for change. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and CRNP for review.

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**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Delegated authority with a requirement for collaborative practice agreement and protocol with an Alabama physician. Physician quality oversight is required for a minimum of 10% of chart audits/reviews. The Standard Formulary of legend drugs limits NPs to the following: "All written prescriptions must adhere to the standard, recommended doses of legend drugs, as identified in the Physicians' Desk Reference or the product information insert, not to exceed the recommended treatment regimen periods."

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**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. But in 2012 Ala. Code § 34-24-50 was amended to read "(3) To use, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions, the designation 'doctor,' 'doctor of medicine,' 'doctor of osteopathy,' 'physician,' 'surgeon,' 'physician and surgeon,' 'Dr.,' 'MD,' or any combination thereof unless such a designation additionally contains the description of another branch of the healing arts for which a person has a license."

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** A separate advanced practice approval card is issued for CRNPs, with an RN license number and four-digit prescribing number; the DEA number and the QACSC will be authorized under the BOME.

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**Supervised practice hours required before full NP practice autonomy?** N/A

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**Supervised practice hours required before full NP prescribing autonomy?** For legend drugs, no; for controlled substances, CRNPs will be required to have demonstrated safe practice for 12 months prior to application for a controlled substance certificate.

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**Additional pharmacology hours required for prescribing?** Yes. “Prescribing Controlled Drugs; Critical Issues and Common Pitfalls,” a continuing medical education (CME) course jointly sponsored by the BOME and the Medical Association of the State of Alabama (8 AMA PRA Category 1™ credits). Cost is \$375.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** CRNPs must have 6 contact hours of pharmacology specific to their area of prescriptive practice (e.g., Pediatric NP, Women’s Health NP, Acute Care NP) as part of the total 24 contact hours required for RN renewal. CE credits must be earned during the 2-year license period (1/1/2013–12/31/2014).

Proposed rules for the QACSC include requirements that the CRNP or CNM must: (1) Be a CRNP or CNM who is practicing in accordance with all BON and BOME rules governing collaboration between a qualified physician and a qualified CRNP or CNM and who is in a collaborative practice with a physician who holds a valid, current, and unrestricted ACSC; and (2) Submit proof of successful completion of 12 hours of AMA PRA Category 1 credits™ or the equivalent CME within 1 year of filing for a QACSC, and provide accurate and complete documentation of a minimum of 12 months of active clinical practice pursuant to one or more collaborative practice agreements approved by the BON and BOME. Temporary approval practice and provisional approval practice are not permitted.

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**BON mechanism for others to verify NP license?** Verify APN name and license number online with the BON, using the RN license number or name ([www.abn.alabama.gov/](http://www.abn.alabama.gov/)). The BON’s site also includes a subscription service for primary source verification of collaborative practice and status changes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. The 2012 Alabama Immigration Law requires currently licensed nurses to submit confirmation of citizenship or legal presence in the United States prior to license renewal; applicants for endorsement must submit documentation with the license application. The Physical Therapy Act was amended in 2012, allowing CRNPs to refer patients for physical therapy. In 2013, the Alabama Controlled Substance Act, Ala. Code § 20-2, was amended to permit CRNPs and CNMs to prescribe controlled substances in Schedules III, IV, and V within an approved collaborative practice with a physician who holds a current CSC certificate and DEA registration. The law designates the BOME as the certifying board for the registration and approval of a CRNP or CNM in obtaining or renewing a QACSC. Implementation in 2013 is subject to adoption of R&R by the BOME ([www.albme.org](http://www.albme.org)). The BON remains the sole licensing and disciplinary authority for CRNPs and CNMs.

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**Legislative/administrative plans for state?** CRNPs will monitor the pending R&R for QACSC under development by BOME ([www.albme.org](http://www.albme.org)) in 2013.

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**Internet address for Nurse Practice Act:** [www.abn.state.al.us/Content.aspx?id=116](http://www.abn.state.al.us/Content.aspx?id=116)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes. Physician-delegated authority as per the written protocol and the collaborative agreement.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** CRNPs are subject to collaborative practice agreements with an Alabama physician. The collaborating physician provides professional medical oversight and direction to the CRNP; is available for direct communication or by radio, telephone, or telecommunications; and is available for consultation or referrals of patients. If the CRNP performs duties at a site away from the collaborating physician, the written protocol must specify the circumstances and provide written verification of physician availability for consultation, referral, and direct medical intervention in emergencies and after hours, if indicated. The collaborating physician must be present in a practice site with the CRNP a minimum of 10% of the CRNP's collaboration time as specified in the protocol application (exceptions in licensed acute care hospitals, licensed skilled nursing facilities, and in the Department of Public Health). The physician shall not collaborate with or supervise any combination of CRNPs, CNMs, and/or assistants to physicians exceeding three full-time equivalent positions unless the CRNP is an employee of the Department of Public Health or an exemption is granted by the BON/BOME.

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**Required physician record/chart review?** Yes. Ten percent (10%) of medical records plus all adverse outcomes.

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**Required NP/physician practice agreement?** Yes. Detailed in BON collaborative practice application.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?**

Yes. The BON collaborative practice application form must also go through the Joint Committee.

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**If so, is agreement required to be kept/stored/updated?** A written standard protocol specific to the specialty practice area of the CRNP and the specialty practice area of the collaborating physician, approved and signed by both the collaborating physician and the CRNP, shall be maintained at each practice site. The collaborative agreement must be updated with the BON when changes occur.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes.

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**If so, are protocols required to be filed with the state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** Yes.

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**Any legislative prohibitions against NP hospital privileges?** No. CRNPs may write admission orders for inpatients as directed by the physician and may write subsequent orders in accordance with established protocols and institutional policies.

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**Additional limitations/clarifications/expansions to NP practice?** The Alabama Department of Public Health adopted regulations in 2009 to authorize the CRNP and CNM to order X-rays. Some healthcare organizations have bylaws requiring the signature of the collaborative physician on the NP order. The Alabama High School Athletic Association, based on input from their medical advisor, requires that a physician sign all student athlete physical forms (even though NPs are statutorily allowed to perform physical exams). There is no statutory requirement for physician counter-signature on inpatient orders; NPs may write “admission orders for inpatients as directed by the physician and subsequent orders in accordance with established protocols and institutional policies”. Ala. Code 32-6-231, “Motor Vehicles and Traffic,” requires physician certification on application for handicap parking placard/decal or license plate. The Physical Therapy Act was amended in 2012, allowing CRNPs to refer patients for physical therapy.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. For controlled substances.

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**NP/physician prescriptive agreement required?** Yes.

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**NP Rx from state authorized formulary required?** Yes.

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**If so, explain specifics of formulary.** CRNPs practicing under protocols may prescribe legend drugs that are included in the Standard Formulary recommended by the Joint Committee and adopted by the BON and the BOME. The drug type, dosage, quantity, and number of refills are authorized in an approved protocol signed by the collaborating physician and the CRNP. Written prescriptions must adhere to the standard recommended doses of legend drugs as identified in the *Physician's Desk Reference* or *Product Information Insert*, not to exceed the recommended treatment regimen periods.

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The written standard protocol must include a formulary of drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and implemented by the CRNP and that are appropriate for the collaborative practice setting.

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**NP authorized to Rx controlled substances?** Yes. As of July 2013 (pending R&R under development by BOME in 2013).

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**If so, what schedules?** Schedules III–V individually determined by request of the collaborating physician.

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Pending R&R under development by BOME in 2013 ([www.albme.org](http://www.albme.org)).

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**If so, what is DEA area field office info?:** To be determined.

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. The CRNP's name printed below or to the side of the physician's name along with the medical practice site address, the telephone number of the CRNP (if different from that of the collaborating physician), and the CRNP's RN license number, and identifying prescriptive authority number assigned by the BON.

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**Physician name required on Rx pad?** Yes. The name, medical practice site address, and telephone number of the collaborating physician or covering physician.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** BON regulations

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**Specified limitations or restrictions on NP drug sampling?** Yes. Only samples of drugs listed in approved formulary may be received and signed for. If the CRNP has DEA and QACSC they may accept C-Sub samples (per proposed rules).

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**Restrictions on out-of-state NP Rx being filled in this state?** Not specified

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** No.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. But commercial insurers generally have followed state Medicaid ruling NOT to list NPs. State law does not specify NPs as PCPs. The state-provided insurance for teachers has recently announced that beginning in October 2013 they will allow carriers to use CRNPs as a provider.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Alabama—Huntsville; (2) Samford University—Birmingham; (3) Troy University—Troy; (4) Troy University—Montgomery; (5) University of Alabama—Birmingham; (6) University of Alabama—Tuscaloosa; (7) University of South Alabama—Mobile; (8) University of Mobile—Mobile; (9) Auburn University—Auburn & Montgomery

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Samford University; The University of Alabama; The University of Alabama—Huntsville; Troy University; University of Alabama—Birmingham; University of South Alabama *\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Alabama State Nurses Association Advance Practice Council; Nurse Practitioner Alliance of Alabama (NPAA, made up of representatives from six regional NP groups); Bay Area NP Association; Wiregrass NP Association; River Region Advanced Practitioners (RRAP); East Alabama (Auburn/Opelika) West Alabama (Tuscaloosa) NP Association; Central AL (Birmingham) NP Association; North Alabama (Huntsville) NP Association (NANPA)

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**Organized opposition to NP legislative or regulatory changes?** Yes. The Medical Association (MASA). The BOME restricts physicians to practicing with three full-time NPs and requires onsite time at every site where they collaborate. The BOME has also begun to recategorize procedures as “the practice of medicine” in order to further restrict access to care.

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**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 35

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

**\*Pearson Report 2014 update: state still deserves a ranking of “F”**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **211 for NPs<sup>†</sup>** (2267 in state<sup>‡</sup> results in a **1:11 ratio**)
- **2819 for MDs/DOs/Interns/Residents** (15,462 in state<sup>‡</sup> results in a **1:5 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number of calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **206 for NPs<sup>†</sup>** (2267 in state<sup>‡</sup> results in a **1:11 ratio**)
- **1153 for MDs/DOs/Interns/Residents** (15,462 in state<sup>‡</sup> results in a **1:13 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number of calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All actions against healthcare providers must be commenced within 2 years after the act or omission giving rise to the claim (unless the cause of action is not, or could not be, discovered, in which case the action must begin within 6 months from the date of such discovery). A healthcare provider may testify as an expert witness

in any action against another healthcare provider based on a breach of the standard of care only if he/she is certified in the same specialty and has practiced within the previous year. A medical malpractice action may be referred to an arbitrator only upon the written agreement of the parties; the agreement is binding and irrevocable.

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**Recent state malpractice liability tort reform?** 2011: Changed the interest rate on judgments from 12% to 7.5%. 2003–2010: None. 1999: Statute limits the award of punitive damages in most nonphysical injury cases to the greater of three times the award of compensatory damages or \$500,000 and limits the award of punitive damages in physical injury cases to the greater of three times the award of compensatory damages or \$1.5 million.

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## THE PEARSON REPORT

**STATE:** ALASKA

**NP title(s) used in this state:** ANP (Advanced Nurse Practitioner)

**Number of NPs in state:** 765 (includes CNMs)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The BON recognizes national certification bodies, which certify the NP role and population foci, such as family, adult, gerontology, neonatal, pediatric, women's health, acute care, and psych/mental health.

**NP title protection?** Yes. The ANP must conspicuously display a name plate with "ANP" and display evidence in the work setting of authorization to practice with a specified sign defining an ANP.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. Regulations require a graduate degree, which could be a master's degree or doctorate.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The NP is not licensed, they are authorized. The authorization is a separate document and number from the RN license.

**Supervised practice hours required before full NP practice autonomy?** No. There is no requirement for supervised practice hours for practice autonomy.

**Supervised practice hours required before full NP prescribing autonomy?** No. Prescriptive authority for legend drugs and controlled substance prescriptive authority may be applied for along with NP authorization.

**Additional pharmacology hours required for prescribing?** Yes. When the application is received the ANP must have 15 contact hours of advanced pharmacology within the preceding 2 years.

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**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** For authorization renewal, ANPs may choose two of three options related to renewal of their RN license: the CE option requires completion of 30 hours of CE within the 2-year period immediately before the date of the renewal application. The ANP applicant must provide evidence of completion of 12 contact hours of education in advanced pharmacology and 12 contact hours of clinical management within the 2-year period immediately before the date of application.

**BON mechanism for others to verify NP license?** Yes. License and authorization information is available on the Division of Occupational Licensing/BON website ([www.nursing.alaska.gov](http://www.nursing.alaska.gov)). It is public information.

**Current listing of all active NP licenses maintained by BON?** Yes. It is available on the BON's website ([www.nursing.alaska.gov](http://www.nursing.alaska.gov)).

**Current listing of authorized NP prescribers maintained by BON?** Yes.

**If so, is this a separate list from all active NP licenses?** No.

**Recent legislative/regulatory changes affecting NP practice?** No.

**Legislative/administrative plans for state?** Yes. Specific plans are still in the development stages.

**Internet address for Nurse Practice Act:** <http://commerce.alaska.gov/dnn/portals/5/pub/NursingStatutes.pdf>

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**NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING**

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No. But when applying to deliver healthcare services, the ANP shall submit a written consultation and referral plan. The plan must describe the clinical practice characteristics, list the method and documentation process for routine consultations and referrals, and describe the process for quality assurance to evaluate the practice (including a written evaluation of the quality assurance review with a plan for corrective action).

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No. Although the consultation and referral plan is part of the initial application.

**If so, are protocols required to be kept/stored/updated?** The ANP's consultation and referral plan is required on initial licensure only. It is kept in the licensing file.

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**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** The January 2009 BON Advisory Opinion, adopted from the 2008 National Council of State Boards of Nursing *Regulatory Implications: The Advanced Practice Registered Nurse in a Pain Management Primary Care Role* is available at [http://www.dced.state.ak.us/occ/pub\\_nursing\\_opinions/APRN\\_Advisory\\_Pain\\_Management.pdf](http://www.dced.state.ak.us/occ/pub_nursing_opinions/APRN_Advisory_Pain_Management.pdf). Additionally, a BON opinion allows the use of Botox and dermal fillers as part of ANP prescriptive authority. The Alaska Board of Education authorized PNP, FNP, and PMHNPs to diagnose autism for the purpose of establishing a student's eligibility for special education. ANPs can delegate injections of certain drugs to CMAs.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. Renewed every 2 years with ANP authorization.

**NP/physician prescriptive agreement required?** No.

**NP Rx from state authorized formulary required?** No. Except specifically for delegation of injections to medical assistants.

**If so, explain specifics of formulary.** (*See above.*)

**BOM/physician involvement in NP prescribing?** No.

**If so, what words are used to characterize involvement?** N/A

**NP authorized to Rx controlled substances?** Yes. The BON may grant controlled substance prescriptive and dispensing authority in addition to the authorization of legend drug prescribing.

**If so, what schedules?** Schedules II–V

**NP issued Rx number by state?** No.

**NP authorized to apply for DEA number?** Yes. With approved controlled substance authorization by BON, renewable every 2 years with ANP authorization.

**If so, what is DEA area field office info?:** Seattle Division Office, 400 Second Ave., West Seattle, WA 98119 (p: 1-888-219-4261)

**DEA number required for nonscheduled as well as scheduled Rx?** No.

**NP name on Rx pad?** The Rx must contain the signature of the prescriber followed by the initials “ANP” and the prescriber’s BON-assigned identification number.

**Physician name required on Rx pad?** No.

**NP name required on Rx bottle?** Yes.

**Authority to receive/dispense drug samples spelled out?** Yes.

**If so, where (e.g., statute, rules, opinion)?** BON regulations

**Specified limitations or restrictions on NP drug sampling?** No.

**Restrictions on out-of-state NP Rx being filled in this state?** Not in BON statutes or regulations; may be in the pharmacy regulations.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Alaska—Anchorage

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** None listed.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Alaska Nurse Practitioner Association ([www.alaskanp.org](http://www.alaskanp.org))

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 85

Descriptive ranking: Grade B. State partially supports patient choice.

*\*Pearson Report 2014 update: state now deserves higher ranking of "A."*

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## Cumulative number of National Practitioner Data Bank (NPDB) filings:

Medical reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports  
(9/1/1990– 3/30/2013):

- **29 for NPs**<sup>†</sup> (765 in state<sup>‡</sup> results in a **1:26 ratio**)
- **835 for MDs/DOs/Interns/Residents** (3521 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **24 for NPs<sup>†</sup>** (765 in state<sup>‡</sup> results in a **1:32 ratio**)
- **349 for MDs/DOs/Interns/Residents** (3521 in state<sup>‡</sup> results in a **1:10 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** The limitations period for bringing an action for personal injury or death is 2 years. Alaska has adopted the doctrine of pure comparative negligence. A claimant’s fault does not bar recovery, but his/her damages are reduced in proportion to the percentage of fault attributed to him/her. In all actions involving the fault of more than one party, the court will enter a judgment against each party liable in accordance with that party’s percentage of fault. A patient and any healthcare provider may execute an agreement to submit to arbitration any dispute arising out of care or treatment. In medical malpractice actions in which the parties have not agreed to arbitrate, the court may appoint a three-member expert panel to arbitrate.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Medical liability reform/noneconomic damages reform lowers the limits on noneconomic damages in medical liability cases to \$250,000–\$400,000 (depending upon severity). In the most severe cases involving disfigurement, severe permanent physical impairment, and wrongful death, the limit on noneconomic damages is \$400,000. The previous limit ranged from \$400,000 to \$1 million, depending on the severity of the injuries.

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## THE PEARSON REPORT

**STATE:** ARIZONA

**NP title(s) used in this state:** RNP (Registered Nurse Practitioner)

**Number of NPs in state:** 4218

**NP specialties legislatively specified?** Specified in BON rules: family, adult/gerontology primary care, adult gerontology acute care, neonatal, pediatric primary care, pediatric acute care, women's health/gender related, psychiatric/mental health; former recognized specialties are grandfathered (e.g., School Nurse Practitioner).

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** By those specialty NP education programs that are approved or recognized by the BON; the SOP is defined in statute and rule.

**NP title protection?** Yes. BON rules specify title protection for any words or letters to indicate RNP, NP, CNM, NM, or CNS unless the individual is certified.

**National certification required for recognition/practice?** Yes (since 2004).

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes (graduate degree in nursing).

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No. But collaboration is required in the sense that Ariz. Admin. Code §§ R4-19-508 states the following: "An RNP shall refer a patient to a physician or another healthcare provider if the referral will protect the health and welfare of the patient and consult with a physician and other healthcare providers if a situation or condition occurs in a patient that is beyond the RNP's knowledge and experience."

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** (See above.)

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. Except that under ARIZ. REV. STAT. § 32-1455 the use of the designation "doctor" by a member of another branch of healing arts other than the BOM is prohibited unless there is set forth with each such designation the other branch of the healing arts concerned (e.g., Doctor of Nursing Practice).

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** RNP's are issued a separate certification with a unique number.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. RNPs must have 45 contact hours of education in graduate-level pharmacology and/or clinical management of drug therapy in the 3 years prior to application for Rx authority (for recent graduates, this pharmacology is generally part of their program).

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**CE requirements for NP practice?** No. CE is not required by the state for maintaining state certification as an RNP; there is a practice requirement for RNP license renewal.

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**If so, what are the specifics?** All RNs (including APRNs) are required to have completed 960 hours of practice in the 5 years preceding the renewal date. For APRNs the hours must be in the category and specialty area of their certification.

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**BON mechanism for others to verify NP license/certification?** Yes.

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**Current listing of all active NP license/certifications maintained by BON?** Yes. See the BON's website (<https://www.azbn.gov/OnlineVerification.aspx>).

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**Current listing of authorized NP prescribers maintained by BON?** There is not a readily available "list" for the public. However, such a list could be generated upon request. All individuals with prescribing privileges are noted as such on their licensure information, which is available to the public on the BON's website.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** No. There has not been legislation that has changed RNP practice; however, there were some changes for CRNAs, including a definition, scope of practice, and ordering privileges (not prescribing). But the legislation did not change the SOP as nearly identical provisions were formerly in the rule.

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**Legislative/administrative plans for state?** The existing Nurse Practice Act is being reviewed to identify areas that need to be updated to conform with the APRN consensus model. When that work is completed, priorities for legislative action will be set.

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**Internet address for Nurse Practice Act:** <http://www.azbn.gov/NursePracticeAct.aspx>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** The Nurse Practice Act includes admitting privileges to acute care facilities within the SOP. However, the Arizona Department of Health rules state that all patients admitted to a hospital must have an attending physician.

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**Additional limitations/clarifications/expansions to NP practice?** Certified PMHNPs are allowed to testify at court hearings and conduct evaluations. Legislation passed in 2009 limits performance of abortion to physicians; legislation passed in 2011 approved another restriction that prohibits RNPs from providing medication for nonsurgical abortions. The *Arizona State Board of Nursing Regulatory Journal* (Vol. 9, April 2013) provided clarification regarding questions such as “Can an Adult RNP see adolescents?”: “According to ARIZ. ADMIN. CODE §§ R4-19-508, the SOP is defined by the educational preparation for which competency has been established and maintained; educational preparation means academic coursework or CE activities that include both theory and clinical practice. Therefore an RNP’s SOP is limited to the patient population foci for which the RNP was educationally prepared (i.e., because educational preparation may vary from school to school, determine the appropriate age range within an RNP’s SOP by looking at the population focus included in the educational program).”

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NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area office info?:** Phoenix Division Office, 3010 N 2nd Street, Suite 301, Phoenix, AZ, 85012 p: 1-800-741-0902

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** BON rules

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**Specified limitations or restrictions on NP drug sampling?** No. Rules include detailed instructions for RNP dispensing of medications, medical devices, and appliances.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. However, NPs continue to encounter admittance resistance to provider networks. The resistance comes from insurance companies who refuse to add NPs to their provider lists. For those insurance companies that do admit NPs to their provider network, they reimburse only at the 60%–85% level for services provided.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Arizona State University—Phoenix; (2) Grand Canyon University—Phoenix; (3) Northern Arizona University—Flagstaff; (4) University of Arizona—Tucson; (5) University of Phoenix—Phoenix and Tucson

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Arizona State University, University of Arizona, Northern Arizona University

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Arizona NP Council (Chapter 9 of AZNA) website for NPs ([www.arizonanp.com](http://www.arizonanp.com)); NP listserve ([www.CAZNAP.org](http://www.CAZNAP.org); must be an NP or student to enroll, no charge)

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**Organized opposition to NP legislative or regulatory changes?** Yes. The AZ Medical Association, the AZ Osteopathic Medical Association, and AZ Family Practice Association.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 100

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Descriptive ranking: Grade A. The state is exemplary for patient choice.

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*\*Pearson Report 2014 update: state still deserves high ranking of "A."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

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Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

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- 71 for NPs<sup>†</sup> (4218 in state<sup>‡</sup> results in a **1:59 ratio**)
- 8361 for MDs/DOs/Interns/Residents (24,107 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **10 for NPs<sup>†</sup>** (4218 in state<sup>‡</sup> results in a **1:422 ratio**)
- **2662 for MDs/DOs/Interns/Residents** (24,107 in state<sup>‡</sup> results in a **1:9 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions must begin within 2 years after the cause of action. A claimant’s recovery is diminished proportionately to his level of fault, but the fault does not act as a bar to recovery (i.e., a pure form of comparative negligence). There is no patient compensation fund or state-sponsored physician liability insurance program. There is no mandate for an arbitrator.

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**Recent state malpractice liability tort reform?** 2010–2013: None. 2009: SB 1018 raises the burden of proof in medical malpractice civil actions against healthcare providers and hospitals to clear and convincing evidence in connection with certain emergency medical services. 2006–2008: None. 2004: Act exempts those involved in food production and sales from liability if a consumer consumes it to excess.

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## THE PEARSON REPORT

### STATE: ARKANSAS

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) includes four roles (effective November 2013): CNP (Certified Nurse Practitioner), CNM, CNS, CRNA. RNP (Registered Nurse Practitioner) was recognized by the BON but has not been issued since November 2000.

**Number of NPs in state:** 2897 (includes all four APRN roles)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The BON has determined those certification examinations by national accrediting agencies that are approved as prerequisites to advanced practice license. The SOP is and must be defined by the BON to enable reimbursement of the advanced practice nurse.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. For practice as an APRN, but not required for an RNP. The more restricted RNP license, which does not require a master's degree or national board certification, has not been issued since November 2000 but is still recognized.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. For CNP practice.

**Requirement for APN member on BON?** Yes. The APRN member must hold an active APRN license with Rx authority.

**Joint BON/BOM regulation over any aspect of practice?** No. But a National Practice Act—specified Prescriptive Authority Advisory Committee (with four APRNs, one physician in collaborative practice, and one pharmacist) advises the BON regarding implementing prescriptive authority.

**Physician involvement required for any aspect of practice?** Yes. Collaborative Practice Agreements are required for APRNs with prescribing authority and for all aspects of an RNP's practice.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Applicable to the RNP for all aspects of practice: "in collaboration with and under the direction of a licensed physician or under the direction of protocols developed with a physician." (Collaborative Practice Agreement) A CNP with prescriptive authority must have a collaborative practice agreement with a physician.



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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** Yes. As written in the Medical Practice Act and Regulation (passed December 20, 2001), Ark. Code Ann. § 17-80-110 through 17-80-113, the title “doctor” is allowed in advertising, documentation, and general title, but one cannot use the title in the provision of healthcare services unless licensed under the Medical Practice Act.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Separate license from RN.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. NP must have documented 300 hours with a preceptor in the prescribing of medications prior to initial application for prescriptive authority.

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**Additional pharmacology hours required for prescribing?** Yes. There are specific requirements for pharmacology coursework to obtain prescriptive authority. All APRNs must complete 5 contact hours of pharmacotherapeutics CE in the APRN’s area of certification each biennium prior to license renewal. All APRNs whose prescriptive authority is inactive must complete 5 contact hours of pharmacotherapeutics in the APRN’s area of certification for each 12 months of non-prescribing activity in addition to the 5 contact hours required for the APRN’s license renewal prior to reactivation of prescriptive authority.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** APRNs must follow CE requirements to maintain national certification. All APRNs must maintain certification by a BON-approved national certifying body.

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**BON mechanism for others to verify NP license?** Yes. Free through a subscription service used mainly by major employers (<https://www.ark.org/arsbn/statuswatch/index.php/nurse/search/new>).

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**Current listing of all active NP licenses maintained by BON?** Yes. See the BON website ([https://www.ark.org/nurse\\_roster/index.php](https://www.ark.org/nurse_roster/index.php)).

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**Current listing of authorized NP prescribers maintained by BON?** (See above.)

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. BON rule title change from APN to APRN and ANP to CNP; addition of another APRN to the Prescriptive Authority Committee; addition to the rules regarding prescribing of medications for anorexia.

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**Legislative/administrative plans for state?** The state nursing association (ARNA) plans to fight for legislation that will allow Medicaid to pay for all of the CPT codes that relate to APRN practice, in addition to asking for a higher rate of reimbursement (to be more comparable to what physicians receive).

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**Internet address for Nurse Practice Act:** <http://www.arsbn.arkansas.gov/lawsRules/Pages/default.aspx>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No (for APRN). Yes (for RNP).

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The RNP's SOP is defined by protocols (developed in collaboration with and signed by a physician) and in accordance with BON R&R; thus for the RNP the degree of supervision is determined by the protocols.

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**Required physician record/chart review?** No. But the APRN must have a provision for quality assurance; chart review by a collaborating physician is one option, but it is not mandatory.

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**Required NP/physician practice agreement?** No (for APRN). Yes (for RNP).

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** BON, but only if requested.

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**If so, is agreement required to be kept/stored/updated?** Given that the BON can request it, then yes, it should always be current and accessible.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes (but only for RNP).

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** Must be reviewed annually.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** For the RNP there are no restrictions specified within protocol. The SOP for the APRN is defined by the certifying body, educational preparation, and competence.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. An APRN with prescriptive authority must have a collaborative practice agreement and protocols with a physician; RNPs do not have independent prescriptive authority.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** An APRN with prescriptive authority must have a collaborative practice agreement and protocols with a physician.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** New Orleans Division Office, Three Lake Way, 3838 N Causeway Blvd Suite 1800, Metairie, LA, 70002 p: 1-800-514-7302 OR 1-800-514-8051

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In the Nurse Practice Act and Chapter 4 Rules: an APRN with a certificate of prescriptive authority may receive and prescribe drugs, medicines, or therapeutic devices appropriate to the APRN's area of practice.

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**Specified limitations or restrictions on NP drug sampling?** Yes. A 2001 decision by the Attorney General reported that APRNs with prescriptive authority have implied authority to dispense samples.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** The Nurse Practice Act allows reimbursement by Medicaid and also prohibits Medicaid from discriminating against practitioners providing covered services based upon the type of practitioner.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** No.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Arkansas State University—Jonesboro; (2) University of Arkansas for Medical Sciences—Little Rock; (3) University of Central Arkansas—Conway; (4) University of Arkansas—Fayetteville.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Arkansas, University of Arkansas for Medical Sciences.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Yes. They are very active. Arkansas Nurses Association, APN Council, and Northeast Arkansas Nurse Practitioner Association.

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**Organized opposition to NP legislative or regulatory changes?** Opposition to APRN legislative or regulatory change is based upon the subject matter; generally, increases in APRN SOP are opposed by the state medical society.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 68

**Descriptive ranking:** Grade D. State restricts patient choice.

**\*Pearson Report 2014 update: state now deserves a ranking of "C-."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **24 for NPs<sup>†</sup>** (2897 in state<sup>‡</sup> results in a **1:121 ratio**)
- **2163 for MDs/DOs/Interns/Residents** (8863 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **12 for NPs<sup>†</sup>** (2897 in state<sup>‡</sup> results in a **1:241 ratio**)
- **422 for MDs/DOs/Interns/Residents** (8863 in state<sup>‡</sup> results in a **1:21 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions must begin within 2 years after the date of the wrongful act. A claimant's negligence reduces his recovery of funds proportionately with his level of fault, but recovery is barred only if the claimant's fault equals or exceeds all the defendants' levels of fault (i.e., the doctrine of modified comparative negligence). There is no patient compensation fund, no state-sponsored liability insurance for physicians, and the state does not require a malpractice case to go to an arbitrator.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Law (1) Repealed joint liability so that defendants who are found 1%–10% at fault will be only responsible for percent damage caused, defendants who are 11%–50% at fault can be assessed an additional 10% if a co-defendant cannot pay, and if one defendant is held 51%–99% at fault he/she can be assessed an additional 20% if the co-defendant cannot pay the judgment. (2) A certificate of merit must be filed in medical malpractice cases where an expert's testimony is required. (3) Required evidence of damages before requiring that medical expenses be paid. (4) Requires that a medical expert be licensed in the same state and specialty as the defendant. (5) Raises the standard to "clear and convincing evidence" of actual fraud, malice, or willful or wanton conduct before imposing punitive damages; limits punitive damages to less than \$1 million.

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## THE PEARSON REPORT

**STATE:** CALIFORNIA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) and NP (Nurse Practitioner)

**Number of NPs in state:** 17,929

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The BRN has not established separate categories for NPs.

**NP title protection?** Yes.

**National certification required for recognition/practice?** No. The BRN requires: (1) successful completion of a program of study that conforms to board standards; and (2) certification by a national or state organization whose standards are acceptable to the BRN.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Standardized procedures must be developed collaboratively by nursing, medicine, and administration in the organized healthcare system where they will be utilized. Once a standardized procedure has been signed off on by the physician, nurse, and facility (if applicable) the practice is considered independent. The “standardized procedure” is agency specific and must meet certain requirements, including collaborative development by nursing, medicine, and administration within the agency.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Except that under CA Bus & Prof Code § 2278, the use of such title, letters, or prefix without further indicating the type of certificate held constitutes unprofessional conduct.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Separate certification from RN license and separate certification for prescribing. Upon renewal of the RN license, the BON requires licensees to indicate if they have had any discipline against their license or been convicted of a misdemeanor or felony since their license was last renewed.

**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. The physician and NP determine the number of supervised hours needed. The law no longer requires a set amount.

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**Additional pharmacology hours required for prescribing?** Yes. The NP must take a course in pharmacology covering the drugs or devices to be furnished or ordered.

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**CE requirements for NP practice?** No. But RNs need 30 contact hours every 2 years for RN license renewal. The California Department of Justice regulations require the submission of fingerprints upon RN license renewal.

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**If so, what are the specifics?** No specifics for practice, but certified NPs who hold active furnishing numbers and who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board.

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** Yes. There is a bill to allow independent autonomous NP practice that has passed the Senate but faces some intense opposition in the House.

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**Internet address for Nurse Practice Act:** <http://www.rn.ca.gov/regulations/npa.shtml>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes. Until the “standardized procedure” is drafted. Once the standardized procedure is signed off on by the physician, the nurse may make their own decisions within the standardized procedure.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Required “standardized procedures” specify the scope of supervision for the NP authorized to perform the procedure functions.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes. A “standardized procedure” is the legal mechanism for RNs and NPs to perform functions that would otherwise be considered the practice of medicine. Standardized procedures must be developed collaboratively by nursing, medicine, and administration in the organized healthcare system where they will be utilized. The procedure functions are basically the diagnosing, prescribing, and severing or penetrating of tissue functions under the MPA. The standardized procedure outlines when the nurse is to refer or seek a second opinion, limitations, required education, settings, how the practice will be evaluated, etc.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** Yes. At practice site.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** Yes. At practice site.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs are authorized to grant disability placards and are able to do DMV testing, and to perform pre-employment physicals for school district employees.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. Drugs or devices furnished or ordered by an NP are limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure. Only NPs and CNMs can use the standardized procedure for furnishing and dispensing medications.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** In addition to involvement in the prescriptive agreement, physician involvement is also required when Schedule II or III controlled substances are furnished or ordered by an NP. Specifically, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the NP's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the NP furnishing the order.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. A BRN Furnishing Number.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Northern: San Francisco Division Office, 450 Golden Gate Ave., PO Box 36035, San Francisco, CA 94102, p: 888 304 3251; South Central: Los Angeles Division Office, 255 East Temple Street, 20th Floor, Los Angeles, CA 90012, p: 1-888-415-9822; California Southern: San Diego Division Office, 4560 Viewridge Ave., San Diego, CA 92123-1672, p: 1-800-284-1152.

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** As specified in BRN R&R and the NP's "standardized procedure."

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP Schools in state:** (1) Azusa Pacific University—Azusa; (2) California State University—Bakersfield; (3) California State University—Dominguez Hills; (4) California State University—Fresno; (5) California State University—Fullerton; (6) California State University—Long Beach; (7) California State University—Los Angeles; (8) Holy Names University; (9) Loma Linda University; (10) Samuel Merritt University; (11) San Diego State University—San Diego; (12) San Francisco State University—San Francisco; (13) Sonoma State University; (14) United States University; (15) University of California—Davis; (16) University of California—Irvine; (17) University of California—Los Angeles; (18) University of California—San Francisco; (19) University of Phoenix—California; (20) University of San Diego—San Diego; (21) University of San Francisco—San Francisco; (22) Western University of Health Sciences.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Azusa Pacific University; Brandman University; California State University—Fresno; California State University—Fullerton; California State University—Los Angeles; Loma Linda University; National University; Samuel Merritt University; University of San Diego; University of San Francisco; Western University of Health Sciences.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** California Association of NPs (CANP; <http://www.canpweb.org/>)

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**Organized opposition to NP legislative or regulatory changes?** The California Medical Association strongly opposes all legislation that would expand NP practice. The Physician Dermatology Association is trying to restrict all Botox and laser treatments to their specialty to ensure financial control. State Orthopedic Surgeons have opposed measures related to workers compensation. Insurance companies have opposed workers compensation measures and some of the practice issues.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal): 75****Descriptive ranking:** Grade C. The state confines patient choice.**\*Pearson Report 2014 update: state still deserves a ranking of "C."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **118 for NPs<sup>†</sup>** (17,929 in state<sup>†</sup> results in a **1:152 ratio**)
- **42,922 for MDs/DOs/Interns/Residents** (133,642 in state<sup>†</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Practice Nurse, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **16 for NPs<sup>†</sup>** (17,929 in state<sup>†</sup> results in a **1:1120 ratio**)
- **9666 for MDs/DOs/Interns/Residents** (133,642 in state<sup>†</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions for injury or death must begin within 1 year after the negligent act is discovered and not more than 3 years from the date of the injury. The plaintiff's negligence is compared to the total negligence of all defendants and distributed accordingly (i.e., a pure comparative negligence rule). There is a cap on noneconomic damages whether for injury or death: one \$250,000 recovery in a wrongful death case. The state does allow for separate caps for the patient and a spouse claiming loss of consortium. There is no patient compensation fund or a state-sponsored liability insurance program for physicians. The state allows but does not require healthcare providers and their patients to contract for the arbitration of disputes. The state requires all settlements be paid

out quarterly to the patient unless there is a precourt settlement between the parties. There is a limit on the amount of money an attorney can receive from the settlement.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2002: Act provided for the inadmissibility of certain evidence related to expressing sympathy or benevolence related to a case but specifies that admissions of fault are not inadmissible in court.

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## THE PEARSON REPORT

**STATE:** COLORADO

**NP title(s) used in this state:** APN (Advanced Practice Nurse) and NP (Nurse Practitioner)

**Number of NPs in state:** 3492 active NPs (2013 have active prescriptive authority)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The Advanced Practice Nurse (APN) SOP is based upon the professional nurse's SOP within the APN's role and population focus and the graduate or post-graduate nursing education in the role and population focus for which the APN has been recognized by the BON for inclusion on the Advanced Practice Registry (APR). The scope of advanced practice nursing may include, but is not limited to, performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures. Prescribing medication is not within the SOP of an APN unless the APN has applied for and been granted prescriptive authority by the BON.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. As of July 1, 2010 (except for APNs on the registry prior to June 30, 2010).

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. As of July 1, 2008, all applicants are required to have graduate or post-graduate nursing education in the role and population focus for which the APN is applying for inclusion on the APR.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No (only required prior to the APN achieving full prescriptive authority, which is granted by the BON).

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The APN authority and prescriptive authority (RXN) are linked to the RN license but are given separate authority numbers that can be verified online. The authorities are not designated on the RN paper license.

**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. Precepted and mentored hours are required. As of July 1, 2010, a mutually structured post-graduate preceptorship of not less than 1800 hours is required for provisional prescriptive authority (RXN-P). The preceptorship must be completed within a 5-year period immediately preceding the filing of the application for RXN-P. The preceptorship shall be conducted with either a physician preceptor or a physician preceptor and RXN preceptor and shall occur in a clinical setting that corresponds to the APN's role/specialty, population focus, and SOP. The clinical experience shall include, but not be limited to, precepted experience in pharmacological management, advanced pharmacology, and precepted experience with specific drugs relevant to the role/specialty, population focus, and SOP of the APN. Interaction between the APN and the preceptor(s) shall occur at least weekly and more frequently if appropriate to provide for patient safety. If the preceptorship is with a physician preceptor and RXN preceptor, the physician preceptor must participate in a minimum of one meeting per month. During the preceptorship, all prescription orders must be signed or otherwise legally authorized by a preceptor or another person with full prescriptive authority. To obtain full prescriptive authority, the RXN-P must complete an additional 1800 hours of documented experience in a mentorship and develop an articulated plan for safe prescribing. The mentorship shall be conducted with either a physician mentor or a physician mentor and RXN mentor in a setting that corresponds to the RXN-P's role/specialty, population focus, and scope of prescriptive authority and must be completed within the 5 years after provisional prescriptive authority is granted. The mentorship shall contain the following elements documented in writing and signed by the RXN-P and all mentors, outlines a process and frequency for ongoing interaction and discussion of prescriptive practice throughout the mentorship between all mentor(s) and the RXN-P to provide for patient safety. The articulated plan is a written document that includes a strategy for safe prescribing and outlines how the RXN intends to maintain ongoing collaboration with physicians and other healthcare professionals in connection with the RXN's practice of prescribing medications within the RXN's role/specialty and population focus.

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**Additional pharmacology hours required for prescribing?** Yes. A minimum of 3 semester credit hours or 4 quart hours completed at the graduate or post-graduate level in an accredited nursing program for which graduate credit has been awarded with an emphasis appropriate to, but need not be identical to, the role/specialty and population focus of the APN, including but not limited to the study of pharmacotherapeutics and pharmacokinetics of broad categories of pharmacological agents.

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**CE requirements for NP practice?** An articulated plan is required of all RXNs and they must document ongoing continuing education in pharmacology and safe prescribing.

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**If so, what are the specifics?** The documentation includes a personal record of the RXN's participation in programs with content relevant to the RXN's prescribing practice. This may include academic courses, programs by entities offering continuing education credit under nationally recognized educational program standards (e.g., the ANCC), educational content on safe prescribing/pharmacology offered by professional healthcare organizations and associations, and other programs with relevant content. Certificates of attendance, information on program content and objectives, or copies of presentations may serve as verification documents.

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**BON mechanism for others to verify NP license?** Yes. Verification of licensure may be obtained from the Division of Professions and Occupations Online Services (<https://www.colorado.gov/dora/licensing/>). Click on “Lookup a Colorado License.” Select “License Type” and search by name.

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**Current listing of all active NP licenses maintained by BON?** Yes. The licensee database can be downloaded from the BON website. The database can be sorted by “NP.”

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**Current listing of authorized NP prescribers maintained by BON?** Yes. The licensee database can be downloaded from the BON website. The database can be sorted by “NP” or “RXN” and then names have to be matched.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative plans for state?** CNA (Colorado Nurses Association) continues to work on non-legislative options for improving access to insurance panels for APNs with various stakeholder groups. CNA is also monitoring the implementation of the Affordable Care Act in the state and the opportunities and implications for APN practice. The Centers for Medicare and Medicaid Services rule allowing opt-out for physician supervision of CRNAs in rural settings is still in the appeal process in Colorado courts.

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**Internet address for Nurse Practice Act:** <http://www.dora.state.co.us/nursing/statutes/NursePracticeAct.pdf>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** An APN may, within his or her SOP and within the APN–patient relationship, sign an affidavit, certification, or similar document that documents a patient’s current health status; authorizes continuing treatment, tests, services, or equipment; or gives advance directives for end-of-life care. Such affidavit, certification, or similar document may not be the prescription of medication unless the APN

has been granted RXN by the BON or in conflict with other requirements of law. Such forms may include but not be limited to forms for jury service, school forms, physical exams, utility company forms, CPR directives, and handicap parking. APNs may place persons on mental health holds but may not discontinue the holds. APNs may not place persons with alcohol or substance abuse problems on involuntary commitments and may not place persons on mental health certifications. APNs are authorized to implement medical orders scope of treatment forms, which include advanced directive planning and do-not-resuscitate orders for adults.

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### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. An APN who is listed on the APR, has a license in good standing without disciplinary sanctions, and has fulfilled requirements established by the board may be authorized by the board to prescribe controlled substances or prescription drugs.

**NP/physician prescriptive agreement required?** No. Not after completing the preceptorship, mentorship, and initial articulated plan. APNs with full prescriptive authority have autonomous prescribing ability and are responsible for reviewing their articulated plans at least annually. The articulated plan is signed by a physician (practicing in Colorado with the same population focus as the APN) one time only. Physicians are not required to be involved in the annual reviews of the APN's articulated plan. Articulated plans may be audited by the BON.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** Yes. But during the preceptorship and mentorship periods only.

**If so, what words are used to characterize involvement?** During preceptorship the word "supervision" is used; once in the mentorship, it is no longer used. There is no required physician involvement after the mentorship is completed. Preceptorship shall be conducted with either a physician preceptor or a physician preceptor and RXN preceptor and shall occur in a clinical setting that corresponds to the APN's role/specialty, population focus, and SOP. The clinical experience shall include, but not be limited to, precepted experience in pharmacological management, advanced pharmacology, and precepted experience with specific drugs relevant to the role/specialty, population focus, and SOP of the APN. Interaction between the APN and the preceptor(s) shall occur at least weekly and more frequently if appropriate to provide for patient safety. If the preceptorship is with a physician preceptor and RXN preceptor, the physician preceptor must participate in a minimum of one meeting per month. During the preceptorship, all prescription orders must be signed or otherwise legally authorized by a preceptor or another person with full prescriptive authority.

To obtain full prescriptive authority, the RXN-P must complete an additional 1800 hours of documented experience in a mentorship and develop an articulated plan for safe prescribing. The mentorship shall be conducted with either a physician mentor or a physician mentor and RXN



mentor in a setting that corresponds to the RXN-P's role/specialty, population focus, and scope of prescriptive authority and must be completed within 5 years after provisional prescriptive authority is granted. The mentorship shall contain the following elements documented in writing and signed by the RXN-P and all mentors, outlines a process and frequency for ongoing interaction and discussion of prescriptive practice throughout the mentorship between all mentor(s) and the RXN-P to provide for patient safety.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Yes. An APN with provisional prescriptive authority and full prescriptive authority may apply for a DEA number.

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**If so, what is DEA area field office info?:** Denver Division, 12154 East Easter Ave., Centennial, CO 80112, p: 1-720-895-4214

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** COLO. REV. STAT. ANN. § 12-38-111.6(10) and Chapter XV, Rules and Regulations for Prescriptive Authority for Advanced Practice Nurses, Section 7.3.

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**Specified limitations or restrictions on NP drug sampling?** No. As defined in COLO. REV. STAT. ANN. § 12-22-102: "nothing in these Rules shall be construed to permit dispensing or distribution by an RXN, except for receiving and distributing a therapeutic regimen of prepackaged drugs prepared by a licensed pharmacist or drug manufacturer registered with the FDA and appropriately labeled, free samples supplied by a drug manufacturer, and distributing drugs for administration and use by other individuals as authorized by law."

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**Restrictions on out-of-state NP Rx being filled in this state?** Not prohibited by the Nurse Practice Act.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. COLO. REV. STAT. ANN. § 12-38-128 does not prohibit or require direct reimbursement.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** No. However, APNs are eligible to enroll in the state Medicaid program and be reimbursed for healthcare services. Insurance companies are required to objectively review APN applications



for insurance empanelment and provide timely feedback if the application is denied. However, some managed-care Medicaid companies have been restricting independent APNs from joining their networks.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Colorado State University—Pueblo; (2) Regis University—Denver; (3) University of Colorado Health Sciences Center—Denver; (4) University of Northern Colorado—Greeley; (5) University of Colorado at Colorado Springs—Colorado Springs.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** American Sentinel University; Colorado Mesa University; Regis University; University of Colorado at Colorado Springs; University of Colorado at Denver; University of Northern Colorado

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Colorado Society of Advanced Practice Nurses ([www.csapn.org](http://www.csapn.org)) and the Colorado Society of Clinical Specialists in Psychiatric Nursing ([www.cscspn.org](http://www.cscspn.org)); includes Psychiatric–Mental Health NPs)

**Organized opposition to NP legislative or regulatory changes?** Issue specific—some local physician organizations have historically fought increasing APN autonomy.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 68

**Descriptive ranking:** Grade D. The state restricts patient choice.

*\*Pearson Report 2014 update: state deserves a higher ranking of "A-."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **39 for NPs<sup>†</sup>** (3492 in state<sup>‡</sup> results in a **1:90 ratio**)
- **6015 for MDs/DOs/Interns/Residents** (18,383 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p.12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **1 for NPs<sup>†</sup>** (3492 in state<sup>‡</sup> results in a **1: 3492 ratio**)
- **1968 for MDs/DOs/Interns/Residents** (18,383 in state<sup>‡</sup> results in a **1:9 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p.12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** APNs and RXNs are required to carry malpractice insurance. Limits and exemptions are found in the rules section of the BON website.

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**Recent state malpractice liability tort reform?** 2011–2013: None. 2009–2010: Nurse Practice Act requires all APNs to carry liability insurance unless they work for an entity that provides them with coverage or if they work for an entity with governmental immunity. Minimum coverage is \$500,000 per claim with an aggregate liability for all claims during the year of \$1.5 million. 2005–2008: None. 2004: Statute exempts from civil liability, manufacturers, packers, distributors, carriers, holders, or sellers of food or an association of one or more such entities when the claim is for weight gain, obesity, a health condition related to obesity or weight gain, or any other injury caused by the long-term consumption of food.

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## THE PEARSON REPORT

### STATE: CONNECTICUT

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) and NP (Nurse Practitioner)

**Number of NPs in state:** 3841 APRNs (this number includes CRNAs and CNSs)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The Department of Public Health (DPH) may issue an APRN license if the applicant is an RN who holds and maintains current certification as an NP from a BON-approved national certifying body that certifies nurses in advanced practice.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The APRN performs acts of diagnosis and treatment of alterations in health status and shall collaborate with a physician.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** Yes. Chapter 946 “Offenses Against Public Policy” in CONN. GEN. ANN. § 53-341 (revised January 1, 2007) prohibits “use of words ‘physician,’ ‘surgeon,’ ‘medical doctor,’ ‘osteopath,’ ‘doctor’ or initials ‘MD,’ ‘DO,’ or ‘Dr.’” with the intent to represent or in a manner that is likely to induce the belief that the person (1) practices medicine, (2) is licensed to practice medicine, or (3) may diagnose or treat any injury, deformity, ailment, or disease for compensation, gain, or reward. A person violating Sec 53-341 shall be fined not more than \$500 or imprisoned not more than 5 years or both. However, there is legal ambiguity since ‘a manner that is likely to induce the belief...’ is unclear, and the Medical Practice Act excludes APRNs “if such service is rendered in collaboration with a licensed physician.”

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** A separate APRN license is issued from RN license.

**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** A “graduate APRN” working in a hospital or other organization under the supervision of a physician or APRN can practice up to 120 days after the date of graduation while awaiting the national certification exam. There is no authorization to prescribe or dispense drugs during this time.

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**Additional pharmacology hours required for prescribing?** No.

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**CE requirements for NP practice?** No.

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes. See the Connecticut Licensing Information Center under the State of Connecticut website.

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**Current listing of all active NP licenses maintained by BON?** Yes. All APRN licenses are listed on the DPH website (<http://www.dph.state.ct.us/>).

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**Current listing of authorized NP prescribers maintained by BON?** Yes. Because an APRN license allows the APRN to prescribe.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** Legislation passed for a global signature; the 2012 act (Public Act 12-197) changes about 20 statutes to allow the signature of APRNs on various certification forms.

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**Legislative/administrative plans for state?** Yes. The submission of SOP legislative changes through the DPH. A bill to provide this (HB 6391) did not pass; the bill was resurrected as an amendment (HB5567) but was not passed.

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**Internet address for Nurse Practice Act:** <http://www.ctnurses.org/displaycommon.cfm?an=4#sec20-88.htm>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The APRN performs acts of diagnosis and treatment of alterations in health status and shall collaborate with a physician.

---

**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** The required collaboration means a mutually agreed upon relationship (between the APRN and physician in the relevant field) that shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the APRN, a method to review patient outcomes, and a method of disclosure of the relationship to the patient.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** No.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** In 2011, a legislative act was passed that requires an inclusion of the option of APRNs stationed at any military base as qualified to ascertain whether a pupil is suffering from any physical disability requiring school work modifications in order to secure for the pupil a suitable program of education. Global signature for APRNs for some statutes.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** Yes. Relative to Rx authority, the collaboration shall be in writing and shall address the level of Schedule II and III controlled substances that the APRN may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures that the APRN may prescribe, dispense, and administer.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Collaboration

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. From the Connecticut Department of Consumer Protection Drug Control Division.

([http://www.ct.gov/dcp/cwp/view.asp?a=1620&q=273650&dcpNav\\_GID=1541](http://www.ct.gov/dcp/cwp/view.asp?a=1620&q=273650&dcpNav_GID=1541)).

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Bldg, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131, p: 1-617-557-2200

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No. The Rx form may contain the name of the collaborating physician (but not required).

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Nurse Practice Act

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Expanded health insurance coverage for breast cancer screening includes “APRNs.”

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Legislation was passed in the 2011 session that requires the listing of APRNs on managed-care organization provider listings and requires PCP designations.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Fairfield University—Fairfield; (2) Quinnipiac University—Hamden; (3) Sacred Heart University—Fairfield; (4) Yale University—New Haven; (5) Saint Joseph College—West Hartford; (6) Southern Connecticut University—New Haven; (7) University of Connecticut—Storrs; (8) Western Connecticut State University—Danbury.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Fairfield University; Quinnipiac University; Sacred Heart University; University of Connecticut; University of Saint Joseph; Yale University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Connecticut APRN Society ([www.CTAPRNS.org](http://www.CTAPRNS.org))

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**Organized opposition to NP legislative or regulatory changes?** Yes. By the state medical society.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 88

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state still deserves ranking of “B.”*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 51 for NPs<sup>†</sup> (3841 in state<sup>‡</sup> results in a **1:75 ratio**)
- 4760 for MDs/DOs/Interns/Residents (16,926 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, ANP, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that

contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **42 for NPs<sup>†</sup>** (3841 in state<sup>‡</sup> results in a **1:91 ratio**)
- **786 for MDs/DOs/Interns/Residents** (16,926 in state<sup>‡</sup> results in a **1:22 ratio**)

<sup>†</sup> NP total includes column count for NP, ANP, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of 5/2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A medical malpractice action must be brought within 2 years from the date when the injury is first sustained or discovered and no action may be brought more than 3 years from the date of the act or omission complained of. The state has adopted the doctrine of modified comparative negligence (i.e., a claimant's action is barred if his negligence exceeds the combined negligence of all defendants. Otherwise, the claimant's recovery is diminished in proportion to his degree of negligence). Expert testimony is required to establish a claim for medical malpractice (except when the lack of due care is gross and obvious). A plaintiff must disclose medical records and experts before filing an offer of judgment and must itemize the damages. A claimant may file an offer of judgment with the clerk of court before trial, and the defendant must either accept the offer or risk a high penalty if the judgment at trial goes against the defendant. The state does not impose a cap on damages recoverable in medical malpractice actions and does not require the reference of medical malpractice panels to an arbitrator or screening panel. Under the Nurse Practice Act each APRN who provides direct patient care must maintain professional liability insurance or other indemnity against liability for professional malpractice for injury or death in the amount of not less than \$500,000 for one person, per occurrence, with an aggregate of not less than \$1.5 million.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

### STATE: DISTRICT OF COLUMBIA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), NP (Nurse Practitioner), CNP (Certified Nurse Practitioner), and CRNP (Certified Registered Nurse Practitioner)

**Number of NPs in district:** 1161

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** An NP applicant must submit evidence of current national certification by a national certifying body approved by the BON.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** No.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Approved NPs are issued a certificate to practice.

**Supervised practice hours required before full NP practice autonomy?** Yes. Once an individual graduates from an NP program they must work and be supervised by an APRN until they are fully licensed; the R&R specify that only an APRN can supervise an APRN during this time.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** No.

**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** To maintain national NP certification: 24 contact hours every 2 years required for RN. For APRN license: 15 CE contact hours in pharmacology every 2 years.



**BON mechanism for others to verify NP license?** Yes. A person can verify an NP's licensure status on the Health Professional Licensing Administration website (<http://app.hpla.doh.dc.gov/weblookup/>).

**Current listing of all active NP licenses maintained by BON?** Yes. A person can look up all active NPs on the Health Professional Licensing Administration website (<http://app.hpla.doh.dc.gov/weblookup/>) and can purchase a mailing list.

**Current listing of authorized NP prescribers maintained by BON?** N/A

**If so, is this a separate list from all active NP licenses?** N/A

**Recent legislative changes affecting NP practice?** No

**Legislative/administrative plans for state?** The BON will be revising the APRN regulations; one proposed rule change will require a master's degree for NP practice. Passage is anticipated in 2014. The DC NP Association (NPADC) is monitoring the implementation of healthcare reform for opportunities and impact on NP practice.

**Internet address for Nurse Practice Act:** [www.hpla.doh.dc.gov](http://www.hpla.doh.dc.gov)

#### NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** 'The practice of advanced practice registered nursing (APRN) means the performance of advanced-level nursing actions, with or without compensation, by a licensed & BON approved certified to include: (A) Advanced assessment; (B) Medical diagnosis; (C) Prescribing; (D) Selecting, administering, and dispensing therapeutic measures; (E) Treating alterations of the health status; and (F) Carrying out other functions identified in Health Occupations Revision General Amendment Act of 2009' as incorporated into D.C. STAT. § 3-1201.02 (02). Hospitals, facilities, and agencies, in requiring specific levels of collaboration and licensed healthcare providers in agreeing to the levels of collaboration, shall apply reasonable, nondiscriminatory standards, free of anticompetitive intent or purpose. The Washington Area Metropolitan Transit Authority (WMATA) includes NPs as qualified professionals to certify eligibility for people with disabilities to have reduced fare or use special features.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. A controlled substance registration number issued by the Department of Health.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Washington DC Division Office, Techworld Plaza, 800 K Street NW, Suite 500, Washington, DC 20001, p: 1-877-801-7974

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Not spelled out in the pharmacy law, but BON and Board of Pharmacy opinion is that NPs as independent practitioners with Rx authority can receive and dispense drug samples.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Not excluded but not included (i.e., no requirement for NP reimbursement).

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. For example, the medical insurer CareFirst BCBS allows NPs to participate as independent PCPs in its network.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Georgetown University—Washington; (2) The Catholic University of America—Washington; (3) Howard University— Washington; (4) The George Washington University—Washington

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Catholic University of America; George Washington University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** NPADC ([www.npadc.org](http://www.npadc.org))

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 95

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

*\*Pearson Report 2014 update: DC still deserves high ranking of "A."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **5 for NPs<sup>†</sup>** (1161 in state<sup>‡</sup> results in a **1:232 ratio**)
- **1593 for MDs/DOs/Interns/Residents** (9966 in state<sup>‡</sup> results in a **1:6 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (Individuals) (1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (1161 in state<sup>‡</sup> results in a **0 ratio**)
- **338 for MDs/DOs/Interns/Residents** (9966 in state<sup>‡</sup> results in a **1:29 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** The District of Columbia follows the doctrine of contributory negligence in medical malpractice cases; thus, a claimant's contributory negligence bars his recovery entirely. There is no cap on the amount of damages recoverable in a medical malpractice action. There is a system of arbitration, under which all cases are eligible; the arbitrator's award may be entered in court and has the same force and effect as a final judgment. Following arbitration, every party is afforded the right to a subsequent civil trial.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** DELAWARE

**NP title(s) used in this state:** APN (Advanced Practice Nurse), CRNP (Certified Registered Nurse Practitioner), and NP (Nurse Practitioner)

**Number of NPs in state:** 831 active licensed NPs

**NP specialties legislatively specified?** Yes.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Defined as that area of practice in which an APN has a master's degree or a post-basic program certificate in a clinical nursing specialty with national certification.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes (generally). When no national certification at the advanced level is available, 1000 hours of supervised practice is required.

**BON sole state authority over NPs?** Yes (for those APNs who do not perform independent acts of diagnosis or prescription). No (for NPs who are performing independently without guidelines and protocols, as they are regulated by a Joint Practice Committee [JPC], which consists of 9 members: 1 public member and 5 APNs appointed by the BON, 1 pharmacist appointed by the BOP, and 2 physicians appointed by the Board of Medical Licensure and Discipline [BMLD]).

**MSN required for practice?** No. NP may have either a master's degree or a post-basic program certification in a clinical nursing specialty with national certification.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** NPs who are practicing independently practice and prescribe without written guidelines or protocols but with a collaborative agreement with a licensed physician, dentist, podiatrist, or licensed Delaware healthcare delivery system and with the approval of the Joint Practice Committee.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Separate APN license.

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**Supervised practice hours required before full NP practice autonomy?** APNs must practice a minimum of 1500 hours in the last 5 years or 600 hours in the past 2 years in the area of specialization in which licensure is granted. APN graduates of a master's program in a clinical nursing specialty for which there is no certifying examination must show evidence of at least 1000 hours of clinical nursing practice within the past 24 months.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. At least 30 hours of advanced pharmacology- and pharmacotherapeutics-related CE within the 2 years prior to application for independent practice and/or independent prescriptive authority. This may be a CE program or a 3-credit, semester-long graduate-level course. The 30 hours may also occur during the APN's program as integrated content as long as acceptable to the JPC.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** As per each NP's requirements for maintaining national certification in their specialty. To maintain Rx authority the NP must have 10 JPC-approved pharmacology CE hours in their specialty every 2 years.

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**BON mechanism for others to verify NP license?** Yes. Online at the Department of State Division of Professional Regulation ([www.dpr.delaware.gov](http://www.dpr.delaware.gov)).

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**Current listing of all active NP licenses maintained by BON?** Yes. But does not include mailing addresses.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. SB 59 relates to the regulation of the manufacture, distribution, and dispensing of controlled substances and to the Delaware Prescription Monitoring Program. SB 114 established chaperone requirements for providers' treatment and examination of minors.

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**Legislative/administrative plans for state?** Yes. The Advanced Practice Committee of the Board plans to introduce consensus model legislation next year.

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**Internet address for Nurse Practice Act:** [www.dpr.delaware.gov](http://www.dpr.delaware.gov)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Authorized NPs perform independent acts of diagnosis or prescription and are granted authority by the BON; APNs may perform independent acts of diagnosis and/or prescription with the collaboration of a licensed physician, dentist, podiatrist, or licensed Delaware healthcare delivery system without written guidelines or protocols and within the SOP as defined in the R&R promulgated by the JPC and approved by the BOM.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes. Depending on the type of practice, a collaborative agreement may be written verification of healthcare facility–approved job description and/or clinical privileges, and/or a written document outlining the consultation, referral, and/or hospitalization plan between an APN and a licensed physician, dentist, podiatrist, or licensed Delaware healthcare delivery system.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** Yes. It must be submitted to the JPC for those with Rx authority.

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**If so, is agreement required to be kept/stored/updated?** Yes. APNs must update their collaborative agreement when deleting old or adding new collaborators. The collaborative agreement information must be current for all APNs.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** APNs are required to practice within established guidelines/protocols. Guidelines/protocols are suggested pathways to be followed by an APN for managing a particular medical problem; they may be developed collaboratively by an APN and a licensed physician, dentist, a podiatrist, or licensed Delaware healthcare delivery system.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** No.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. If the APN has prescriptive authority or is practicing “independently” without guidelines/protocols.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes. The names and credentials of qualified APN applicants will be forwarded to the JPC for approval and then forwarded to the BMLD for review and final approval.

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**If so, what words are used to characterize involvement?** R&R regarding the independent practice and prescriptive authority of APNs are the responsibility of the JPC, subject to the approval of the BMLD.

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**NP authorized to Rx controlled substances?** Yes. Those with Rx authority.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Yes. Those with Rx authority.

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**If so, what is DEA area field office info?:** Philadelphia Division Office, William J. Green Federal Building, 600 Arch Street, Room 10224, Philadelphia, PA 19106, p: 1-888-393-8231.

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. Those with Rx authority.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In Board of Pharmacy statute and in BON R&R: for APNs without Rx authority, dispensing of drugs, medications, or therapeutics are not independent of the supervision of a physician, dentist, or podiatrist. Those APNs with Rx authority may request and issue professional samples of legend, including Schedule II–V controlled substances and properly labeled over-the-counter medications.

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**Specified limitations or restrictions on NP drug sampling?** No. (*See above.*)

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Delaware—Newark;  
(2) Wilmington College—New Castle

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** None

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** APN Council connected with the Delaware Nurses Association (<http://www.delapn.org/>)

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 77

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state still deserves ranking of "C."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

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Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports  
(9/1/1990–3/30/2013):



- **6 for NPs<sup>†</sup>** (831 in state<sup>†</sup> results in a **1:139 ratio**)
- **1019 for MDs/DOs/Interns/Residents** (4838 in state<sup>†</sup> results in a **1:5 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (831 in state<sup>†</sup> results in a **0 ratio**)
- **212 for MDs/DOs/Interns/Residents** (4838 in state<sup>†</sup> results in a **1:23 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Any medical malpractice action, whether for injury or death, must be brought within 2 years after the date of the injury. The state has adopted the modified doctrine of comparative negligence. Under this doctrine, a claimant’s action is barred if his negligence exceeds the combined negligence of all defendants; otherwise, the claimant’s recovery is diminished in proportion to his degree of negligence. There is no limit on the damages a claimant may recover. There is a system of mandatory malpractice review panels that is designed to prevent controversies from advancing to litigation; the panel will advise the court whether the evidence supports the conclusion that the defendants failed to comply with the standard of care.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** FLORIDA

**NP title(s) used in this state:** ARNP (Advanced Registered Nurse Practitioner)

**Number of NPs in state:** 12,910 (active) NPs; 18,105 total (active) Advanced Practice Nurses

**NP specialties legislatively specified?** ARNP includes NP specialties, CRNAs, CNMs, and CNSs

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Defined by educational credential and language in the Nurse Practice Act.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Effective July 2006: all new applicants for ARNP must have national certification.

**BON sole state authority over NPs?** No. The Florida Department of Health requires that all practitioners, including ARNPs, file information in a mandatory practitioner profile questionnaire for both initial certification and renewal. It is each practitioner's responsibility to keep the practitioner profile (made public after practitioner verification) current. There is joint BON–BOM control over advance practice protocols (available on the Web as of July 2006).

**MSN required for practice?** Yes. Except for those “grandfathered” in.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes.

**Physician involvement required for any aspect of practice?** Yes. For medical acts and prescribing.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** General supervision by a Florida licensed physician or dentist is required for the ARNP protocol.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. But new law specifies that all healthcare licensees must provide notice to patients of what type of license they have, with name tag and advertising requirements. A bill requiring NPs with a doctorate to inform patients that they are not medical doctors before using the title “Doctor” in a clinical setting died in committee in 2013 (the FL Medical Association is expected to refile the bill in 2014).

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Qualified applicants are issued an ARNP license number listed on their RN license; their specialty area is listed on the license. A July 2009 addition to the Florida statutes disqualifies health professionals from licensure if they have been convicted of or plead guilty or nolo contendere to certain felonies involving drugs, abuse, violence, or fraud unless the sentence and

any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application; thus, the BON is precluded from issuing a license or admitting a candidate for application. Those that seek renewal are not restricted if the applicant was convicted prior to renewal. The BON has posted further information on the ARNP licensing web page under the heading of “Health Care Fraud; Disqualification for License, Certificate, or Registration.”

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for controlled substance prescribing?** N/A

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** CE records are housed in the electronic tracking system and reviewed by the Department of Health, Division of Medical Quality Assurance at the time of renewal. All RNs must complete 24 hours of appropriate CE during each 24-month renewal period. One contact hour is required for each calendar month of the licensure cycle, including 2 hours on prevention of medical errors. An HIV/AIDS course is now a one-time 1-hour CE requirement to be completed prior to the first renewal. Domestic violence CE is now a 2-hour requirement every third renewal. Starting in 2015, there will be a 2-hour CE requirement to include laws and rules that govern the practice of nursing. RNs who also hold an ARNP certificate may satisfy the CE requirements for both licenses by completing appropriate courses for an RN, or may satisfy up to 50% of the requirement by completing continuing medical education coursework.

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**BON mechanism for others to verify NP license?** There is a statewide computer system under the DOH called Medical Quality Assurance Profiling that can be used to verify profiled practitioners ([ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP](http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP)).

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**Current listing of all active NP licenses maintained by BON?** Yes. Available as a free download, ASCI file format.

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**Current listing of authorized NP prescribers maintained by BON?** No. All NPs can Rx. There is an extra dispensing license required if “selling” or distributing packaged meds (not samples).

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** In 2011, there was a favorable FTC ruling on removing some SOP limitations, but no change to date in the legislation. Florida has a recent mandatory controlled substance reporting system. Florida-approved prescribers (which as of October 2011 includes NPs) gained access to the prescription drug-monitoring database, E-FORCSE, to request patient advisory reports (PARs). PARs report patients’ controlled substance prescription histories; PARs may assist healthcare practitioners in determining if a patient is “doctor shopping” or trying to obtain multiple prescriptions for controlled substances from multiple healthcare practitioners — a felony in the State of Florida. Effective July 1, 2013, SB 0536/HB 0413 “Relating to Physical Therapy” authorizes Physical Therapists to implement physical therapy treatment plans of a specified duration that are provided by ARNPs.

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**Legislative/administrative plans for state?** Yes. Legislative changes and/or plans to expand to full SOP for NPs in Florida, including (1) expand Rx authority to include DEA prescriptive authority as Florida is the only state without controlled substance prescribing authority for NPs; (2) allow signature of NPs on certain death certificates when the NP was the designated provider; (3) seek authorization to involuntarily commit patients under the Florida Mental Health Act (Baker Act); (4) obtain requirements that in-house pharmacists recognize the postoperative orders of CRNAs and CNMs; (5) seek inclusion as a PCP in any Medicaid/Medicare reform measures; and (6) increase the number of insurance companies who recognize ARNPs as PCPs. ARNP and PA SOP has become a legislative priority for certain influential bodies in Florida in the past year (see <https://flanp.org/files/Fl-Tax-watch-ARNPs.pdf>).

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**Internet address for Nurse Practice Act:** <http://www.floridasnursing.gov/>

*\*new URL*

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The degree and method of general supervision, determined by the ARNP and the physician or dentist, must be specifically identified in the written protocol and shall be appropriate for prudent healthcare providers under similar circumstances. Samples of protocols used are available on the BON website.

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**Required physician record/chart review?** Yes. NPs can see patients referred for specialty care as long as the patient is informed of the credentials of the practitioner they will see and agrees with this. The supervising/collaborating physician in a specialty practice must review and co-sign the specialty medical consultation report that must be sent to the referring practitioner within 10 working days after the visit.

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**Required NP/physician practice agreement?** Yes. A practice protocol is required that must be filed biannually at license renewal with review/oversight by the BON to ensure the protocol meets the standards for protocols.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** Yes. The original is filed with the BON by the ARNP; a notice is filed with the BOM by the supervising physician.

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**If so, is agreement required to be kept/stored/updated?** A copy of the original protocol and a copy of a required notice must be kept at the practice site by each party of the protocol. After the termination of the relationship between the ARNP and the supervising professional, each party is responsible for ensuring that a copy of the protocol is maintained for future reference for 4 years.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes. (*See above.*)

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** Yes. The original is filed with the BON by the ARNP; a notice is filed with the BOM by the supervising physician.

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**If so, are protocols required to be kept/stored/updated?** The ARNP's original protocol is filed with the BON. The physician's notice is filed with the BOM. If there are no changes to the protocol only a dated signature page is needed with a statement that there have been no changes or amendments since the last submission.

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**Any legislative prohibitions against NP hospital privileges?** No. Most NPs can get privileges in hospitals at some level. However, CNMs have difficulty obtaining OB privileges in private hospitals.

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**Additional limitations/clarifications/expansions to NP practice?** A physician may supervise ARNPs offering primary care services at no more than four satellite offices in addition to the primary place of practice. In any medical practice there must be a sign or notice posted stating when the physician is in the office, but there is no set requirement for physician presence. A physician may supervise ARNPs offering specialty services at no more than two satellite offices in addition to the primary place of practice. A Board-certified/eligible physician in plastic surgery or dermatology must supervise ARNPs offering primarily dermatologic or skin care at no more than one satellite office in addition to the primary place of practice; there are additional specifications including mile specifications for the satellite clinics and rules regarding posting the physician's schedule. Only Board-certified psychiatric nurses (RNs, NPs, and CNSs with master's or doctorate degree with 2 years post-master's degree experience) can sign for Baker Act (involuntary examination) of a patient (<http://www.myflfamilies.com/service-programs/mental-health/baker-act-manual> [new URL]). However, an Attorney General ruling in 2008 stated that PAs are covered to order involuntary exams under the current statute. A 2009 bill requires that laboratories accept specimens from ARNPs. A 2013 law authorizes Physical Therapists to implement physical therapy treatment plans of a specified duration that are provided by ARNPs.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. The written approval in the protocols by the supervising practitioner gives the ARNP prescriptive privileges. The protocol states which medications can be prescribed (i.e., generic and broad drug categories that the supervising physician has agreed the ARNP may prescribe).

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**NP/physician prescriptive agreement required?** Yes. Prescriptive categories/list that is mutually approved (per protocols).

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The ARNP protocol contains a description of the duties of the physician or dentist, which shall include consultant and supervisory arrangements in case the physician or dentist is unavailable.

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**NP authorized to Rx controlled substances?** No.

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**If so, what schedules?** N/A

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** No.

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**If so, what is DEA area field office info?** N/A

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**DEA number required for nonscheduled as well as scheduled Rx?** N/A

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**NP name on Rx pad?** Yes. New Rx label act in 2003 requires RPh (registered pharmacists) to list NPs, but this has been problematic because RPhs sometimes have trouble being reimbursed (NPs are not credentialed under insurance plans). Many NPs successfully provide their national provider identifier to RPh.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes. Some RPhs are not following the law due to reimbursement issues because the NP is not recognized as a PCP and thus payment to the pharmacy is delayed or denied. While complaints have been made to MQA/BOP, no RPh has been disciplined for not following this labeling law. NP organizations are working with major insurance providers to clear up this issue.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Under Florida Department of Health rules, all dispensing practitioners must be registered and hold a dispensing license for an extra fee of \$100. Dispensing is defined as selling medicinal drugs to patients in the office. A prescriber who provides complimentary samples is not by law a “dispensing practitioner” and therefore does not need to register with the Department.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No. But many NPs have reported on the listserv that they have difficulty getting mail order/Internet prescriptions filled. Despite the law that prevents Florida NPs from writing for controlled substances, Florida-based mail-order pharmacies do fill out-of-state prescriptions by NPs who hold a DEA number.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** No.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Florida has enacted legislation requiring all Medicaid patients to be enrolled in HMOs. Although the Florida Agency for Health Care Administration states that NPs qualify as PCPs for Medicaid HMOs, some insurance providers have stated that they will not empanel ARNPs due to practice limitations in Florida, specifically lack of DEA prescribing rights and the requirement for “general” supervision by a physician. Many insurance providers are also not recognizing NPs as PCPs on Medicare HMO and Advantage panels. BCBS of Florida announced a new program in July 2009 to empanel NPs (and other APNs), but unfortunately they labeled this new group a “physician extender” panel. NP representatives of FNP and AANP Florida have met with BCBS and requested a title change. The aim is to have all NPs credentialed and reimbursed at 85% (same rate as Medicare), but this will be negotiated



individually as they roll out the program. Not all insurance companies credential NPs and many still bill under the practice or supervising physician. The Florida workers compensation statute now includes NPs and reimburses NPs at an 80% rate. NPs are currently able to bill under the 14 approved Medicaid HMO programs but only if certified for Medicaid “Fee for Service” (MediPass), which will cease to exist as patients are enrolled in Medicaid HMOs.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP Schools in state:** (1) Florida A&M University—Tallahassee; (2) Florida Atlantic University—Boca Raton; (3) Florida Gulf Coast University—Fort Myers; (4) Florida International University—North Miami; (5) Florida State University—Tallahassee; (6) University of Central Florida—Orlando; (7) University of Florida—Gainesville, Jacksonville; (8) University of North Florida—Jacksonville; (9) University of South Florida—Tampa; (10) Barry University—Miami Shores; (11) Florida Southern College—Lakeland; (12) Jacksonville University—Jacksonville; (13) Nova Southeastern—Palm Beach Gardens; (14) South University—Tampa, West Palm Beach; (15) University of Miami—Coral Gables; (16) University of Tampa—Tampa.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Barry University; Florida Atlantic University; Florida International University; Florida State University; Jacksonville University; NOVA Southeastern University; University of Central Florida; University of Florida; University of Miami; University of North Florida; University of South Florida

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Florida Association of Nurse Practitioners (<https://flanp.org>), Florida NP Network ([www.fnnpn.org](http://www.fnnpn.org)), Florida Nurses’ Association APN Council/Task Force ([www.floridanurse.org](http://www.floridanurse.org))

**Organized opposition to NP legislative or regulatory changes?** Yes. Tremendous opposition from the state medical associations.

**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 49

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: state still deserves ranking of “F.”*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 291 for NPs<sup>†</sup> (12,910 in state<sup>†</sup> results in a **1:44 ratio**)
- 27,538 for MDs/DOs/Interns/Residents (64,977 in state<sup>†</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active

license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **52 for NPs<sup>†</sup>** (12,910 in state<sup>‡</sup> results in a **1:248 ratio**)
- **3774 for MDs/DOs/Interns/Residents** (64,977 in state<sup>‡</sup> results in a **1:17 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** ARNPs must maintain professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000, or maintain a letter of credit in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000. (Physicians in Florida may practice without liability insurance due to a loophole in the legislation). 2013: CM&F and NSO now offer both occurrence and claims made policies in Florida. Lewis and Clark LTC RRG (formerly Sophia Palmer) ceased operations in 2012. 2011: Law provides emergency room practitioner limits on noneconomic damages of \$150,000 per claimant, with an aggregate of \$300,000. 2004: Exempts from civil liability manufacturers, distributors, or sellers of foods or nonalcoholic beverages a claim based upon a person’s weight gain or obesity. A medical malpractice action must be brought within 2 years from the date of the incident or from the date when the incident was or should have been discovered. The state adheres to the pure form of comparative negligence where a claimant’s award is diminished in proportion to the claimant’s fault, but the claimant’s fault, no matter how great, will not act as a bar to recovery. A claimant’s notice of intent to initiate medical malpractice litigation must include a verified written medical expert opinion corroborating that there are reasonable grounds to believe that each named defendant was negligent. Florida has established two patient compensation funds: (1) the Florida Birth-Related Neurological Injury Compensation Plan (provides compensation for birth-related neurological injuries without regard to the negligence of any healthcare provider); and (2) the Florida Patient Compensation Fund (a system of state-sponsored excess insurance for medical malpractice liability). An important arbitration program is the system of voluntary binding arbitration for the determination of damages, which basically gives defendants an option to limit



non economic damages in return for admitting liability. Several practices now require patients to sign an arbitration agreement waiving their right to a jury trial if a dispute over their medical care ever arises. 2003: A healthcare practitioner not insured by a medical malpractice or fund must report certain closed claim information to the Florida Department of Financial services, Office of Insurance Regulation. There is a cap on medical malpractice noneconomic damages at \$500,000 from each practitioner defendant and a total cap of no more than \$1 million total from all practitioner defendants (with a \$500,000 cap on pain and suffering). The law provides emergency room practitioner limits on noneconomic damages of \$150,000 per claimant, with an aggregate of \$300,000.

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**Recent state malpractice liability tort reform?** 2013: SB 1792 (effective July 1, 2013) clarifies a healthcare practitioner's or provider's right to legal counsel, authorizes a prospective defendant to interview a claimant's treating healthcare providers, and revises the qualifications of experts authorized to testify in medical negligence actions against a specialist. 2011: Waiver of sovereign immunity in tort actions, recovery limits, limitation on attorney fees, statutes of limitations, exclusions, indemnification, and risk management programs. Also, provided that the judgment interest rate will be based on the discount rate of the Federal Reserve Bank of NY for the previous 12 months (plus 4%). 2010: none. 2009: Class action reform provided that a stay of judgment is executed during interlocutory appeal. 2007–2008: none. 2006: Joint and several liability removed. Law barred application of the rule of joint and several liability in the recovery of all damages; law established venue reform to prohibit out-of-state residents from filing class action lawsuits unless the claim occurred or emanated from the state; required claimants to prove actual damages in order to maintain certain types of class actions. Law limited the amount a signatory can be required to pay to secure the right to appeal to \$100 million. Law limited the appeal bond amount in any civil action (except class actions) to \$50 million. 2005: Asbestos/silica litigation reform establishes minimum medical criteria for filing asbestos and silica claims; revises statute of limitations for filing asbestos and silica claims. 2003: Florida is one of the few states that allow doctors (not NPs) to go "bare" on the condition that they post a bond, establish an escrow account, or obtain an irrevocable letter of credit to cover malpractice verdicts up to \$250,000 and hang a sign in their waiting room informing their patients that they practice without insurance. Physicians electing to go bare practice mainly in Miami-Dade, Broward, and Palm Beach counties, where medical malpractice premiums were the highest.

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## THE PEARSON REPORT

**STATE:** **GEORGIA**

**NP title(s) used in this state:** NP (Nurse Practitioner) and APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 5729

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** NP specialty SOP is recognized by the BON's R&R consistent with the standards of practice of the Board-approved organization by which the NP is certified. The BON has listed the approved nationally recognized certifying organizations and biennially reviews and evaluates the certification process of these organizations. The SOP is defined by the national certifying board of the NP's specialty; their SOP is limited by state legislation and the R&R of other boards (pharmacy and medicine) if the NP applies for prescriptive authority.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. Certification is required initially, as well as for continued practice.

**BON sole state authority over NPs?** No. Authority to practice as an APRN is delegated under the Medical Practice Act. There are two statutes under which an NP can practice (employing protocols between the NP and physician): with or without prescriptive authority. For NPs practicing *without* prescriptive authority, the BON's R&R apply. For NPs practicing *with* prescriptive authority, a written Nurse Protocol Agreement submitted by the physician to the BOM for approval. This Nurse Protocol Agreement must conform to BOM R&R. The BOM has taken a much more aggressive stance in attempting to regulate APRNs in the past year.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes, as of 2013.

**Joint BON/BOM regulation over any aspect of practice?** Yes. For prescriptive authority under the terms of a nurse protocol agreement (defined by Official Code of Georgia, O.C.G.A. § 43-34-25, which is a written document mutually agreed upon and signed by an RN and a licensed physician, by which the physician delegates to that nurse the authority to perform certain medical acts; such acts shall include without being limited to, ordering dangerous drugs, medical treatments, or diagnostic studies). The BOM promulgates the R&R for the Nurse Protocol Agreement.

**Physician involvement required for any aspect of practice?** Yes.

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**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Delegation

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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** This is an issue of current controversy. The BON interprets the statute as having no prohibition on nurses using their terminal degree (under GA. CODE ANN. § 10-1-422 [2005], any individual who “uses the term ‘Doctor’ or ‘Dr.’ in conjunction with his name in any letter, business card, advertisement, sign, public listing, display, or circular of any nature shall designate the degree to which he is entitled by reason of his diploma of graduation from a school or other entity, professional or otherwise or the degree as honorary when an honorary acknowledgment has been made; any person willfully violating, with intent to defraud, shall be guilty of a misdemeanor.”) However, the BOM has stated a position that it is unlawful for nurses to use their terminal degree title in clinical situations, although it is acceptable in nonclinical settings. Clarification has been requested from both boards.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON adds authorization to RNs who meet the requirements to practice as APRNs. The APRN designation is added to the existing RN license. Additional initial and renewal fees are required, but there is no separate license.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No. NP may write for legend and controlled substances (except Schedules I and II) if allowed in the nurse protocol agreement (SB 480) effective July 1, 2006.

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**Additional pharmacology hours required for prescribing?** The BOM R&R state that if the APRN has written prescriptive authority, the delegating physician must ensure that the APRN receives pharmacology training annually and must keep record of it; there is no requirement specifying a minimum number of pharmacology CE hours.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** The NP must meet the CE requirements of his/her national certifying body to maintain certification. Certification is a requirement for NP authorization in the state. Legislation passed in 2013 mandates continuing education for all RNs.

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**BON mechanism for others to verify NP license?** Yes. Listed by RN license number on the BON website ([www.sos.state.ga.us/plb/rn](http://www.sos.state.ga.us/plb/rn)).

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**Current listing of all active NP licenses maintained by BON?** A roster request can be sent to [mamonk@sos.state.ga.us](mailto:mamonk@sos.state.ga.us). The number of APRN licenses by category is listed on the BON website. A roster of all NPs can be obtained through a written request and submission of a \$100 fee.

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**Current listing of authorized NP prescribers maintained by BON?** No. This is maintained by the BOM for those NPs who choose to practice under O.C.G.A. § 43-34-25.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative changes affecting NP practice?** Legislative changes reconstituted the BON, combining the RN and LN boards. For the first time, there is required APRN representation on the BON. Though they can order plain X-rays and ultrasound, NPs do not have the authority to order radiographic imaging tests such as MRI, CT, or nuclear medicine scans. SB 94 was passed in the state Senate to grant this authority and will be taken up by the House in the 2014 legislative session.

Mandatory continuing competency requirements for all RNs was also mandated by legislation, which was supported by the nursing community. The Georgia Pain Management Act was passed—a much needed action to control “pill mill” operations. However, APRNs are concerned that the statute is overly broad and gives unprecedented authority to the BOM to regulate pain management; CRNAs in particular are concerned about potential effects on practice.

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**Legislative/administrative plans for state?** Goals: removal of statutory restriction on APRNs ordering radiographic imaging tests (MRI, CT, etc.); authorization to prescribe Schedule II medications; and recognition as Primary Care Providers by various credentialing bodies, addressing regulatory and administrative barriers to full implementation of current statutory authority.

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**Internet address for Nurse Practice Act:** <http://www.files.georgia.gov/GCMB/Files/FAQs%20NP%20May%202010.pdf>

[www.lexisnexis.com/hottopics/gacode/](http://www.lexisnexis.com/hottopics/gacode/)

Enter “43-26-1” for the Nurse Practice Act, “43-34-23” for NP delegation by protocol without prescriptive authority, and “43-34-25” for the prescriptive authority statute.

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** An APRN is authorized to perform advanced nursing functions and certain medical acts that include but are not limited to ordering drugs, treatments, and diagnostic studies as are delegated by the physician via the Nurse Protocol Agreement.

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**Required physician record/chart review?** Yes. Physicians are required to review and sign 10% of all NPs’ medical records. All records of patients receiving a prescription for a controlled substance must be reviewed by a physician and the patient must be evaluated by a physician on at least a quarterly basis.

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**Required NP/physician practice agreement?** Yes. A written protocol is required.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** For the NP to have *written* prescriptive authority, the physician must submit the written nurse protocol agreement to the BOM for approval.

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**If so, is agreement required to be kept/stored/updated?** Yes. It must be reviewed, revised, or updated annually (but as of 2008 it is no longer necessary to provide annual updates to the BOM).

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Two different types of protocols, depending on whether or not the NP has written prescriptive authority.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** The requirement is for a protocol agreement to be written and reviewed annually and kept at the practice site. BON regulations apply. If written prescriptive authority, the Nurse Protocol Agreement must be filed with the BOM.

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**If so, are protocols required to be kept/stored/updated?** Yes.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** Protocol agreements define what medical acts are delegated to the NP. NPs cannot “employ a physician to be their delegating physician.” Radiographic imaging tests can only be ordered by NPs in “life threatening situations.” A 2009 cosmetic laser bill included APRNs (among other “medical practitioners”), addressed new provisions relating to the licensing of cosmetic laser practitioners, and changed certain provisions relating to the two levels of cosmetic laser services licenses. The NP may pronounce death but may not sign the death certificate. NPs can be delegated the authority to “sign, certify, and endorse all documents relating to health care provided to a patient within his or her authorized scope of practice.”

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes.

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**NP Rx from state authorized formulary required?** No. However, drugs must be listed in the nurse protocol agreement.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The BOM R&R require a quarterly chart review of 10% of charts. The delegating physician must be onsite 4 hours per month at each APRN practice location. The APRN may perform medical acts that include but are not limited to the ordering of drugs, medical devices, medical treatments, diagnostic studies, and (in certain life-threatening situations) radiographic imaging tests including CT, MRI, PET, nuclear scans.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Atlanta Division Office Registration, 75 Spring Street SW, Room 740, Atlanta, GA 30303, p: 1-888-219-8689

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** Yes. But not consistently implemented due to difficulties of third-party payer restrictions and technical difficulties in having systems able to put both names on the bottle.

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**Authority to receive/dispense drug samples spelled out?** Yes. Under HB 303, the facility must list the number and dosage of medical samples received. Under the nurse protocol agreement the APRN may distribute samples but needs to document this in the patient chart.

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**If so, where (e.g., statute, rules, opinion)?** O.C.G.A. § 43-34-25

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**Specified limitations or restrictions on NP drug sampling?** Yes.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** No. There is no statute that prohibits such recognition, but also no statute that mandates NP recognition as a PCP. Recognition by third-party payers is on a case-by-case basis and is rare except in extremely underserved areas.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Emory University—Atlanta; (2) Georgia State University—Atlanta; (3) University of Phoenix—Atlanta, Augusta, Columbus; (4) Albany State University—Albany; (5) Armstrong Atlantic State University—Savannah; (6) Brenau University—Gainesville; (7) Georgia College and State University—Milledgeville; (8) Georgia Southern University—Statesboro; (9) Kennesaw State University—Kennesaw; (10) Mercer University—Atlanta; (11) North Georgia College and State University—Dahlonega; (12) Valdosta State University—Valdosta; (13) Georgia Health Sciences University—Augusta

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Georgia Southern University; Mercer University at Georgia Baptist School of Nursing; Brenau University—Gainesville; Georgia College and State University; Georgia Health Sciences University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** United Advanced Practice Registered Nurses of Georgia (affiliated with AANP; [www.uaprn.org](http://www.uaprn.org)); GA NAPNAP (affiliated with the National Association of Pediatric Nurse Practitioners); The Coalition of Advanced Practice Registered Nurses (includes representatives from all APRN groups including CRNAs, CNMs, and CNSs; [www.caprnr.org](http://www.caprnr.org)); and the Georgia Nurses Association ([www.georgianurses.org](http://www.georgianurses.org))

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**Organized opposition to NP legislative or regulatory changes?** Definitely. The Medical Association of Georgia is strongly in opposition to NP autonomy. The Georgia Radiological Society is actively opposing SB 94 referenced previously.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 53

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

**\*Pearson Report 2014 update: state still deserves ranking of "F."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **32 for NPs<sup>†</sup>** (5729 in state<sup>‡</sup> results in a **1:179 ratio**)
- **8504 for MDs/DOs/Interns/Residents** (31,782 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **11 for NPs<sup>†</sup>** (5729 in state<sup>‡</sup> results in a **1:521 ratio**)
- **2002 for MDs/DOs/Interns/Residents** (31,782 in state<sup>‡</sup> results in a **1:16 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Georgia has a 2-year statute of limitations running from the date of injury or death and a 5-year statute of “ultimate repose and abrogation,” and has adopted a variation of comparative negligence (i.e., the claimant’s recovery is diminished in proportion to his degree of negligence). There is no cap on the amount of compensatory damages that may be awarded, except that punitive damages are capped at \$250,000 unless the claimant can successfully demonstrate that the defendant had intent to harm. The parties in a medical malpractice action may, by agreement, request an appointment of a referee, but the agreement cannot be made prior to the alleged act of malpractice and the claimant must be represented by an attorney.

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**Recent state malpractice liability tort reform?** 2008–2013: None. 2007: Establishes objective medical criteria required to bring asbestos or silica claims. 2006: Establishes that a party declining a settlement offer is potentially liable for attorney fees and costs if the defendant is not found liable. 2005: Provides for comparative negligence amongst all cases; strengthens expert witness rules and requirements; allows courts to dismiss cases with little or no connection to the venue; provides that expressions of sympathy, regret, apology, etc. by healthcare providers are inadmissible as evidence and do not constitute an admission of liability; decreases liability for claims arising from emergency medical care; limits noneconomic damages to \$350,000 per healthcare provider to a total of \$1.05 million in aggregate; and exempts from civil liability manufacturers and producers of food for claims arising out of weight gain or obesity or health claims.

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## THE PEARSON REPORT

**STATE:** HAWAII

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), NP (Nurse Practitioner)

**Number of NPs in state:** 807 active APRNs as of April 14, 2013

**NP specialties legislatively specified?** Yes. HAW. REV. STAT. § 457-8.5(a)(4)

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** APRN SOP is generally defined in HAW. REV. STAT. § 457 and further clarified in HAW. ADMIN. § 16-89. BON also has authority to adopt provisions of the NCSBN's Model Nursing Practice Act and NCSBN's Model Nursing Administrative Rules.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. However, if applicant was an APRN or NP in another state prior to October 1, 2009, applicant may apply for Hawaii APRN with either MSN or verification of current national certification and unencumbered licensed as an APRN in another state.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. (*See above regarding national certification.*)

**Requirement for APN member on BON?** Yes (APRN).

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The applicant for a Hawaii APRN license must hold a Hawaii RN license. The RN and APRN licenses are issued separately and the RN must be maintained for the APRN license.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** Yes. A course in advanced pharmacology from an accredited nursing program or 30 hours of CE in pharmacology are required within the 3 years preceding the submission date of the APRN-Rx application. Eight hours of pharmacology and 22 hours of substantive CE in specialty area are required to renew the APRN-Rx license.

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**CE requirements for NP practice?** Thirty hours of CE are required for prescriptive authority.

**If so, what are the specifics?** Per HAW. ADMIN. § 16-89-123(a)(2): “Documentation of successful completion, during the prior biennium, of thirty contact hours of appropriate continuing education as determined by the board in the practice specialty area, eight contact hours of which shall be in pharmacology, including pharmacotherapeutics, related to the APRN’s clinical practice specialty area, approved by board-recognized national certifying bodies, the American Nurses Association, the American Medical Association, or accredited colleges or universities. Documentation of successful completion of continuing education required for recertification by a recognized national certifying body, earned within the current renewal biennium, may be accepted in lieu of the thirty hours of continuing education required for renewal.”

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**BON mechanism for others to verify NP license?** Online at the BON ([www.hawaii.gov/dcca/pvl/boards/nursing](http://www.hawaii.gov/dcca/pvl/boards/nursing)).

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**Current listing of all active NP licenses maintained by BON?** Available online by request and nominal fee or by written request with nominal reproduction fee. No confidential information (residence address or Social Security Number) is disclosed.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative changes affecting NP practice?** PENDING approval by Governor, a new bill will allow an APRN with prescriptive authority to provide expedited partner therapy to partners of the patient under certain conditions. The BON amended administrative rules (effective March 28, 2013) to align with recent statute amendments to eliminate the issuance of a separate APRN-Rx license.

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**Legislative/administrative plans for state?** The Hawaii Center for Nursing submitted a resolution to the state legislature to form a task force to identify laws and/or administrative rules of other state departments that restrict an APRN from practicing to their full extent.

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**Internet address for Nurse Practice Act:** [http://hawaii.gov/dcca/pvl/boards/nursing/statute\\_rules](http://hawaii.gov/dcca/pvl/boards/nursing/statute_rules) (go to “Statute/Rule Chapter.”)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. APRN-Rxs must file a separate application for prescriptive authority.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** Yes. An exclusionary formulary.

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**If so, explain specifics of formulary.** The DCCA may be asked by the BON to convene a Joint Formulary Advisory Committee (JFAC) if needed. The JFAC is composed of two BON-appointed APRNs, two BOM-appointed physicians, three pharmacists appointed by the BOP, one medical faculty person, and one school of nursing person. The JFAC recommends the applicable formulary. The BON considers the recommendations of the JFAC in adopting the exclusionary formulary.

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V, HAW. ADMIN. § 329, the Uniform Controlled Substances Act under the purview of the Department of Public Safety, Narcotics Enforcement Division (DPS-NED).

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**NP issued Rx number by state?** Yes. By DPS-NED.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?** DEA website

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**DEA number required for nonscheduled as well as scheduled Rx?** No (scheduled only).

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes. However, this issue is not addressed in BON laws or rules; this is a pharmacy labeling practice issued pursuant to HAW. ADMIN. § 328, the Food, Drug, and Cosmetics Act, under the purview of the Department of Health, Food, and Drug Branch.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** HAW. REV. STAT. § 457-8.6(d)(1)

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**Specified limitations or restrictions on NP drug sampling?** Yes.

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**Restrictions on out-of-state NP Rx being filled in this state?** Not addressed in BON laws or rules. “Out-of-state practitioner” is defined in HAW. REV. STAT. § 328, under the purview of the Department of Health, Food, and Drug Branch.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS THAT MAY AFFECT NP PRACTICE

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**Number and listing of NP schools in state:** (1) Hawaii Pacific University—Kaneohe; (2) University of Hawaii at Manoa—Honolulu; (3) University of Phoenix—Honolulu.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Hawaii at Hilo

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Hawaii Association of Professional Nurses

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**Organized opposition to NP legislative or regulatory changes?** The Hawaii Medical Association has been a consistent opponent, but in recent years there has been more cooperation between the medical and nursing communities.

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**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 55

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: state now deserves higher ranking of “A-.”*

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## Cumulative number of National Practitioner Data Bank (NPDB) filings:

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

■ **5 for NPs<sup>†</sup>** (807 in state<sup>‡</sup> results in a **1:161 ratio**)

■ **1072 for MDs/DOs/Interns/Residents** (8671 in state<sup>‡</sup> results in a **1:8 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **3 for NPs<sup>†</sup>** (807 in state<sup>‡</sup> results in a **1:269 ratio**)
- **286 for MDs/DOs/Interns/Residents** (8671 in state<sup>‡</sup> results in a **1:30 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A medical malpractice action for injury or death must be brought within 2 years of the time the claimant discovers or reasonably should have discovered the injury (as long as it is within 6 years). Hawaii has adopted the doctrine of modified comparative negligence (i.e., a claimant’s action is barred if his negligence exceeds the combined negligence of all defendants). No expert opinion is required before filing a medical malpractice negligence complaint. By statute, recovery of damages for pain and suffering is limited to \$375,000. Medical claims conciliation panels must review potential cases and issue advisory opinions on liability and damages. Review by the conciliation panel is a prerequisite to filing a complaint in court.

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**Recent state malpractice liability tort reform?** 2007–2012: None. 2006: Limited the appeal bond to \$25 million regardless of the amount of judgment. 2005: None.

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## THE PEARSON REPORT

**STATE:** IDAHO

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner) and APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 841

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Per the BON's R&R, in addition to the core standards, APRNs must practice consistent with the definition of advanced practice nursing, recognized national standards, and the standards set forth in the R&R. A decision-making model is applied by the BON to determine an RN and an APRN's SOP. The APRN can determine if a specific function can be performed legally by determining if the act is (1) expressly forbidden in the Nurse Practice Act R&R; (2) was part of APRN's curriculum and APRN determines own ability to perform safely; (3) appropriate for practice setting and APRN's national standards.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. APRNs who completed a nationally accredited undergraduate or certificate APRN program prior to January 1, 2016 are exempt from the requirement for a graduate/post-graduate degree for initial licensure.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** The Advisory Committee to the BON addresses issues related to the advanced practice of nursing of NPs (and other APRNs). The Advisory Committee consists of four APRNs appointed by the BON, four physicians nominated by the BOM and appointed by the BON, one consumer appointed by the BON, and one pharmacist nominated by the BOP and appointed by the BON. The BON APRN member is ex-officio. The committee responds to BON questions regarding advanced practice nursing, considers non routine applications for Rx authority, makes recommendations to the BON, and recommends to the BON the SOP of advanced practice nurses, using national standards as a guideline. The BON cannot expand the SOP or prescriptive authority of an advanced practice nurse beyond that recommended by the Advisory Committee. Routine applications for Rx authority are managed by the BON staff following directives of the BON.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.



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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Two licenses are issued: the RN license and the NP license.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Thirty contact hours of pharmacology-specific formal instruction must be completed before Rx and dispensing authority is granted. APRNs who complete their APRN education after December 31, 2015 will automatically be granted prescriptive and dispensing authority with their APRN license. NP license renewal requires 30 contact hours of CE, including 10 hours in pharmacology if the NP has Rx authority. License renewal requires an NP to provide evidence of completion of a peer review process acceptable to the BON.

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**BON mechanism for others to verify NP license?** Available on BON website ([www.ibn.idaho.gov](http://www.ibn.idaho.gov)); there is a daily update.

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**Current listing of all active NP licenses maintained by BON?** Yes. Interested applicants can request a copy of this list after paying printing and mailing costs.

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**Current listing of authorized NP prescribers maintained by BON?** Yes. Interested applicants can request a copy of this list after paying printing and mailing costs.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative changes affecting NP practice?** Yes. Legislation passed in 2012 and the R&R adopted in 2013 became effective July 1, 2013 to bring Idaho into full conformance with the national consensus model for APRN regulation. Changes addressed titling, Advisory Committee membership, requirement for graduate/post-graduate education, and grandfathering provisions.

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**Legislative/administrative plans for state?** Plans are being formulated.

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**Internet address for Nurse Practice Act:** [www.legislature.idaho.gov/idstat/Title54/T54CH14.htm](http://www.legislature.idaho.gov/idstat/Title54/T54CH14.htm)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. The Advisory Committee is not involved in NP diagnosing or treating; the Advisory Committee advises the BON on issues related to licensure, discipline, defining SOP, and other issues directed by the BON.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs are allowed to sign death certifications, state disability parking, and state workman's compensation.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. Prescriptive authority is a process separate from licensure to practice; however, once granted, prescriptive authority renews automatically with NP licensure renewal. APRNs who complete their APRN education after December 31, 2015 will automatically be granted prescriptive and dispensing authority with their APRN license.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes (minimal).

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**If so, what words are used to characterize involvement?** The Advisory Committee to the BON addresses issues related to the advanced practice of nursing of NPs (and other APRNs). The Advisory Committee consists of four APRNs appointed by the BON, four physicians nominated by the BOM and appointed by the BON, one consumer appointed by the BON, and one pharmacist nominated by the BOP and appointed by the BON. The BON APRN member is ex-officio. The committee responds to BON questions regarding advanced practice nursing, considers non-routine applications for Rx authority, makes recommendations to the BON, and recommends to the BON the SOP of advanced practice nurses using national standards as a guideline. The BON cannot expand the SOP or prescriptive authority of an advanced practice nurse beyond that recommended by the Advisory Committee. Routine applications for Rx authority are managed by the BON staff following directives of the BON.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V if appropriate to APRN's defined SOP.

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**NP issued Rx number by state?** Yes. Through the BOP for controlled substances.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Seattle Division Office, 400 Second Avenue West, Seattle, WA 98119, p: 1-888-219-4261

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The Nurse Practice Act. The SOP of a BON Rx-authorized NP may include the prescribing and dispensing of pharmaceutical and non-pharmaceutical agents.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** No specific language, but there is nothing that prevents reimbursement.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP Schools in state:** (1) Idaho State University—Pocatello; (2) Boise State University—Boise

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) Program(s) in the state:** Idaho State University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation.*

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**Statewide NP association(s):** Very active statewide NP association: NP of Idaho ([www.NPIDaho.org](http://www.NPIDaho.org)).

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**Organized opposition to NP legislative or regulatory changes?** Yes. Traditionally from the state's medical association, but no activity since 2003.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 82

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state now deserves a higher ranking of "B+"*

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## Cumulative number of National Practitioner Data Bank (NPDB) filings:

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 18 for NPs<sup>†</sup> (841 in state<sup>†</sup> results in a **1:47 ratio**)
- 1012 for MDs/DOs/Interns/Residents (5130 in state<sup>†</sup> results in a **1:5 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- 10 for NPs<sup>†</sup> (841 in state<sup>†</sup> results in a **1:84 ratio**)
- 243 for MDs/DOs/Interns/Residents (5130 in state<sup>†</sup> results in a **1:21 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

**Relevant medical malpractice law applicable to NPs:** The limitation period applicable to medical malpractice actions for injury or death is 2 years from the time the cause of action. Contributory negligence of a claimant does not bar recovery if the claimant’s fault is less than the defendant’s fault. In any medical malpractice action, the claimant must prove by direct expert testimony that the defendant negligently failed to meet the applicable community standard of healthcare practice. All medical malpractice injury or death cases must be presented to a BOM-established hearing panel; the findings and determinations of the panel are inadmissible in any civil action.

**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Provides a civil liability exemption for a manufacturer, seller, or marketer of a food or beverage when the claim is for weight gain, obesity, a health condition associated with weight gain or obesity, or caused by food consumption.

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## THE PEARSON REPORT

**STATE:** ILLINOIS

**NP title(s) used in this state:** APN (Advanced Practice Nurse) and CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 5288

**NP specialties legislatively specified?** Yes, CNP, CNM, CRNA, and CNS.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification by one of the national certifying bodies listed in the Rules for Administration of the Nurse Practice Act.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** No. The “boards” for all of the health professions are all advisory in nature. Final authority rests with the Secretary of the Department of Financial and Professional Regulation.

**MSN required for practice?** Yes. The requirement is a graduate degree (not specifically an MSN) appropriate for national certification in a clinical advanced practice nursing specialty or post-master’s certificate from a graduate-level program.

**Requirement for APN member on BON?** The Board of Nursing and Advanced Practice Nursing Board is a single advisory board that provides oversight for LPN, RN, and APN practice. In addition to numerous LPN and RN representatives, there are four APN representatives, one each for CNPs, CNMs, CRNAs, and CNSs. There is no physician representation on the nursing board.

**Joint BON/BOM regulation over any aspect of practice?** The Nurse Practice Act stipulates that with the exception of emergency rules, any proposed rules, amendments, second notice materials, and adopted rule or amendment materials or policy statements concerning APNs shall be presented to the Medical Licensing Board for review and comment. The recommendations of both the Board of Nursing and the Medical Licensing Board shall be presented to the Secretary for consideration in making final decisions. Whenever the Board of Nursing and Medical Licensing Board disagree on a proposed rule or policy, the Secretary shall convene a joint meeting of the officers of each to discuss resolution of any disagreements. However, ALL rules for ALL acts are subject to a public comment period; therefore, APNs, as well as the general public, also have an opportunity to comment on any changes to the rules of the Medical Practice Act.

**Physician involvement required for any aspect of practice?** Yes.

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**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** A written collaborative agreement (WCA) shall describe the working relationship of the APN with the collaborating physician. The agreement authorizes the categories of care, treatment, or procedures to be performed by the APN. An APN may collaborate with a podiatrist if the APN is providing services within a podiatrist's SOP. A collaborating physician needs to only provide 'collaboration and consultation with the advanced practice nurse at least once a month'; no face-to-face meeting is required. CRNAs may also have a written agreement for anesthesia services with dentists. APNs who are credentialed and privileged in a hospital, hospital affiliate (as defined in the Hospital Licensing Act), or ambulatory surgical treatment centers may practice without a WCA. APNs working in these settings without a WCA may write discharge prescription medications, including controlled substances, if so privileged by their institution. The prescriptions must include the name of the APN and an attending or discharging physician.

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**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. But an APN must identify himself/herself as such.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** An APN must possess both an RN license and an APN license.

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**Supervised practice hours required before full NP practice autonomy?** None other than what are required in an APN's educational program in order to sit for a certification exam.

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**Supervised practice hours required before full NP prescribing autonomy?** N/A

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**Additional pharmacology hours required for prescribing?** APNs applying for a controlled substance license for the first time that also includes Schedule II authority must have completed at least 45 graduate contact hours in pharmacology; furthermore, APNs who prescribe Schedule II medications must annually complete 5 hours of continuing education in pharmacology.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Fifty hours of continuing education per 2-year license renewal cycle; APNs who prescribe Schedule II medications must annually complete 5 hours of continuing education in pharmacology.

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**BON mechanism for others to verify NP license?** Anyone can check a license at the IDFPR website (<http://nursing.illinois.gov/nursepracticeact.asp>).

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**Current listing of all active NP licenses maintained by BON?** The IDFPR keeps a separate list of all APNs; the list can be purchased. However, lists that are purchased from IDFPR do not indicate the APN specialty (i.e., NP, CNM, CRNA, or CNS).

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**Current listing of authorized NP prescribers maintained by BON?** The IDFPR list does not indicate those APNs with Rx authority.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** A bill was introduced in 2013 to remove the WCA requirement, but it was significantly amended. The bill that finally was passed provides clarification that the WCA shall be for services the collaborating physician generally provides or may provide in his or her clinical medical practice, which means categories of care or treatment—not specific tasks or duties—for which the physician has the experience and ability to provide collaboration and consultation. The Public Act 098-0192 bill also states that “Absent an employment relationship, a written collaborative agreement may **not**: (1) restrict the categories of patients of an advanced practice nurse within the scope of the advanced practice nurses training and experience, (2) limit third-party payors or government health programs, such as the medical assistance program or Medicare with which the advanced practice nurse contracts, or (3) limit the geographic area or practice location of the advanced practice nurse in this State.”

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**Legislative/administrative plans for state?** Goal is to continue to work on legislation that will provide more autonomy for NPs.

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**Internet address for Nurse Practice Act:** <http://www.ildpr.com/WHO/ar/apn.asp>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** APNs must have a WCA with a physician or podiatrist in order to practice as an APN; exceptions to the WCA requirement exist for those APNs who are credentialed and privileged to work in a hospital, hospital affiliate, or ambulatory surgical treatment center.

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**Required physician record/chart review?** Chart review is not specifically required, nor is cosigning charts. APNs with a WCA are to collaborate and consult with their collaborating physician at least once a month, but there is no requirement for a face-to-face meeting.

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**Required NP/physician practice agreement?** Yes.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No. However, a copy of the signed WCA (for those APNs who must have a WCA) must be available to the Board of Nursing and Advanced Practice Nursing Board upon request.

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**If so, is agreement required to be kept/stored/updated?** The APN's orders and services to patients must be periodically reviewed in accordance with accepted standards of medical practice and advanced nursing practice.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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**NP SCOPE OF PRACTICE—PRESCRIBING**

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**NP Rx authority granted separate from practice authority?** Rx authority must be stipulated in the WCA. For APNs without a WCA who work in a hospital, hospital affiliate, or ambulatory surgical treatment center, the authority for ordering or prescribing medications would be included in the APN's institutional privileges.

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**NP/physician prescriptive agreement required?** Yes. (Delegation must be stipulated in the WCA or institutional privileges.)

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** 'A collaborating physician or podiatrist may, but is not required to, delegate prescriptive authority to an advanced practice nurse as part of a written collaborative agreement.' APNs are authorized to prescribe legend medications and devices, including controlled substances, only upon written delegation of authority from a collaborating physician or podiatrist. The authority includes acceptance of samples and dispensing of over-the-counter, legend, and Schedule III–V controlled substance medications. A delegation of authority form shall be submitted to the Department prior to the issuance of a controlled substance license. APNs may only prescribe and dispense within the SOP of the collaborating physician.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedule II–V medications; Schedule II are limited to oral dosage, topical, and transdermal application. This delegation must identify the specific Schedule II controlled substances by either brand name or generic name. The prescription must be limited to no more than a 30-day oral dosage, with any continuation authorized only after prior approval of the collaborating physician. The APN must discuss the condition of any patients for whom a Schedule II or II-N is prescribed monthly with the collaborating physician.

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**NP issued Rx number by state?** Yes. An APN who has been delegated controlled substances prescriptive authority by the physician as part of the WCA shall be required to obtain an 'Illinois midlevel practitioner controlled substance license.'

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**NP authorized to apply for DEA number?** Yes. But they first must obtain an Illinois controlled substance license.

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**If so, what is DEA area field office info?:** Chicago Division Office, 230 S. Dearborn Street, Suite 1200, Chicago, IL 60604, p: 1-312-353-1234

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**DEA number required for nonscheduled as well as scheduled Rx?** Not legally. However, some reimbursement plans will not pay for prescriptions that do not have a DEA number.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes. All prescriptions written and signed by an APN shall indicate the name of the collaborating physician. The collaborating physician's signature is not required. Discharge prescriptions written by an APN without a WCA, but who is privileged by his/her institution, must include the name of the attending or discharging physician.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Nurse Practice Act

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**Specified limitations or restrictions on NP drug sampling?** Yes. The authority to Rx Schedule II controlled substances may not be delegated by the collaborating physician.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** There are no legislative prohibitions regarding reimbursement. In terms of Medicaid, APNs are eligible for reimbursement at the same rate as physicians and for an "enhanced rate" (available to certain providers who provide maternal-child services), and all types and categories of APNs (NPs, CNMs, CRNAs, and CNSs) are eligible for Medicaid reimbursement. However, most Medicaid recipients obtain their benefits through a Medicaid managed-care system, Illinois Health Connect, which is managed by a contracted entity, Automated Health Systems (AHS). APNs who wish to obtain PCP status under this program are required to petition the medical director of AHS for PCP status. Several APNs have been accorded PCP status. There are several managed-care companies that cover dual-eligible recipients (Medicare and Medicaid); many of these companies credential APNs as PCPs.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** There are no legal prohibitions and many APN are listed on provider panels.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP Schools in state:** (1) DePaul University—Chicago; (2) Governors State University—University Park; (3) Lewis University—Romeoville; (4) Loyola University Chicago—Chicago; (5) North Park University—Chicago; (6) Olivet Nazarene—Bourbonnais; (7) Resurrection University—Oak Park; (8) Rush University—Chicago; (9) Saint Francis Medical Center College of Nursing—Peoria; (10) Saint Xavier University—Chicago; (11) Southern Illinois University—Edwardsville; (12) University of Illinois at Chicago (Chicago, Peoria, Rockford, Rock Island, Urbana); (13) University of St. Francis—Joliet; (14) Illinois State University—Normal; (15) Northern Illinois University—DeKalb.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Governors State University; Illinois State University; Kaplan University; Lewis University; Loyola University Chicago; Rush University; Saint Francis Medical Center College of Nursing; Southern Illinois University Edwardsville; University of Illinois at Chicago; University of St. Francis.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The Illinois Society for Advanced Practice Nursing ([www.isapn.org](http://www.isapn.org))

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**Organized opposition to NP legislative or regulatory changes?** The sunset practice act of 2007 was rewritten via a bill negotiated by the Illinois Society for Advanced Practice Nursing, Illinois Nurses Association, Illinois State Medical Society, Illinois Hospital Association, and other organizations. Since that time there have been small changes to the practice act to facilitate APN practice; however, attempts to remove written collaborating physician requirement, including in 2013, have been unsuccessful.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 55

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: state now deserves a ranking of "D+."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 38 for NPs<sup>†</sup> (5288 in state<sup>‡</sup> results in a **1:139 ratio**)
- 16,262 for MDs/DOs/Interns/Residents (43,049 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- 13 for NPs<sup>†</sup> (5288 in state<sup>‡</sup> results in a **1:407 ratio**)
- 3489 for MDs/DOs/Interns/Residents (43,049 in state<sup>‡</sup> results in a **1:12 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** The Illinois Supreme Court determined years ago that legal experts testifying for or against a defendant in a malpractice suit must be from the same profession as the defendant. This law applies also to NPs named in malpractice suits.

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**Recent state malpractice liability tort reform?** 2011–2013: None. Illinois has twice adopted tort reform legislation that included caps on noneconomic damages for medical malpractice claims, but neither act remains in force due to constitutionality issues according to the Illinois Supreme Court. The most recent legislative action, the 2005 Medical Liability Reform Act, which would have limited the damage caps (noneconomic damages in medical liability cases to \$500,000 per physician and \$1 million per hospital), was deemed unconstitutional in 2010.

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## THE PEARSON REPORT

**STATE:** INDIANA

**NP title(s) used in this state:** APN (Advanced Practice Nurse) and NP (Nurse Practitioner)

**Number of NPs in state:** 3989

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification is accepted by the Board of Nursing, as specified in the R&R.

**NP title protection?** Yes.

**National certification required for recognition/practice?** No. Those who completed a certificate program, rather than an accredited graduate program, must be certified and maintain certification as an NP by a national organization, which requires taking a national certifying examination.

**BON sole state authority over NPs?** Yes. BOM-approved rules for prescribing but BOM has no further involvement.

**MSN required for practice?** No.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Under the NPA statute, APNs must operate in collaboration with a licensed practitioner (physician, dentist, podiatrist, or optometrist). Under the R&R, NP SOP includes consultation and collaboration with other members of the healthcare team as appropriate to provide reasonable client care and collaboration with or referral to a practitioner in managing the plan of care. For prescriptive authority the collaborative practice agreement must be in writing.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** No separate license is issued, but NPs with prescriptive authority are issued identification numbers by the BON.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. To obtain initial authority to Rx legend drugs the applicant must complete a graduate-level course in pharmacology of at least 2 semester hours of academic credit from an approved college (within the past 5 years), or as part of a degree program with specified collaborative experience as an APN (within the last 5 years) and complete 30 hours of CE in the past 2 years, of which at least 8 contact hours include pharmacology.

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**CE requirements for NP practice?** Yes. But applicable only to NPs with prescriptive authority.

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**If so, what are the specifics?** Following the initial prescriptive authority period, 30 hours of approved CE in each subsequent renewal period are required, of which at least 8 hours are in pharmacology.

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**BON mechanism for others to verify NP license?** Yes. The Indiana Professional Licensing Agency website (<http://www.in.gov/pla>).

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**Current listing of all active NP licenses maintained by BON?** No. There is no NP license.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** As of July 1, 2013, NPs can make referrals to Physical Therapists and certify an individual as eligible for a disability license plate.

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**Legislative plans for state?** To maintain the present status of Rx authority, SOP, and title protection; to be identified as designated Primary Care Providers within the state-managed Medicaid programs.

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**Internet address for Nurse Practice Act:** <http://www.in.gov/pla/2497.htm>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes. If the SOP also includes prescribing. IND. ADMIN. CODE tit. 848, r. 5-2-1 (Advanced Practice Nursing and Prescriptive Authority for Advanced Practice Nursing) states that “no Written Practice Agreement shall be necessary unless the Advanced Practice Nurse seeks prescriptive authority.”

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Under the NPA statute, all APNs are required to collaborate with a licensed practitioner as evidenced by a written practice agreement, or by privileges granted by the governing board of a hospital with the advice of the medical staff of the hospital, which defines the manner in which the APN and the licensed practitioner (physician, dentist, podiatrist, or optometrist) will cooperate, coordinate, and consult with each other in the provision of health care to their patients. Under the R&R, NP SOP includes consultation and collaboration with other members of the healthcare team as appropriate to provide reasonable care, and collaboration with or referral to a practitioner in managing the plan of care. R&R clarify that the collaborative agreement is only necessary for Rx authority.

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**Required physician record/chart review?** Yes. Five percent of a random sampling. See IND. ADMIN. CODE tit. 848, r. 5-7-(F).

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**Required NP/physician practice agreement?** Yes. But R&R clarify that the collaborative agreement is only necessary for Rx authority.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** BON

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**If so, is agreement required to be kept/stored/updated?** Yes. For changes and upon renewal of Rx authority.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/prohibitions to NP practice?** No. APNs have immunity for reporting examinations to the Bureau of Motor Vehicles. Additionally, APNs have the authority to order Occupational Therapy services and to sign handicapped driving stickers; an NP is also a member of the birth registry problems committee. APNs are legislatively prohibited from entering into a collaborative practice agreement with a Physician Assistant. NPs can make referrals to Physical Therapists and certify someone as eligible for a disability license plate.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. A collaborative practice agreement with a licensed practitioner must be reduced to writing if prescriptive authority is sought. The written practice agreement must describe any limitations the licensed practitioner has placed on the APN's Rx authority. Documentation of Rx practices must include at least a 5% random sampling of the charts and medications prescribed for patients. The BON is charged with conducting an audit of a random sampling of not less than 1% of all APN collaborative agreements every 2 years to ensure that they are in congruency with the law.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Decisions made by the BON regarding requirements for initial and renewed prescriptive authority must meet the approval of the BOM. Written practice agreements for APNs applying for Rx authority are not valid until Rx authority is granted by the BON.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V if permitted on the written practice agreement; only a physician can treat a patient with a Schedule III–IV drug for the purpose of weight reduction or obesity.

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**NP issued Rx number by state?** Yes. An identification number of an Indiana controlled substances registration is issued if the BON grants authority to an APN to Rx legend drugs.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Chicago Division Office, 230 S. Dearborn Street, Suite 1200, Chicago, IL 60604, p: 1-312-353-1236

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** No.

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**If so, where (e.g., statute, rules, opinion)?** N/A

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**Specified limitations or restrictions on NP drug sampling?** No. Except that APNs along with many other prescribing practitioners are subject to sanctions if they repackage and then sell free samples they received from the drug manufacturers.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Not specified.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Saint Francis—Fort Wayne; (2) University of Phoenix—Indianapolis; (3) Ball State University—Muncie; (4) Indiana State University—Terre Haute; (5) Indiana University—Indianapolis; (6) Indiana University—Purdue University (Fort Wayne); (7) Indiana Wesleyan University—Marion; (8) Purdue University—West Lafayette; (9) Purdue University—Calumet (Hammond); (10) University of Indianapolis—Indianapolis; (11) University of Southern Indiana—Evansville; (12) Valparaiso University—Valparaiso; (13) Goshen College—Goshen

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Ball State University; Indiana State University; Indiana University—Purdue University (Indianapolis); Purdue University; University of Southern Indiana; Valparaiso University.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Indiana State Nurses Association; APN Special Interest Forum ([www.IndianaNurses.org](http://www.IndianaNurses.org)); Coalition of Advanced Practice Nurses of Indiana ([www.capni.org](http://www.capni.org))

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 65

**Descriptive ranking:** Grade D. The state restricts patient choice.

**\*Pearson Report 2014 update: state still deserves ranking of "D."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **19 for NPs<sup>†</sup>** (3989 in state<sup>‡</sup> results in a **1:210 ratio**)
- **7343 for MDs/DOs/Interns/Residents** (26,512 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **6 for NPs<sup>†</sup>** (3989 in state<sup>‡</sup> results in a **1:665 ratio**)
- **778 for MDs/DOs/Interns/Residents** (26,512 in state<sup>‡</sup> results in a **1:34 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from the BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A medical malpractice action must be brought within 2 years from the date of the alleged act, omission, or neglect except where the long latency period of a medical condition prevents the injured party from discovering the malpractice within 2 years. A patient compensation fund functions as a system of excess insurance for healthcare providers. To become a "qualified provider," a healthcare provider must

file proof of financial responsibility (purchased malpractice liability) and pay the surcharge. All claims for more than \$15,000 against qualified providers must be heard by a medical review panel, which consists of one lawyer and three healthcare providers. The healthcare providers on the panel express an expert opinion about whether the evidence supports the conclusion that the defendant(s) acted or failed to act within the appropriate standards of care and, if so, whether that was a factor in the injury. The panel's opinion is admissible as evidence in any subsequent action but it is not conclusive.

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**Recent state malpractice liability tort reform?** 2010–2013: None. 2009: Jury service reform provides that an individual at least 75 years of age may be exempted from jury duty. 2007–2008: None. 2006: Legislation permits the Attorney General to negotiate and compromise a portion of punitive damages in medical liability cases. 2005: None.

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## THE PEARSON REPORT

**STATE:** IOWA

**NP title(s) used in this state:** ARNP (Advanced Registered Nurse Practitioner), CNP (Certified Nurse Practitioner), and NP (Nurse Practitioner) (The term “ARNP” also refers to Certified Clinical Nurse Specialist, Certified Nurse Midwife, and Certified Registered Nurse Anesthetist.)

**Number of NPs in state:** 1601

**NP specialties legislatively specified?** The BON approves the following specialty areas: ANP, FNP, GNP, NNP, PMHNP, PNP, SNP, WHCNP, ACNP, PNNP.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The SOP for the ARNP is defined in IOWA ADMIN. CODE § r. 655.

**NP title protection?** The ARNP title is restricted to those who are board certified in their specialty and recognized through registration with the BON. The NP title is not protected. RNs may practice at the advanced level without registration as an ARNP. Registration with the BON at the advanced level permits the nurse to use the title ARNP and authorizes the nurse to prescribe substances or devices within the nurse’s recognized nursing specialty.

**National certification required for recognition/practice?** ARNPs must be board certified in their specialty. National certification is not required for practice under the NP title.

**BON sole state authority over NPs?** Yes (for the ARNP).

**MSN required for practice?** ARNP applicants must have graduated from BON-approved master’s program or complete a formal advanced practice educational program with study in a nursing specialty area.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No. Per the BON, ARNPs may prescribe, dispense, admit, and treat independently. The ARNP does not have to have a collaborative agreement. As applicable to any RN working independently, ARNPs must practice within their educationally prepared SOP. Having a collaborative agreement with a physician is the decision of the physician and the ARNP, but it is not necessary. ARNPs must practice within their educationally prepared SOP area and they cannot practice medicine. An NP is someone who has graduated from an NP program and who may not prescribe independently without getting the ARNP designation and a DEA number; the other aspects of the NP’s SOP are limited only by their educational preparation in their scope of practice. IOWA ADMIN. CODE § r. 655-7.1(152) definition of ARNP is as follows: “...In the advanced role, the nurse practices nursing in assessment, intervention, and management within the boundaries of the

nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary healthcare team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.”

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**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The ARNP may perform selected medically designated functions when a collaborative practice agreement exists; the collaborative agreement is not required and “medically delegated functions” are not defined.

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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** There is no separate license to be an ARNP; instead there is additional BON registration.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** No.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** The ARNP CE requirements shall be met as required for certification by the relevant national certifying body. The NP not registered as an ARNP would need to meet the CE requirements of an RN.

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**BON mechanism for others to verify NP license?** ARNP verification is available online from the BON using the RN license number ([www.nursing.iowa.gov](http://www.nursing.iowa.gov)).

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**Current listing of all active NP licenses maintained by BON?** Yes. An ARNP list can be purchased for a fee.

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**Current listing of authorized NP prescribers maintained by BON?** No.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** The Iowa Supreme Court rendered a decision on May 31, 2013, recognizing the full authority of the Iowa BON to decide what procedures or activities are within the SOP of NPs. The lower court, which had held that physician groups such as the Iowa Medical Society, the Iowa Board of Medicine, and the Iowa Society of Anesthesiologists, had such authority, was overturned by the Supreme Court. As a result, ARNPs may: (1) supervise radiological technicians in their use of fluoroscopy when the ARNP is rendering such services as chronic pain management, PICC line insertion, and needle biopsies; (2) order respiratory therapy services; (3) order orthotic, prosthetic, and pedorthic services; (4) sign orders for seclusion room in subacute mental health units as well as develop and oversee treatment plans with other mental health professionals; (5) perform examinations, provide testimony to magistrates, and order treatment including chemotherapy if the person believed to be mentally ill is in involuntary emergency commitment.

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**Legislative/administrative plans for state?** To work on proposed revisions to Iowa Code, Chapter 152 including: (1) defining the functions of the ARNP to require licensure of the ARNP rather than registration, (2) removing restrictive language that authorizes nurses to perform acts or specialties that are recognized by the medical and nursing professions and are approved by the BON. The bill gives the BON the authority to regulate nursing practice.

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**Internet address for Nurse Practice Act:** [http://www.nursing.iowa.gov/nav/nursing\\_practice.html](http://www.nursing.iowa.gov/nav/nursing_practice.html)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. ARNPs may practice independently within their recognized nursing specialties; they are not required to have physician supervision. An ARNP may have a collaborative agreement with a physician if the practice so warrants, but there is no BON requirement to do so. There is a provision for entering into a collaborative agreement if an ARNP accepts medical delegation.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** A collaborative practice agreement is a voluntary agreement where an ARNP and physician practice together within the framework of their respective professional SOPs. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No. However, many hospital medical staff bylaws interpret “clinical privileges” to preclude “admitting privileges.”

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**Additional limitations/clarifications/expansions to NP practice?** ARNPs are allowed to sign quarterly reports to the courts for outpatient services. ARNPs are authorized to administer medications and treatment for chlamydia and gonorrhea. Administrative rules from the Department of Human Services allow ARNPs to treat clients in long-term care facilities. Educationally qualified ARNPs are able to supervise certain fluoroscopic procedures. ARNPs may sign the following: death certificates (unless there is a non-natural cause of death and as long as the ARNP has been in charge of the deceased patient’s care); Department of Transportation forms that disclose a physical or mental condition that renders a person

incompetent to operate a motor vehicle; all quarterly reports to the court on commitments; respiratory therapy services and orthotic, prosthetic, and pedorthic services orders; orders for seclusion rooms in subacute mental health units. They may also develop and oversee treatment plans with other mental health professionals, perform examinations, provide testimony to magistrates, and order treatment including chemotherapy of persons believed to be mentally ill in involuntary emergency commitments.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. ARNPs are granted prescriptive authority within their specialty area.

**NP/physician prescriptive agreement required?** No. Prescriptive authority is granted by the BON.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** No.

**If so, what words are used to characterize involvement?** The ARNP who qualifies for and is registered in a recognized nursing specialty may prescribe substances or devices, including controlled substance or devices, if engaged in the practice of a nursing specialty regulated under rules adopted by the BON in consultation with the BOM and the BOP; the BON has the final authority.

**NP authorized to Rx controlled substances?** Registration with the DEA and the Iowa Board of Pharmacy Examiners extends the authority for the ARNP to prescribe controlled substances.

**If so, what schedules?** Schedules II–V

**NP issued Rx number by state?** Yes. Registration as a practitioner with the DEA and the state BOP extends this authority to controlled substances.

**NP authorized to apply for DEA number?** Yes. If registered as an ARNP.

**If so, what is DEA area field office info?:** St. Louis Division Office, United Missouri Bank Building, 7911 Forsyth Boulevard, Suite 500, St. Louis, MO 63105; p: 1-888-803- 1179

**DEA number required for nonscheduled as well as scheduled Rx?** No.

**NP name on Rx pad?** Yes.

**Physician name required on Rx pad?** No.

**NP name required on Rx bottle?** Yes.

**Authority to receive/dispense drug samples spelled out?** Yes.

**If so, where (e.g., statute, rules, opinion)?** Rules related to drug sampling apply to all RNs. An RN may supply, when pharmacist services are not available or when in the best interest of the patient, on the direct order of the supervising physician, a quantity of properly packaged and labeled Rx drugs, controlled substances, or contraceptive devices necessary to complete a course of therapy.

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**Specified limitations or restrictions on NP drug sampling?** Yes. As long as it is within the NP's SOP.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Effective 2010, "Clean Claims Payment for ARNPs" (adds SF 2201 [Section 16] to Iowa Code section 514F.6) directs the Insurance Commissioner to adopt rules to add ARNPs and PAs to provide for the retrospective payment of clean claims for covered services during the credentialing period.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP Schools in state:** (1) University of Iowa—Iowa City  
(2) Allen College—Waterloo; (3) Clarke College—Dubuque; (4) Graceland University—Lamoni; (5) Briar Cliff University—Sioux City; (6) Kaplan University Davenport.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Allen College; Clarke University; University of Iowa.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Iowa Association of NPs, Iowa NP Society, Iowa Association of Nurse Anesthetists

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**Organized opposition to NP legislative or regulatory changes?** In general, physician groups oppose ARNP role expansion. In 2010, the Iowa Society of Anesthesiologists and the Iowa Medical Society sought to minimize the authority of the BON to regulate ARNP practice specifically related to chronic interventional pain management. The Iowa Supreme Court rendered a decision on May 31, 2013 recognizing the full authority of the Iowa BON to define nursing SOP in Iowa. The lower court, which had held that physician groups such as the Iowa Medical Society, the Iowa Board of Medicine, and Iowa Society of Anesthesiologists, had such authority, was overturned by the Supreme Court. As a result, ARNPs may supervise radiological technicians in their use of fluoroscopy when the ARNP is rendering such services as chronic pain management, PICC line insertion, and needle biopsies.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 86

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state now deserves ranking of "B+."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 10 for NPs<sup>†</sup> (1601 in state<sup>†</sup> results in a **1:160 ratio**)
- 3734 for MDs/DOs/Interns/Residents (11,202 in state<sup>†</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **1 for NPs<sup>†</sup>** (1601 in state<sup>‡</sup> results in a **1:1601 ratio**)
- **1038 for MDs/DOs/Interns/Residents** (11,202 in state<sup>‡</sup> results in a **1:11 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Medical malpractice actions must be brought within 2 years after the date upon which the claimant knew or reasonably should have known of the injury or death. The doctrine of modified comparative negligence applies, where a claimant’s action is barred if his negligence exceeds the combined negligence of all other parties. Medical malpractice claimants must prove their claim of negligence via expert testimony, unless the lack of care is extremely obvious to an average juror. There is no requirement for medical malpractice actions to go to an arbitrator. Malpractice tort reform passed in 2006 allows for a compassionate statement allowing that evidence of regret or sorrow is inadmissible as evidence.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** KANSAS

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 2577

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** R&R establish categories of APRN that are consistent with nursing practice specialties recognized by the nursing profession. APRN authority to practice is defined by the SOP of the category for which application is made.

**NP title protection?** Yes.

**National certification required for recognition/practice?** No. But APRNs must have graduated from a BON-approved educational and training program.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** 'Each APRN shall function in an expanded role to provide primary, secondary, and tertiary health care in the APRN's category of advanced practice. Each APRN shall be authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients, and to make medical decisions, based on the authorization for collaborative practice with one or more physicians. This regulation shall not be deemed to require the immediate and physical presence of the physician when care is given by an APRN. Each APRN shall be directly accountable and responsible to the consumer. If an APRN is prescribing drugs, a written protocol that contains a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe shall specify all drugs that may be prescribed by the APRN.'

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** APRNs are issued a license by the BON.

**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Each applicant who completes an APRN program after January 1, 2001 shall have completed 3 college hours in advanced pharmacology or its equivalent, 3 college hours in advanced pathophysiology or its equivalent, and 3 college hours in advanced health assessment or its equivalent.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** All licensees shall submit proof of completion of 30 contact hours of approved continuing nursing education (CNE) specific to their role every 2 years.

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes. Individuals/organizations may request verification from the BON.

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**Current listing of authorized NP prescribers maintained by BON?** No.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** The previous title ARNP (Advanced Registered Nurse Practitioner) became APRN (Advanced Practice Registered Nurse) on January 1, 2012 (HB 2182). MSN is required for practice as of January 1, 2012 (HB 2182). APRNs are issued a license by the BON (as of January 1, 2012 per HB 2182)—previously APRNs were issued a certificate of qualification by the BON. All licensees shall submit proof of completion of 30 contact hours of approved CNE specific to their role every 2 years (HB 2182). Current APRNs are “grandfathered in” without additional application (effective January 1, 2012 per HB 2182).

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**Legislative/administrative plans for state?** The goal is to increase APRN independent prescribing authority by eliminating any physician oversight or supervision for NPs. The Kansas State Nurses Association, the BON, and advanced practice nurse leaders from across the state established a task force to develop statutory language and regulations based upon the consensus model. The goal of the task force is to develop strategies for a grassroots campaign to pass statutory language and regulations that Kansas APRNs believe will allow them to practice to the full extent of their education and expertise. The goal is to make statutory changes that are in line with the national consensus model (e.g., title, continuing education requirement, licensure instead of certificate of graduation, etc.).

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**Internet address for Nurse Practice Act:** <http://www.ksbn.org/npa/npa.htm>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** ‘Each APRN shall function in an expanded role to provide primary, secondary, and tertiary health care in the APRN’s category of advanced practice.

Each APRN is authorized to make independent decisions about the advanced practice nursing needs of families, patients, and clients, and to make medical decisions based on the authorization for collaborative practice. The R&R requiring a “collaborative practice agreement” state that any APRN who interdependently develops and manages the medical plan of care for patients or clients is required to have a signed authorization for collaborative practice with a physician(s) who is licensed in Kansas. This regulation shall not be deemed to require the immediate and physical presence of the physician when care is given by an APRN. Each APRN shall be directly accountable and responsible to the consumer.’

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** Each APRN shall ensure that each protocol is reviewed by the APRN and physician at least annually and maintained in the APRN’s principle place of practice.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes. APRNs manage the medical plan of care prescribed for the client, based on an authorization for collaborative practice adopted jointly by the NP and the attending physician.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** APRNs participate, when appropriate, in the joint review and revision of adopted protocols or guidelines when the APRN is involved in the medical plan of care. Each APRN shall ensure that each protocol is reviewed by the APRN and physician at least annually.

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**Any legislative prohibitions against NP hospital privileges?** No. NPs can manage a medical plan of care based on an authorization for collaborative practice with one or more physician(s).

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. Authority to prescribe is subsumed under the practice certificate, but prescriptive parameters must be spelled out in written protocols. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe and shall specify all drugs that may be prescribed by the APRN.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Each written protocol that an APRN is to follow when prescribing, administering, or supplying a prescription-only drug shall meet requirements. The authorization for collaborative practice shall include, but is not limited to: (1) a cover page containing the names and telephone numbers of the APRN and the physician, their signatures, and the date of review by the APRN and the physician that is maintained in either hard copy or electronic format at the APRN's principle place of practice; (2) if an APRN is prescribing drugs, a written protocol that contains a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe and shall specify all drugs that may be prescribed by the APRN. The written protocol can consist of published protocols or practice guidelines that have been reviewed and agreed upon by both the APRN and the physician.

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**NP authorized to Rx controlled substances?** Yes. In prescribing controlled substances, the scope of authority of the APRN must not exceed the normal and customary practice of the responsible physician.

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**If so, what schedules?** Schedules II–V as long as the Rx is from a class of drugs prescribed pursuant to protocol.

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** St. Louis Division Office, United Missouri Bank Building, 7911 Forsyth Boulevard, Suite 500, St. Louis, MO 63105; p: 1-888-803-1179

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. Rx must be signed by the APRN with the letters "A.P.R.N."

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**Physician name required on Rx pad?** Yes. All written prescription orders shall include the name, address, and telephone number of the responsible physician.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** KAN. STAT. ANN. § 65-1130

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**Specified limitations or restrictions on NP drug sampling?** Yes. The APRN may not dispense drugs, but may request, receive, and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Kansas—Kansas City; (2) Fort Hays State University—Hays; (3) Pittsburg State University—Pittsburg; (4) Washburn University—Topeka; (5) Wichita State University (offers DNP) —Wichita

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Kansas; Wichita State University; Washburn University

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Kansas Alliance of Advanced Nurse Practitioners (KAANP); Great Plains NP Society (western Kansas)

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 73

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state still deserves a ranking of "C."*

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## Cumulative number of National Practitioner Data Bank (NPDB) filings:

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Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 19 for NPs<sup>†</sup> (2577 in state<sup>‡</sup> results in a **1:136 ratio**)
- 4500 for MDs/DOs/Interns/Residents (10,951 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **4 for NPs<sup>†</sup>** (2577 in state<sup>‡</sup> results in a **1:644 ratio**)
- **634 for MDs/DOs/Interns/Residents** (10,951 in state<sup>‡</sup> results in a **1:17 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A medical malpractice action must be brought within 2 years after the fact of injury becomes reasonably apparent but in no event more than 4 years after the act. The doctrine of modified comparative negligence applies, where a claimant’s action is barred if his negligence is equal to or greater than the combined negligence of all defendants. The “one-action rule” specifies that all parties must have their fault determined in a single trial. In any personal injury action, noneconomic damages are limited to a total of \$250,000 per plaintiff against all defendants; punitive damages are limited to less than \$5 million. Punitive damages are not available in a wrongful death case. Any party or the judge must submit the action to a medical screening panel made up of three healthcare providers and a nonvoting lawyer. The panel’s written report is admissible at trial.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Exempts from civil liability food manufacturers, producers, etc. for claims arising out of weight gain, obesity, or health conditions associated with weight gain or obesity.

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## THE PEARSON REPORT

**STATE:** KENTUCKY

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) and NP (Nurse Practitioner)

**Number of NPs in state:** 3465 (4933 total APRNs)

**NP specialties legislatively specified?** Yes. The NP must be certified in at least one population foci: family, adult and gerontology, neonatology, pediatrics, women's health, or psychiatric/mental health. The BON administratively recognizes SOPs from specifically approved APRN certifying organizations.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The APRN SOP is defined in both the statutes and regulations. APRNs are required to have national certification, and the accepted certifications are specified in the NPA statute and the BON regulations. APRNs must conform to the SOP and standards of their national certifying organization.

**NP title protection?** Yes, APRN is protected.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes (as a minimum). Required for new graduates after January 2005.

**Requirement for APN member on BON?** Yes. One position.

**Joint BON/BOM regulation over any aspect of practice?** No. The Nurse Practice Act creates an Advanced Practice Registered Nurse Advisory Council of nine members (one from the BON, one from the BOM, one from the BOP, and six APRNs) that meets annually or more often, but the Council has no regulatory or statutory authority and serves only in an advisory role to BON.

**Physician involvement required for any aspect of practice?** Yes, but prescribing only.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** A written collaborative prescribing agreement for APRN prescriptive authority with a physician is required before prescribing or dispensing drugs. Two separate collaborative agreements for prescriptive authority are required for prescribing: one for nonscheduled drugs (CAPA-NS) and one for controlled substances (CAPA-CS).

---

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Except that under KY. REV. STAT. ANN. § 311.375 no person who holds a doctor degree shall use or employ the title “Doctor” or “Dr.” in or upon any letter, statement, card, prescription, sign, listing, or other writing without affixing suitable words or letters designating the particular doctor degree held by such person.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** APRNs are licensed separately as RNs and as APRNs. License cards are no longer issued.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** There are no practice hours required before an APRN may prescribe nonscheduled drugs. There is a requirement for the APRN to be licensed as an APRN for 1 year before prescribing scheduled drugs.

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**Additional pharmacology hours required for prescribing?** Yes. For controlled substances (1.5 hours).

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** In addition to maintaining national certification, APRNs must have 2 hours of HIV CE every 10 years, plus 5 hours of pharmacology CE every year.

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** No (for nonscheduled drugs). Yes (for scheduled drugs). An APRN must send a notification form to the BON informing the BON that a CAPA-CS exists.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative changes affecting NP practice?** In 2013, the legislature passed bills (the “pill mill bills”) that affected the prescribing of Schedule II or Schedule III controlled substances containing hydrocodone by any practitioner licensed to prescribe these substances. The bills require certain licensure boards, including the BON, to promulgate regulations setting prescribing standards, which the Board has done.

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**Legislative/administrative plans for state?** The Kentucky Coalition of NPs/Nurse Midwives (KCNPNM) is monitoring and will oppose legislation that would place new restrictions on APRN practice. Legislation is planned for the 2014 legislative session to eliminate the requirement for the collaborative agreement for prescriptive authority for nonscheduled drugs (CAPA-NS).

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**Internet address for Nurse Practice Act:** <http://www.lrc.ky.gov/Statutes/chapter.aspx?id=38813>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. But consultation and collaboration are required for situations outside the APRN’s SOP.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** APRN practice means the performance of additional acts by RNs who have gained added knowledge and shall include prescribing treatments, drugs, and devices and ordering diagnostic tests that are consistent with the SOP of the APRN. When performing in those situations outside the APRN's SOP, the APRN shall seek consultation or referral.

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No. But hospital regulations specify that a physician must have overall responsibility for each patient. Each hospital's bylaws specify if and how APRNs will be granted privileges.

**Additional limitations/clarifications/expansions to NP practice?** APRNs are able to sign a form authorizing license plates for persons with disabilities; APRNs receive reports on mandated auditory screening done on newborns; APRNs may sign, report, examine, order, or certify such things as a child's immunization record, ordering and reporting HIV tests and results, certifying a family childcare home provider's good health, the need for a communication device, and reporting communicable diseases.

#### NP SCOPE OF PRACTICE—PRESCRIBING

**NP Rx authority granted separate from practice authority?** Yes.

**NP/physician prescriptive agreement required?** Yes.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** Physician, yes; BOM, no.

**If so, what words are used to characterize involvement?** Before the APRN can Rx or dispense nonscheduled legend drugs the APRN must enter into a written collaborative agreement for prescriptive authority with a physician that defines the scope of the prescriptive authority (i.e., a collaborative agreement for prescriptive authority for nonscheduled drugs—CAPA-NS). If the APRN has been registered to practice for at least 1 year, he or she may also enter into a collaborative agreement for APRN prescriptive authority for controlled substances (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances. The CAPA-CS must be in writing, signed by APRN and physician, and available at each practice site; the BON must be officially notified.

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**NP authorized to Rx controlled substances?** Yes. If the APRN has a CAPA-CS and DEA number.

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**If so, what schedules?** Schedules II–V may be defined within the APRN’s CAPA-CS with the following limitations: Schedule II to a 72-hour supply (except for APRNs certified in psychiatric/mental health who may prescribe a 30-day supply of psychostimulants); Schedule III to a 30-day supply with no refills; Schedule IV and V to a 6-month supply of medication, except for certain Schedule IV drugs (Ativan, Klonopin, Soma, Valium, and Xanax) that are limited to a 30-day supply with no refills.

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** 431 Howard St., Detroit, MI 48226, 1-800-230-6844

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** State NPA statute

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**Specified limitations or restrictions on NP drug sampling?** Yes. APRNs may dispense sample medications in accordance with the collaborative agreement for prescriptive authority.

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**Restrictions on out-of-state NP Rx being filled in this state?** Prescriptions from out-of-state APRNs are allowed. However, these prescriptions must comply with current Kentucky APRN prescribing laws and BOP regulations.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. APRNs have been added to a reimbursement bill that improves the insurer credentialing process, requires insurers to provide fee schedules, requires notification of applicants for credentialing within 90 days, and requires issuance of payment to providers for services rendered during the credentialing process.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS THAT MAY AFFECT NP PRACTICE

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**Number and listing of NP schools in state:** (1) Indiana Wesleyan University—Louisville; (2) University of Kentucky—Lexington; (3) Bellarmine University—Louisville; (4) Murray State University—Murray; (5) Spalding University—Louisville; (6) University of Louisville—Louisville; (7) Western Kentucky University—Bowling Green; (8) Frontier Nursing University—Hyden; (9) Eastern Kentucky University—Richmond; (10) Northern Kentucky University—Highland Heights

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Frontier Nursing University; University of Kentucky; Western Kentucky University; Northern Kentucky University; Eastern Kentucky University; Bellarmine University; Murray State University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Kentucky Coalition of NPs/Nurse Midwives (KCNPNM) ([www.kcnpnm.org](http://www.kcnpnm.org)); Kentucky Nurses Association

**Organized opposition to NP legislative or regulatory changes?** Yes. The Kentucky Medical Association and the Kentucky Academy of Family Physicians.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 80

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state still deserves ranking of "B."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **41 for NPs<sup>†</sup>** (3465 in state<sup>‡</sup> results in a **1:85 ratio**)
- **5585 for MDs/DOs/Interns/Residents** (16,665 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **23 for NPs<sup>†</sup>** (in state<sup>‡</sup> results in a **1:151 ratio**)
- **1686 for MDs/DOs/Interns/Residents** (16,665 in state<sup>‡</sup> results in a **1:10 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Any medical malpractice action must be brought within 1 year from the time the injury was or reasonably should have been discovered. A claimant's negligence does not bar recovery (i.e., a pure comparative negligence state). Any damage award must be reduced by the claimant's percentage of fault. The plaintiff in a medical malpractice action does not have to attach an expert's affidavit to the complaint and there is no requirement for the arbitration of medical malpractice claims.

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**Recent state malpractice liability tort reform?** 2008–2013: None. 2007: The total appeal bond required collectively of all during the appeal of a civil action may not exceed \$100 million, regardless of the amount of the judgment. 2006: None. 2005: Obesity litigation reform exempts from civil liability manufacturers, sellers, etc. of food for claims arising out of weight gain, obesity, and related health conditions.

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## THE PEARSON REPORT

**STATE:** LOUISIANA

**NP title(s) used in this state:** Advanced Practice Registered Nurse (APRN) and Nurse Practitioner (NP). Specialties: ACNP (Acute Care Nurse Practitioner), ACPNP (Acute Care Pediatric Nurse Practitioner), ANP (Adult Nurse Practitioner), APMHNP (Adult Psychiatric and Mental Health Nurse Practitioner), FNP (Family Nurse Practitioner), FPMHNP (Family Psychiatric and Mental Health Nurse Practitioner), GNP (Gerontological Nurse Practitioner), NNP (Neonatal Nurse Practitioner), PNP (Pediatric Nurse Practitioner), WHNP (Women's Health Nurse Practitioner)

**Number of NPs in state:** 2361

**NP specialties legislatively specified?** No. The BON is granted the authority to determine specialties.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The NP SOP is defined by educational preparation, national certification, R&R, BON practice opinions, and collaborative practice agreements (CPA).

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g. collaboration, supervision, direction, authorization, delegation)?** Collaboration. NPs who engage in acts of medical diagnosing and prescribing are required to have a CPA with one or more licensed physicians or dentists. This formal agreement is mutually developed between the NP and physician and addresses the parameters of the collaborative practice and clinical practice guidelines for managing patients.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Separate APRN license issued with NP designation.

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**Supervised practice hours required before full NP practice autonomy?** Yes. NPs in Louisiana may medically diagnose and prescribe for patients autonomously in accordance with a CPA approved by the BON. Approval of a CPA by the BON requires the NP to provide evidence of: (1) 500 hours of clinical practice hours within 1 year in the clinical specialty for which the applicant was educationally prepared as an NP immediately prior to applying for prescriptive and distributing authority; practice in another state as a licensed NP may be accepted to meet this requirement; OR (2) 500 hours of clinical practice in medical management of patients in a preceptorship in which the NP applicant is precepted by a physician or another APRN who has approval for medical management/ prescriptive authority by the BON. The student experience must occur in a formal Board-approved educational program, preparing graduates to sit for the respective advanced practice specialty licensure exam and certification process.

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. (*See above.*)

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**Additional pharmacology hours required for prescribing?** Yes. The APRN applicant for Rx authority must complete a minimum of a 3-hour credit course in both pathophysiology and pharmacology. Courses must be master's level with contact hours. The NP approved for Rx authority must obtain 6 contact hours of CE in pharmacotherapeutics in their area of specialization.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** NP must complete CE required to maintain national certification. Six contact hours of pharmacotherapeutics in the area of specialization are required for NPs with prescriptive authority.

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**BON mechanism for others to verify NP license?** Yes. See the BON website ([www.lsbns.state.la.us](http://www.lsbns.state.la.us)).

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** Goal: To continue to put forth legislation to remove the CPA requirement.

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**Internet address for Nurse Practice Act:** <http://www.lsbns.state.la.us/Portals/1/Documents/rules/npafull.pdf>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** NPs who 'engage in medical diagnosis and management shall have a Collaborative Practice Agreement' that includes the availability of the physician or dentist and the methods of management including clinical practice guidelines (i.e., written documents jointly agreed upon by the collaborating professionals that describe a specific

plan, arrangement, or sequence of orders, steps, or procedures to be followed or carried out in providing patient care in various clinical situations), and coverage of the healthcare needs of the patient during any absence of any of the providers. NPs whose practice does not require medical diagnosis and management are not required to have a CPA.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** Yes. BON approval is a requirement to practice.

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**If so, is agreement required to be kept/stored/updated?** The CPA must be updated at least annually.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Clinical practice guidelines that describe a specific plan, arrangement, or sequence of orders, steps, or procedures to be followed or carried out in providing patient care in various clinical situations are included in the CPA.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** Guidelines must be reviewed and signed yearly at the practice site.

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**Any legislative prohibitions against NP hospital privileges?** No. Psychiatric Mental Health Nurse Practitioners have authority to perform psychiatric emergency commitments.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. An application requesting an APRN be granted Rx authority to prescribe assessment studies, drugs, and therapeutic devices and to distribute free drug samples and other gratuitous medications is a separate application from APRN licensure.

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**NP/physician prescriptive agreement required?** Yes.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes (collaboration).

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**If so, what words are used to characterize involvement?** NPs apply to the BON for Rx authority, which, once granted, must be specified in the CPA clarifying that the NP prescribing is in collaboration with a physician.

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**NP authorized to Rx controlled substances?** Yes. NPs granted Rx authority by the BON are allowed to Rx controlled substances. The BON may authorize an NP with limited Rx authority to Rx controlled substances on an individual practice basis. Such an applicant must have practiced with limited Rx and distributing authority with the same collaborative physician for 500 hours immediately preceding the request.

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**If so, what schedules?** Schedules II–IV (Schedule II under certain circumstances; no controlled substances for treating chronic and intractable pain and/or obesity).

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**NP issued Rx number by state?** Yes. An identification number is assigned by the BON to approved APRNs.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** New Orleans Division Office, Three Lake Way, 3838 N. Causeway Blvd., Suite 1800, Metairie, LA 70002; p: 1-800-514-7302 OR 1-800-514-8051

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** No requirements.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In written CPA.

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**Specified limitations or restrictions on NP drug sampling?** Yes. The issuing of free samples and other gratuitous medications are defined by the NP's clinical practice guidelines contained in a CPA for limited Rx authority.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Nothing prohibits it; the state benefit PPO pays 80% of a physician fee for reimbursement to NPs for services rendered.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. No restriction in the law.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Louisiana State University Health Sciences Center—New Orleans; (2) Loyola University—New Orleans; (3) McNeese State University—Lake Charles; (4) Northwestern State University of Louisiana—Shreveport; (5) Southern University and A&M College—Baton Rouge; (6) University of Louisiana at Lafayette—Lafayette; (7) Southeastern Louisiana University—Hammond; (8) Grambling University—Grambling

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Louisiana State University Health Sciences Center; Loyola University New Orleans; Southeastern Louisiana University; Southern University and A&M College; The University of Louisiana at Lafayette.

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*\*Programs (as of October, 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Louisiana Association of Nurse Practitioners ([www.lanp.org](http://www.lanp.org))

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**Organized opposition to NP legislative or regulatory changes?** Yes. The Medical Society and BME continue to attempt to gain authority over nursing practice.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 62

**Descriptive ranking:** Grade D. The state restricts patient choice.

**\*Pearson Report 2014 update: state still deserves a ranking of "D."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 69 for NPs<sup>†</sup> (2361 in state<sup>‡</sup> results in a **1:34 ratio**)
- 8105 for MDs/DOs/Interns/Residents (16,538 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- 30 for NPs<sup>†</sup> (2361 in state<sup>‡</sup> results in a **1:79 ratio**)
- 1221 for MDs/DOs/Interns/Residents (16,538 in state<sup>‡</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A medical malpractice action must be filed within 1 year from the date of discovery of the alleged act, omission, or neglect. A claimant's recovery is reduced by his or her percentage of fault (i.e., the doctrine of pure comparative negligence). Most claims are brought against qualified healthcare providers under the Louisiana Medical Malpractice Act and are subject to review by a medical review panel of one (nonvoting)

lawyer and three physicians. There is no damage cap applicable to those not insured by the state, but qualified healthcare providers have their liability limited to \$100,000. State healthcare providers are automatically entitled to be covered by the fund if they are covered by a policy of malpractice liability insurance of at least \$100,000 per claim and pay the surcharge assessed by the Louisiana Insurance Rating Commission. Arbitration is allowed but not mandated. Patients may, without court approval, enter into binding medical arbitration agreements. All other claims against qualified healthcare providers must be reviewed by a medical review panel.

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**Recent state malpractice liability tort reform?** 2010–2013: None. 2009: HB 671 specifically names NPs and CNSs in the Medical Malpractice Law Act 14, which means that they are included in the cap covered through the LA Patient Compensation Fund. 2006–2008: None. 2005: Was the first state in the nation to exempt from liability any manufacturer, distributor, or seller of a food or nonalcoholic beverage for liability based on an individual's weight gain or obesity. Limit of damages against the state is \$500,000 for personal injury and wrongful death.

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## THE PEARSON REPORT

**STATE:** MAINE

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) and CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 1194

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** R&R specify BON-approved national certification.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** As of January 1, 2006, an applicant for initial licensure must hold a master's degree with preparation in the specialty area for which the application is made.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The first 2 years of practice must be under the supervision of a licensed physician or a supervising NP practicing in the same practice category who will provide oversight for the NP, or as an employee of a clinic or hospital that has a medical director who is a licensed physician. The CNP applicant must submit written evidence to the BON upon completion of the required clinical experience.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** The title DNP has not been specifically addressed in Maine, but according to the Board of Licensure in Medicine nothing prevents an individual who has received a doctorate degree from a reputable college or university, other than the degree of "Doctor of Medicine," from prefixing the letters "Dr." to that individual's name, if that individual is not engaged, and does not engage, in the practice of medicine or surgery or the treatment of a disease or human ailment.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON issues licenses to the four categories of APRN. This license is separate from the RN license. An APRN who practices strictly as an APRN does not have to maintain an RN license (may maintain a current APRN license only).



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**Supervised practice hours required before full NP practice autonomy?** Yes. Recent graduates of NP programs must practice under a physician or supervising NP for the first 2 years (based on a full-time work week), after which time independent practice is authorized.

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**Supervised practice hours required before full NP prescribing autonomy?** If more than 5 years have elapsed since completion of an NP program and the applicant does not meet the practice requirement of 1500 hours, the applicant shall complete 500 hours of clinical practice supervised by a physician or NP in the same specialty area of practice.

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**Additional pharmacology hours required for prescribing?** The BON requires that in order to be certified as a CNP (as part of the 24 months of supervised experience) the applicant must have prescribed medications in the last 2 years; if not, the applicant must provide the BON with documentation of 15 contact hours of recent (within the last 2 years) CE in pharmacology. If the applicant has prescribed medications in the past 5 years (under the supervised experience) the applicant must provide the BON with documentation of 45 contact hours (3 credits) of recent (within the last 2 years) CE in pharmacology.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Seventy-five contact hours biannually in the area of practice for which the individual has been approved as an APRN, at least 30 of which must be Category 1 hours.

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**BON mechanism for others to verify NP license?** Yes. Available on the BON website ([www.maine.gov/boardofnursing](http://www.maine.gov/boardofnursing)). Click on “Verify a License Online.”

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**Current listing of all active NP licenses maintained by BON?** Yes. Available on the BON website ([www.maine.gov/boardofnursing](http://www.maine.gov/boardofnursing)). Click on “Licensing” to verify a license online with a last name; a list of all active NP licenses may be purchased for \$50 via a CD supplied by the requester or via email.

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**Current listing of authorized NP prescribers maintained by BON?** Yes. (All NPs have Rx authority.)

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** None at this time.

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**Internet address for Nurse Practice Act:** <http://www.state.me.us/boardofnursing/Administrative/Rules/index.htm>

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**NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING**

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No physician practice agreement, but the BON requires a registration of the initial 2-year supervisory relationship for new graduates of an NP program for a minimum of 24 months (under the supervision of a licensed physician or a supervising NP, or employment by a clinic or hospital that has a medical director who is a licensed physician).

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**If so, is agreement required to be kept/stored/updated?** Yes.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** Yes. There are rules through the Department of Human Services that require NPs to be supervised by a physician when providing patient care in the hospital setting.

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**Additional limitations/clarifications/expansions to NP practice?** NPs may provide testimony in workman's compensation proceedings and may sign death certificates; additionally, CNPs may delegate certain activities relating to the APRN SOP to employees or support staff when those activities are carried out by custom and usage and are under the control of the CNP who is legally liable for the activities. A CNP or an APRN may be selected as one of the two examiners in cases of involuntary treatment of mental health patients. PMHNPs and Psychiatric CNSs are authorized to petition the District Court for emergency involuntary admission of a participant in the Department of Health and Human Services Progressive Treatment Program in a state mental institute. 'USE OF CONTROLLED SUBSTANCES FOR TREATMENT OF PAIN: a joint rule of the Board of Osteopathic Licensure, the Board of Licensure in Medicine, the Board of Dental Examiners, the Board of Nursing, and the Board of Podiatric Medicine to ensure adequate relief of pain to the citizens of Maine; the rule defines a "clinician" as an Allopathic (MD) or Osteopathic (DO) Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM), dentist (DMD or DDS), or podiatrist (DPM).'

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** Yes.

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**If so, explain specifics of formulary.** Defined in the R&R as those nonscheduled drugs that are FDA approved and those listed on Schedules II, III, III-N, IV, and V.

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**BOM/physician involvement in NP prescribing?** No. Unless during first 2 years of practice and the new graduate may select to have an NP or a physician supervise prescribing.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Building, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131; p: 1-617-557-2200

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** BON Rules

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**Specified limitations or restrictions on NP drug sampling?** Yes. Must be among those drugs included in the formulary for prescription writing.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Husson College—Bangor; (2) University of Maine—Orono; (3) University of Southern Maine—Portland

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Southern Maine

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Maine Nurse Practitioners Association ([www.mnpa.us](http://www.mnpa.us))

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**Organized opposition to NP legislative or regulatory changes?** Occasionally the state medical association or the insurance industry has opposed NPs, but 'NPs have always prevailed.'

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 72

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state now deserves a higher ranking of "A-."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

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Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **15 for NPs<sup>†</sup>** (1194 in state<sup>‡</sup> results in a **1:80 ratio**)
- **1558 for MDs/DOs/Interns/Residents** (6190 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **6 for NPs<sup>†</sup>** (1194 in state<sup>‡</sup> results in a **1:199 ratio**)
- **507 for MDs/DOs/Interns/Residents** (6190 in state<sup>‡</sup> results in a **1:12 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** An action for medical malpractice must be brought within 3 years from the date of the alleged negligent act or omission. A claimant’s action is barred if the jury finds him to be “equally at fault” (i.e., a form of the doctrine of modified comparative negligence). A medical malpractice claimant is not required to attach an expert’s affidavit to the complaint. There is no cap on the amount of damages that may be collected in a medical malpractice action, though noneconomic damages for wrongful death are limited to \$150,000 and punitive damages to \$75,000. All complaints must be filed with a prelitigation screening panel before a medical malpractice claim may be filed.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** **MARYLAND**

**NP title(s) used in this state:** NP (Nurse Practitioner) and CRNP (Certified Registered Nurse Practitioner)

**Number of NPs in state:** 3954

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** State regulations, education, and certification.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. Master's degree or higher.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes. But minimal. NP must have a named collaborator in the form of a 1-page attestation. No physician signature is required.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Collaboration is the term used to describe the relationship.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. Except that under the statute MD. HEALTH OCC. CODE ANN. § 14-206 (2006) a "person may not use the word or term 'Dr.' with the intent to represent that the person practices medicine." Because the penalty is severe (misdemeanor and on conviction is subject to a fine not exceeding \$5000, imprisonment not exceeding 5 years, or both) it would likely behoove the NP to clarify his/her profession to avoid problems.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON no longer prints paper licenses (since 2007). The NP designation is listed on the BON website right below the RN information. The same licensure number applies to both.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** Yes. NP must have taken a 3-credit pharmacology course if not a part of the NP program. Board retains the right to approve the NP program before certifying the NP.

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**CE requirements for NP practice?** No. Only as required by the national certifying organization for recertification.

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes. Go to the BON website to look up a license ([www.mbon.org](http://www.mbon.org)).

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**Current listing of all active NP licenses maintained by BON?** Yes. But not printed or available publicly. However, a list may be purchased from the BON.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** A purchaser may request a list of active NPs or all NPs and may request the two lists designated as “active” and “inactive.”

---

**Recent legislative/regulatory changes affecting NP practice?** None

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**Legislative/administrative plans for state?** Plans: (1) to continue making provider-neutral language the “standard” by correcting incorrect language that currently exists; (2) to cooperate with physicians to address medical tort reform; (3) to tie up “loose” legislative ends to have NPs accurately and properly recognized in the insurance code.

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**Internet address for Nurse Practice Act:** [http://www.mbon.org/main.php?v=norm&p=0&c=practice/nurse\\_practice\\_act.html](http://www.mbon.org/main.php?v=norm&p=0&c=practice/nurse_practice_act.html)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes (indirectly). The NP must file an “attestation” form with the BON that lists the name and license number of the Maryland licensed physician ‘with whom the NP will collaborate and consult.’

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** NPs function under a collaborative relationship with a named physician. The CRNP functions independently; the physician does not have to be onsite.

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**Required physician record/chart review?** Not per statute. However, there may be an employer policy.

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**Required NP/physician practice agreement?** No. An attestation is filed with the BON.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** The attestation plan is filed with the BON only.

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs may sign death certificates and handicapped parking certification, issue emergency DNR orders, verify that an underaged female may get married if she is pregnant or has just delivered a child, and sign birth certificates for hospital births. For specific skills that were acquired after the formal NP program, the NP must specify procedures to be performed along with the documentation of proof of education, training, and competency for performing each specific procedure.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. With the exception of new NP graduates, who may be authorized to practice pending national board certification, but who may not prescribe until successful examination results are reported to the BON.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** The approved formulary drug list is updated regularly. NP must obtain authorization to use a nonformulary drug.

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Washington DC Division Office, Techworld Plaza, 800 K Street NW, Suite 500, Washington, DC 20001; p: 1-410-962-7580

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. There are no restrictions preventing this.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes. NPs treating patients in specified healthcare locations may personally prepare and dispense a full course of any drug that they are authorized to prescribe. NPs practicing in other healthcare locations may personally prepare and dispense only starter dosages. Starter dosages and samples do not require written prescriptions and samples do not have to meet pharmacist law labeling requirements.

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**If so, where (e.g. statute, rules, opinion)?** Nurse Practice Act, BON R&R, and pharmacist law.

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**Specified limitations or restrictions on NP drug sampling?** Yes. The NP may personally prepare and dispense a starter dosage of any drug the NP is authorized to prescribe. The NP must appropriately label the starter dosage, record the dispensed medicine in the patient's medical record, and provide the starter dose free of charge. "Starter dosage" means an amount of a drug sufficient to begin therapy of a short duration of 72 hours or less.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Indemnity insurance, Medicare, Medicaid, and MCOs reimburse directly.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. However, some major indemnity insurance companies and HMOs choose not to credential NPs. As of November 2010, medical insurer CareFirst BCBS of Baltimore allows NPs to participate as independent PCPs within its network. NPs may be leaders of Medical Homes in the Maryland Health Plan.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Coppin State University—Baltimore; (2) Johns Hopkins University—Baltimore; (3) University of Maryland—Baltimore; (4) Bowie State University—Bowie; (5) Salisbury University—Salisbury; (6) Uniformed Services University of the Health Sciences—Bethesda

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Coppin State University; Johns Hopkins University; Salisbury University; Uniformed Services University of the Health Sciences; University of Maryland.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** NPAM (NP Association of Maryland) (<http://www.npamonline.org/>); Maryland Academy of Advanced Practice Clinicians (NP/PA group; [www.maaponline.enpnetwork.com](http://www.maaponline.enpnetwork.com))

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**Organized opposition to NP legislative or regulatory changes?** The state medical association routinely presents organized opposition to NP legislative or regulatory changes.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 57

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**Descriptive ranking:** Grade F. State severely restricts patient choice.

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*\*Pearson Report 2014 update: state deserves new ranking of "B+."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **35 for NPs<sup>†</sup>** (3954 in state<sup>‡</sup> results in a **1:113 ratio**)
- **7998 for MDs/DOs/Interns/Residents** (28,596 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (3954 in state<sup>‡</sup> results in a **0 ratio**)
- **1872 for MDs/DOs/Interns/Residents** (28,596 in state<sup>‡</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Medical malpractice action must be filed either within 5 years from the date when the injury was committed or 3 years from the date when the injury was discovered. Negligence by a claimant will bar his recovery completely (i.e., traditional common law doctrine of contributory negligence—one of the few states remaining that has this). There is a limit on recoverable noneconomic damages for any personal injury cause of action for medical malpractice (\$500,000). Claims for medical malpractice must be reviewed by an arbitration panel unless one or the other party waives this. The arbitration panel determines, itemizes, and apportions damages against a healthcare provider (if found liable). Although any party may reject the panel’s findings, the findings are admissible and presumed correct in court, unless vacated by the court.

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**Recent state malpractice liability tort reform?** 2005–2011: None.

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## THE PEARSON REPORT

**STATE:** MASSACHUSETTS

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 7367

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** N/A

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** No.

**MSN required for practice?** No.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes. Promulgation by the BON in conjunction with the Board of Registration in Medicine of advanced practice nursing regulations that govern the ordering of tests and therapeutics and the prescribing of medications. Said promulgation occurs only after the two boards have met, consulted, and concurred on the content.

**Physician involvement required for any aspect of practice?** Yes. There are collaborative guidelines that must be followed for prescriptive practice.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Collaboration, supervision, delegation.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The NP is first licensed as an RN and then may be authorized (not a separate license) by the BON to practice in the advanced role with a designation CNP. The NP retains the same number.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** Yes. A minimum of 24 contact hours in pharmacotherapeutics beyond those acquired through a generic nursing education program are required for initial prescriptive authority; may be part of a graduate program.

**CE requirements for NP practice?** No. There are BON CE requirements for RN practice; any additional CE requirements are determined by the certifying organization.

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** No. The listing is maintained by the Department of Public Health, Drug Control Program.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** Yes. The Global Signature legislation signed into law by Governor Patrick (August 4, 2012)—“An Act improving the quality of health care and reducing costs through increased transparency, efficiency, and innovation.” This legislation enables NPs to sign any document or form that requires a physician signature (with the exception of home health orders, which are governed under Medicare).

Revised regulations (which clarify that there is no physician involvement in “diagnosing and treating” as part of the NP’s SOP, only for prescribing) for all APRNs are in process. Approved by the BON; concurred with by the Board of Medicine. The approved language (244 CMR 10.07: *Advanced Practice Registered Nurse (APRN) Engaged in Prescriptive Practice*) is: (1) designed to provide consistency with the BOM regulations at 243 CMR 2.10; (2) allows for the APRN and the supervising physician to determine the frequency of prescriptive practice review; (3) specifies guideline provision is for prescriptive practice only; (4) clearly indicates guideline development is a collaborative process; (5) no longer specifies the site of APRN practice; and (6) no longer requires guideline review by the BON or the medical staff and nursing administrative staff of the institution employing the APRN.

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**Legislative/administrative plans for state?** Legislation to remove supervision and joint promulgation is now with the legislature. The Robert Wood Johnson Regional Action Committee formed and is seeking to implement IOM recommendations. The Massachusetts Coalition of NPs is actively involved in payment reform legislation to ensure inclusion of NPs and provider-neutral language.

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**Internet address for Nurse Practice Act:** <http://www.mass.gov/dph/boards/rn>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs may sign any document or form that requires a physician signature.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. Issued by the Department of Public Health Drug Control Program and the DEA.

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**NP/physician prescriptive agreement required?** Yes. Prescriptive practice guidelines are required.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes. Prescriptive practice guidelines.

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**If so, what words are used to characterize involvement?** An APRN engaged in prescriptive practice will do so in accordance with written guidelines mutually developed and agreed upon with the APRN and the physician supervising the APRN's prescriptive practice. In all cases the written guidelines will: (1) identify the supervising physician and the APRN; (2) include a defined mechanism for the delegation of supervision to another physician including, but not limited to, duration and scope of the delegation; (3) describe the nature and scope of the APRN's prescribing practice; (4) identify any limitations on medications to be prescribed; (5) include a defined mechanism and time frame to monitor prescribing practices; (6) specify that the initial prescription of Schedule II drugs must be reviewed within 96 hours; (7) be kept on file in the workplace and be reviewed and re-executed every 2 years; and (8) conform to M.G.L. c. 94C, the regulations of the Department of Public Health at 105 CMR 700.000 *et seq.*, M.G.L. c. 112, §§ 80B, 80C, 80E, 80G, 80H and 244 CMR 10.00.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–VI (in MA, Schedule VI drugs are those prescribed medications not included in Schedules II–V).

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**NP issued Rx number by state?** Yes. For Schedule VI prescribing.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Building, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131; p: 1-617-557-2200

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**DEA number required for nonscheduled as well as scheduled Rx?** Yes.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Department of Public Health Regulations

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**Specified limitations or restrictions on NP drug sampling?** Yes. For Schedules II–V, a single dose or enough for “immediate treatment”; for Schedule VI, no more than 30 days, or 90 days if indigent.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. NPs are listed as PCPs for the state Medicaid plan. Legislation grants PCP status to NPs, prohibits discrimination against NPs as a class of PCPs by third-party payers, and gives consumers the opportunity to choose NPs as their PCP through listing in a directory.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Boston College—Chestnut Hill; (2) Northeastern University—Boston; (3) Salem State University—Salem; (4) Massachusetts College of Pharmacy and Health Sciences—Boston; (5) MGH Institute of Health Professions—Boston; (6) Regis College—Weston; (7) Simmons College—Boston; (8) University of Massachusetts—Amherst; (9) University of Massachusetts—Boston; (10) University of Massachusetts—North Dartmouth; (11) University of Massachusetts—Lowell

**Note:** *The BON does not regulate graduate nursing programs.*

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** MGH Institute for Health Professions; Northeastern University; Regis College; Simmons College; University of Massachusetts—Amherst; University of Massachusetts—Boston; University of Massachusetts—Dartmouth; University of Massachusetts—Lowell; University of Massachusetts—Worcester.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Massachusetts Coalition of NPs (MCNP; [www.mcnpweb.org](http://www.mcnpweb.org)); Eastern Massachusetts Chapter of the National Association of Pediatric Nurse Practitioners (NAPNAP; [www.emnapnap.org](http://www.emnapnap.org)); Gerontological Advanced Practice Nurses Association MA Chapter (GAPNA; [www.gapna.org](http://www.gapna.org)).

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**Organized opposition to NP legislative or regulatory changes?** No.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 56

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: State now deserves a higher ranking of “C+.”*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports



(9/1/1990–3/30/2013):

- **100 for NPs<sup>†</sup>** (7367 in state<sup>‡</sup> results in a **1:74 ratio**)
- **8590 for MDs/DOs/Interns/Residents** (33,767 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (7367 in state<sup>‡</sup> results in a **0 ratio**)
- **1875 for MDs/DOs/Interns/Residents** (33,767 in state<sup>‡</sup> results in a **1:18 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Medical malpractice action for injury or death must be brought within 3 years and in no event more than 7 years after the alleged act or omission. A claimant’s action is barred if his negligence exceeds the combined negligence of all defendants (i.e., the doctrine of modified comparative negligence). If a jury finds the defendant liable, it may not award more than \$500,000 for pain and suffering unless there is substantial loss (a standard that is easy to meet so the cap is not firm). Medical malpractice actions must be reviewed by a tribunal (a judge, a physician, and a lawyer) to determine whether ‘the evidence presented if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff’s case is merely an unfortunate medical result.’ The panel findings are admissible at trial. If the panel finds against the claimant, they must post a \$6000 bond to pay for defendants’ costs (if the claimant is also unsuccessful at trial).

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** MICHIGAN

**NP title(s) used in this state:** NP (Nurse Practitioner)

**Number of NPs in state:** 4700

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The BON issues specialty certification to RNs who have advanced training beyond that required for initial licensure and who have demonstrated competency through examination or other evaluative processes in a specialty field.

**NP title protection?** Yes. As part of the specialty certification.

**National certification required for recognition/practice?** Yes. For initial specialty certification. For renewal, the NP must submit proof of current national certification/recertification or 40 hours of CE earned in the 2-year period preceding the date of the application.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** There is currently no language in the NPA statute requiring master's preparation, resulting in some non master's-prepared NPs being grandfathered in. Currently, initial specialty certification requires certification by an approved national certification board (which requires a master's to sit for the exam).

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes. For Rx authority and reimbursement for Medicaid and Medicare and some other insurers; a recent Attorney General staff lawyer "interpreted" APN practice as essentially delegated and supervised by medicine.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** According to a 1980 Attorney General opinion, a physician may delegate prescribing to a registered professional nurse. Rules passed in 1999 authorize physicians to delegate prescribing of controlled substances to an NP, with certain restrictions and with a signed collaborative agreement.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** Yes. The statute Mich. Comp. Laws § 333.16265 prohibits the written use of terms "doctor" or "Dr." except by those engaged in chiropractic, dentistry, medicine, optometry, osteopathic medicine and surgery, podiatric medicine and surgery, psychology, or veterinary medicine; the current statute does not exempt any professional nursing degrees.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Rather than a separate license, those who qualify as NPs are issued an additional “specialty certification” that incorporates the RN license number.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** No.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** For specialty certification renewal, the NP must submit proof of current national certification/recertification or 40 hours of CE earned in the 2-year period preceding the date of the application.

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**BON mechanism for others to verify NP license?** Yes. Anyone can verify an RN and APRN license by going to the MI-LARA website (<http://w3.lara.state.mi.us/free/>).

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**Current listing of all active NP licenses maintained by BON?** Yes. The list may be purchased for professional purposes.

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**Current listing of authorized NP prescribers maintained by BON?** No.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** The Public Health Code defines RN practice; however the APRN practice description is brief and is limited to NPs, CNPs, and CRNAs. CNSs are not mentioned in the NPA statute. Bills (SB 481 and HB 4774) were introduced in June 2011 to address the issues of autonomous practice for NP, CNS, and CNM providers. The language in the bills is based on the recommendations from the 2008 consensus model for APRN regulation. Long-term goals are to promote legislation that will remove barriers to NP practice and improve access to care for patients. The bills also address the ability of NP, CNM, and CNS providers to order physical therapy and occupational therapy and write prescriptions without delegation. The legislation was reintroduced as SB 2 and passed out of the Senate in November 2013; the bill has now been referred to the House.

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**Internet address for Nurse Practice Act:**

[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27529\\_27542---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27542---,00.html)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. As long as NPs are providing ‘care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability.’

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The occupational regulation sections of the Michigan Public Health Code Act 368 of 1978 defines nursing, and this serves as the legal SOP statement

to include APNs. RNs are licensed to practice independently within this scope, and because APNs practice at an advanced level and their SOP can be accounted for under the Public Health Code for registered nursing, the interpretation is that NPs practice nursing diagnosis and treating (except prescribing) independently. However, because the word “diagnose” is not in the Public Health Code definition of RNs, and some argue that APNs use medical diagnosis in their practice, the state licensing and regulatory department through the Michigan Department of Community Health legal staff has “interpreted” that APN practice is essentially delegated and supervised by medicine (i.e., that the word “diagnose” is included in the Medical Practice Act but not in a description of RN or APN practice). According to this line of reasoning, an APN providing medical diagnosis is the “practice of medicine.” Recent changes were made regarding who administers licensing and regulations of health professionals; this is now under the Department of Licensing and Regulatory Affairs.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

Except referral to PT, referrals are limited to physicians; a 2004 bill allows NPs to perform state-mandated physical examinations.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. NPs prescribe medications currently through a delegated authority agreement with a licensed physician or dentist.

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**NP/physician prescriptive agreement required?** Yes. But for controlled substances prescribing only.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes. It is a delegated act.

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**If so, what words are used to characterize involvement?** The BOM is not involved. A prescriber is defined as a licensed health professional acting under the delegation of and using, recording, or otherwise indicating the name of the delegating physician. NPs prescribe controlled substances under a delegation of prescriptive authority agreement signed by their delegating physician, which, according to the BOM administrative rules and Public Health Code, must be reviewed annually.

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**NP authorized to Rx controlled substances?** Yes.

**If so, what schedules?** NPs who practice in the hospital setting, free-standing surgical suite, and those who practice in oncology/hospice/palliative care may apply for Schedules II–V if permitted by the delegation of prescriptive authority agreement. All other NPs are eligible for Schedules III–V. A delegating physician may not delegate the Rx of Schedule II controlled substances on the day of hospital discharge for more than a 7-day period. Schedules III–V may be prescribed as long as permitted by the delegation protocol.

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**NP issued Rx number by state?** No.

**NP authorized to apply for DEA number?** Yes. Prescriptions for controlled substances written by an NP must include the name of the delegating physician, the physician's DEA number, and the NP's DEA number. DEA registration is not required for inpatient hospital medical orders provided that the NP is an employee or agent of the hospital.

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**If so, what is DEA area field office info?:** Detroit Division Office, 431 Howard Street, Detroit, MI 48226; p: 1-800-230-6844

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** There is no specific requirement for this, although the NP may sign the prescription.

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**Physician name required on Rx pad?** Yes. A delegated prescription must bear the name of the physician who delegates; this applies to controlled and uncontrolled substances.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** A delegating physician may delegate in writing to an RN the ordering, receipt, and dispensing of complimentary starter dose drugs (other than controlled substances). For controlled substances, authority is granted in the delegation of prescriptive authority agreement signed by the NP's delegating physician.

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**If so, where (e.g., statute, rules, opinion)?** The BOM administrative rules and the Public Health Code.

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**Specified limitations or restrictions on NP drug sampling?** As per physician delegation. For controlled substances, per the delegation of prescriptive authority agreement signed by the NP's delegating physician.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** There is no legislation that permits or restricts reimbursement by a third party or HMO.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** No statutes limit NP reimbursement. The barriers to practice reimbursement are related to antiquated statutes around NP practice. Some insurance companies do empanel NPs and directly reimburse them. Other insurance companies cite the NP practice statute ambiguities as

a reason to not directly empanel and reimburse NPs. The Department of Labor and Economic Growth has decided that because NPs are under physician-delegated authority they cannot form an LLC, with or without a physician.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Grand Valley State University—Grand Rapids; (2) Madonna University—Livonia; (3) Michigan State University—East Lansing; (4) Northern Michigan University—Marquette; (5) Oakland University—Rochester; (6) Saginaw Valley State University—University Center; (7) University of Michigan—Ann Arbor; (8) University of Michigan—Flint; (9) University of Detroit Mercy—Detroit; (10) Wayne State University—Detroit

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Grand Valley State University—Grand Rapids; Madonna University—Livonia; Michigan State University; Oakland University—Rochester; Saginaw Valley State University; University of Detroit Mercy—Detroit; University of Michigan—Ann Arbor; University of Michigan—Flint; Wayne State University—Detroit.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Michigan Council of NPs (<http://www.micnp.org/>)

**Organized opposition to NP legislative or regulatory changes?** Yes. The Michigan State Medical Society and the Michigan Osteopathic Association usually oppose.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 57

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "F."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 42 for NPs<sup>†</sup> (4700 in state<sup>†</sup> results in a **1:112 ratio**)
- 18,190 for MDs/DOs/Interns/Residents (44,786 in state<sup>†</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **21 for NPs<sup>†</sup>** (4700 in state<sup>‡</sup> results in a **1:224 ratio**)
- **2624 for MDs/DOs/Interns/Residents** (44,786 in state<sup>‡</sup> results in a **1:17 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

**Relevant medical malpractice law applicable to NPs?** A medical malpractice action must be brought within 6 years after the act or omission. A claimant’s negligence does not bar recovery, but it causes damages to be reduced by the claimant’s percentage of fault (i.e., the doctrine of pure comparative fault). There is one exception: If the claimant’s fault is greater than the aggregate fault of all other persons, then he cannot recover any noneconomic damages. An expert witness in a medical malpractice case must be a licensed healthcare professional and must be board certified and practicing or teaching in the same specialty as the defendant. A complaint alleging malpractice must be accompanied by an affidavit of merit, signed by a qualified healthcare professional. The limit on the amount recoverable for noneconomic damages resulting from the negligence of all defendants was \$280,000 or \$500,000 (for paralysis due to brain or spinal cord injury, impairment of cognitive capacity, or loss of reproductive ability); these amounts increase annually with the cost of living. All malpractice allegations are subject to mandatory review before a mediation panel evaluation to include a finding on the applicable standard of care. A party that rejects the panel’s evaluation and proceeds to trial must pay the opposing party’s actual costs, unless the verdict is more favorable to the rejecting party than the mediation evaluation. The medical malpractice parties may agree to binding arbitration if the total damages claimed, including interest and costs, are less than \$75,000.

**Recent state malpractice liability tort reform?** 2013: Medical liability reform defines what entails noneconomic damages. Medical liability reform regarding prejudgment interest reform ensures that a full 91-day period is given to defendants who submit an affidavit of meritorious defense and ends the practice of prejudgment interest being awarded on attorney fees and costs. 2005–2012: None.



## THE PEARSON REPORT

**STATE:** MINNESOTA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 3450

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** An applicant must be certified by a national nurse certification organization acceptable to the BON. The CNP is certified for APRN practice in a specific field of NP practice.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. By certifying organizations acceptable to the BON.

**BON sole state authority over NPs?** Yes. However, prescribing is a medically delegated function for CNPs. CNPs must maintain a written agreement with a physician based upon standards established by the Minnesota Nurses Association and the Minnesota Medical Association.

**MSN required for practice?** No.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** APRN statutory language includes: (1) 'The 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.' (2) 'Nurse practitioner practice' means, within the context of collaborative management: diagnosing, directly managing, and preventing acute and chronic illness... (3) Definition of collaborative management: '...a mutually agreed upon plan between an APRN and one or more physicians... that designates the scope of collaboration necessary to manage the care of patients.'

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. Except that under MINN. STAT. § 144.6585, "Identification of Health Care Providers," any healthcare provider who is licensed, credentialed, or registered by a health-related licensing board as defined under section 214.01, subdivision 2, must wear a name tag that indicates by words, letters, abbreviations, or insignia the profession or occupation of the individual.



**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** CNPs are not issued a separate license from their RN license; certification is registered on the APRN registry.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** No.

**CE requirements for NP practice?** Determined by the national certification organization.

**If so, what are the specifics?** N/A

**BON mechanism for others to verify NP license?** No. The APRN registry indicates certification as a CNP but is not a primary source of verification.

**Current listing of all active NP licenses maintained by BON?** The BON keeps a registry of NPs with current national certification.

**Current listing of authorized NP prescribers maintained by BON?** No.

**If so, is this a separate list from all active NP licenses?** N/A

**Recent legislative/regulatory changes affecting NP practice?** No.

**Legislative/administrative plans for state?** The Minnesota APRN Coalition was formed by combining members of various APRN groups. They have endorsed the consensus model for APRN regulation and are considering pursuing legislation to incorporate the consensus model recommendations into the Nurse Practice Act.

**Internet address for Nurse Practice Act:**

<http://mn.gov/health-licensing-boards/nursing/laws-and-rules/nurse-practice-act/>

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** Yes. The definition of NP practice includes ‘within the context of collaborative management,’ which is then defined as ‘... a mutually agreed upon plan ... that designates the scope of collaboration necessary to manage the care of patients.’

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** “Collaborative management” is a mutually agreed upon plan between an APRN and physician(s) that designates the scope of collaboration necessary to manage the care of patients.

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** An APRN certified in mental health may act as an examiner to place a patient on emergency hold for care and treatment and to petition the court for retention for treatment; they may also act as a “health officer” for purposes of taking an individual into custody for transport to a treatment facility. APRNs are now listed as one of the providers able to diagnose AD/HD.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** Yes.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** NPs prescribe by written agreement with a physician based on standards jointly established by the state nurses association and the state medical association. NP Rx authority is physician delegated via a written agreement that defines the delegated responsibilities related to the prescription of drugs and therapeutic devices. Written agreements must be maintained at the primary practice site of the APRN and collaborating physician.

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**NP authorized to Rx controlled substances?** Yes. As authorized in the written agreement.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Minneapolis/St. Paul Resident Office, 100 Washington Avenue South, Suite 800, Minneapolis, MN 55401; p: 1-612-344-4136

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** MINN. STAT. § 148.235(4b)

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**Specified limitations or restrictions on NP drug sampling?** Yes. The authority to dispense extends only to the drugs that are described in the written agreement. The authority to dispense includes, but is not limited to, the authority to receive and dispense sample drugs.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**

There is no prohibition against this.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Capella University; College of St. Scholastica—Duluth, St. Paul and St. Cloud; (2) Saint Catherine University—St. Paul; (3) Metropolitan State University—St. Paul; (4) Minnesota State University—Mankato; (5) University of Minnesota—Minneapolis; (6) Winona State University—Winona

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Augsburg College; Capella University; Metropolitan State University; Minnesota State University at Mankato; Minnesota State University at Moorhead; Saint Catherine University; The College of St. Scholastica; University of Minnesota; Walden University; Winona State University.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Association of Southeast Minnesota Nurse Practitioners; Northern Nurse Practitioner Association; MN NP (AANP affiliate); MN Chapter of NAPNAP

**Organized opposition to NP legislative or regulatory changes?** Yes. There are multiple physician professional groups opposed to the APRN bill to eliminate the requirement for the written prescribing agreement: the Minnesota Medical Association, the Minnesota Psychiatric Society, and the Minnesota Society of Anesthesiologists.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 75

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state still deserves ranking of "C."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 13 for NPs<sup>†</sup> (3450 in state<sup>‡</sup> results in a **1:265 ratio**)
- 3471 for MDs/DOs/Interns/Residents (20,174 in state<sup>‡</sup> results in a **1:6 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **1 for NPs<sup>†</sup>** (3450 in state<sup>‡</sup> results in a **1:3450 ratio**)
- **820 for MDs/DOs/Interns/Residents** (20,174 in state<sup>‡</sup> results in a **1:25 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All professional liability claims against healthcare providers, regardless of the injury or the basis of the cause of action, must be brought within 2 years from the date of the cause of action. The claim is barred if the plaintiff’s fault exceeds the combined fault of all defendants or if the plaintiff’s recovery is lessened in proportion to the degree of fault. The claimant’s attorney must file an affidavit stating that a qualified expert found facts that the defendant’s actions deviated from the applicable standard of care. There is no specific statute requiring that medical malpractice cases be arbitrated before litigation. However, the state courts are authorized to establish a system of mandatory, nonbinding arbitration to assist the courts in disposing of any controversy that may lead to civil litigation.

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**Recent state malpractice liability tort reform?** 2005–2013: None. 1992: Statute provides absolute defense against medical liability when doctors adhere to practice parameters and states that noncompliance to practice parameters may not be used as a basis for a cause of action.

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## THE PEARSON REPORT

**STATE:** **MISSISSIPPI**

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse) includes Certified Nurse Practitioners (CNP), Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA)

**Number of NPs in state:** 2455 (not including 702 CRNAs)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The BON recognizes NP educational programs, national certification, and approved practice documentation.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Collaboration and collaborative practice agreement

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** Yes. Mississippi’s truth in advertising law, SB 2670 (2012), requires: (1) that any advertisement identify the type of license a healthcare provider holds; and (2) that the healthcare provider post and affirmatively communicate the specific licensure to patients including by displaying in his/her office a writing (of sufficient size so as to be visible and apparent to all current and prospective patients) that clearly identifies the type of license held.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** NP certification is issued separate from the RN license.

**Supervised practice hours required before full NP practice autonomy?** Yes. New graduates who will sit for national board certification exams within 3 months of graduation may be issued temporary authority to practice for the first 6 months following graduation under the supervision of a CNP or licensed physician, pending board certification results. All new graduates are required to complete 720 hours of supervised practice.

**Supervised practice hours required before full NP prescribing autonomy?** Yes. (See above.)

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**Additional pharmacology hours required for prescribing?** Yes. For controlled substances prescribing.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** NPs must renew their certification as an NP in conjunction with the renewal of their RN license and submit to the BON documentation of at least 40 contact hours related to the advanced clinical practice of the NP within the last 2 years. Two of these hours must be directly related to the Rx of controlled substances. Additionally, the BON has the legal authority to conduct criminal background checks and fingerprinting for new RN graduates, new state licensees, and those with reinstatements of lapsed licenses.

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**BON mechanism for others to verify NP license?** Yes. Via the BON website.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** No.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** Mississippi's truth in advertising law, SB 2670 (2012), requires: (1) that any advertisement identify the type of license a healthcare provider holds; and (2) that the healthcare provider post and affirmatively communicate the specific licensure to patients including by displaying in his/her office a writing (of sufficient size so as to be visible and apparent to all current and prospective patients) that clearly identifies the type of license held.

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**Legislative plans for state?** The Mississippi Nurses Association will be seeking autonomous practice for APRNs.

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**Internet address for Nurse Practice Act:** <http://www.msbn.ms.gov/Documents/NursingPracticeAct.pdf>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Prior to practice as an NP, the applicant must submit protocol/practice guidelines (developed by the NP and collaborating physician) for BON approval. The protocol must be mutually agreed upon by the APRN and collaborating physician, who must be in a "same" practice. An NP who cannot find or who loses a collaborating physician is allowed a period of 90 days to practice without one, with an additional 90 days if he or she still cannot find one; the BOML serves as the collaborating physician during this time.

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**Required physician record/chart review?** Yes. A quality assurance program of 10% or 20 charts per month to provide a valid evaluation of practice is required between the NP and physician and is available for BON and BOML review. A log to validate this must be kept and be available. Each APRN shall meet face to face with a collaborating physician once per quarter for the purpose of quality assurance. Signed minutes of meetings must be kept at the practice site and available for review.

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**Required NP/physician practice agreement?** Yes. All renewals are now online.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** BON

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**If so, is agreement required to be kept/stored/updated?** Yes. The signed agreement is kept at the practice site. The NP must notify the BON immediately if there are any changes in the collaborative/consultative relationship with a licensed physician. All changes in the relationship with the physician/dentist, practice site, and/or protocol or practice guidelines must be BON approved before continuing practice as an NP. The agreement must be renewed every 2 years.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. Except for controlled substances prescribing. The BON has the authority to conduct random audits of patient records at practice sites where APRNs have protocols allowing for prescribing of controlled substances. CRNAs do not prescribe controlled substances.

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**NP/physician prescriptive agreement required?** Yes. It is included in the practice agreement documentation.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The NP must submit a protocol/practice document that is mutually agreed upon by the APRN and collaborating physician for BON approval. The NP and collaborative/consultative physician must have an active quality assurance/continued quality improvement plan in place with regard to prescribing practices.

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**NP authorized to Rx controlled substances?** Yes. The BON may deny controlled substances authority or grant Schedules II–V.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** New Orleans Division Office, Three Lake Way, 3838 N. Causeway Blvd, Suite 1800, Metairie, LA 70002; p: 1-800-514-7302 or 1-800-514-8051

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The BON R&R.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** Yes.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Delta State University—Cleveland; (2) Mississippi University for Women—Columbus; (3) University of Mississippi Medical Center—Jackson; (4) University of Southern Mississippi—Hattiesburg; (5) Alcorn State University—Natchez.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** The University of Southern Mississippi; University of Mississippi Medical Center

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Mississippi Nurses Association

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**Organized opposition to NP legislative or regulatory changes?** Yes. The state medical association.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 65

**Descriptive ranking:** Grade D. The state restricts patient choice.

*\*Pearson Report 2014 update: state now deserves higher ranking of "C-."*

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#### Cumulative number of National Practitioner Data Bank (NPDB) filings:

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 44 for NPs<sup>†</sup> (2455 in state<sup>‡</sup> results in a **1:56 ratio**)
- 3346 for MDs/DOs/Interns/Residents (9543 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **15 for NPs<sup>†</sup>** (2455 in state<sup>‡</sup> results in a **1:164 ratio**)
- **651 for MDs/DOs/Interns/Residents** (9543 in state<sup>‡</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Common law and statutes applicable to other torts generally govern medical malpractice claims; there is little legislation specific to medical malpractice. A medical malpractice action must be brought within 2 years after the alleged act, omission, or neglect is discovered or could have been discovered. A claimant’s contributory negligence does not bar recovery, but the damages are reduced by the jury in proportion to the amount attributable to the claimant (i.e., a pure comparative negligence state). There is no requirement for medical malpractice claims to be heard by an arbitration panel.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Medical liability reform established a hard cap of \$500,000 for noneconomic damages.

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## THE PEARSON REPORT

**STATE:** MISSOURI

**NP title(s) used in this state:** NP (Nurse Practitioner), APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 6923

**NP specialties legislatively specified?** Yes. By nationally recognized certifying bodies that are acceptable to the BON.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification, as outlined in the BON's R&R. Authorized applicants are awarded a document of recognition by the BON; the request for verification of RN license and APRN document of recognition forms list specified categories available (with "other category" also listed).

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. State is no longer accepting new APRNs as uncertified. Those who are currently certified must maintain their status and stay current; if they lapse they will have to be recertified to reapply.

**BON sole state authority over NPs?** Yes (regulatory authority).

**MSN required for practice?** A graduate degree is required (MSN, DNP, etc.).

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No (for regulation). Yes (in relation to collaborative practice).

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Delegation as detailed in a written collaborative practice arrangement.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON issues a separate document of recognition. Effective March 2010, new applicants receive a separate number for their document of recognition (prior to this date the number was the same as the RN license number).

**Supervised practice hours required before full NP practice autonomy?** Not specified in R&R as supervised hours, but NPs who enter into written signed collaborative agreements must work with the collaborating physician for a period of 1 calendar month before the APRN

can work at a site without the presence of the collaborating physician when providing diagnosis and treatment of acutely or chronically ill or injured persons.

**Supervised practice hours required before full NP prescribing autonomy?** Only as described above.

**Additional pharmacology hours required for prescribing?** No.

**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** Board-certified NPs fulfill state requirements by maintaining national certification; uncertified NPs must complete 60 hours of CE in their clinical specialty biannually.

**BON mechanism for others to verify NP license?** Yes. On (nursys.com) or with a phone call (1-573-751-0073), people are able to confirm whether a MO state RN is BON recognized to practice as an APRN; the BON also maintains and updates a monthly list of recognized APRN categories for statistical purposes ([www.pr.mo.gov/nursing.asp](http://www.pr.mo.gov/nursing.asp)).

**Current listing of all active NP licenses maintained by BON?** Yes. It is updated monthly and available as above.

**Current listing of authorized NP prescribers maintained by BON?** As per above, all BON-recognized NPs have uncontrolled prescriptive privileges with a collaborative practice arrangement; a list of those with controlled substance prescriptive authority may be requested in writing from the BON.

**If so, is this a separate list from all active NP licenses?** Yes.

**Recent legislative/regulatory changes affecting NP practice?** Controlled substance prescriptive authority for Schedules III–V was passed in 2008. The rules went into effect November 30, 2010; controlled substance prescribing began December 1, 2012. SB 330 passed and is effective August 28, 2013; it will allow for the waiver of the physician proximity requirement for no more than 28 days per year in order for the APRN to provide care at a rural health clinic that is located more than 50 miles from the hospital sponsor. No rules will be promulgated related to this bill. SB 370, amended onto HB 315, passed and requires, by January 1, 2014, that the Board of Registration for the Healing Arts in the Division of Professional Registration within the department and the State Board of Nursing in the division establish the utilization of telehealth by nurses. An APRN who provides nursing services in accordance with a collaborative practice arrangement under section 334.104 is permitted to provide the services outside the geographic proximity requirements of section 334.104 if the collaborating physician and the nurse utilize telehealth in the care of the patient and if the services are provided in a rural area located in a healthcare professional shortage area. Rules are to be promulgated jointly.

**Legislative plans for state?** To change NP “recognition” to “license.”

**Internet address for Nurse Practice Act:** <http://pr.mo.gov/nursing.asp>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The written collaborative practice arrangement (defined as written collaborative practice agreement, or CPA) contains jointly agreed upon protocols or standing orders for the delivery of healthcare services. A written collaborative practice arrangement is not necessary unless the APRN is functioning under delegated medical acts, including making medical diagnoses, prescribing medical treatments, and prescribing drug therapies.

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**Required physician record/chart review?** Yes. Every 2 weeks the collaborating physician is to review 10% of the total patients seen by the APRN. Once controlled substance prescribing begins, 20% of all cases where the APRN prescribed controlled substances must be reviewed. This review may fulfill the obligation of the required overall 10% total case review, if applicable.

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**Required NP/physician practice agreement?** Yes. If the APRN is performing delegated medical acts including making medical diagnoses, prescribing medical treatments, and prescribing therapies.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** Yes. A documentation of the review process must be on file and available with evidence of revisions “as necessary.” Any termination of the collaborative practice arrangement shall be in writing and maintained for a minimum of 8 years after termination.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No. Written protocols or standing orders are not required if a CPA is used.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** Physical Therapists may now receive referrals from APRNs. Also, an APRN who provides nursing services in accordance with a collaborative practice arrangement is permitted to provide the services outside the geographic proximity requirements if the collaborating physician and the nurse utilize telehealth in the care of the patient and if the services are provided in a rural area located in a healthcare professional shortage area.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Only controlled substance authority will be separate.

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**NP/physician prescriptive agreement required?** An APRN may be delegated prescriptive authority by a physician through the written collaborative practice arrangement. Controlled substance authority will be delegated and described in the CPA.

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**NP Rx from state authorized formulary required?** No. However, there is a requirement for a list of controlled substances that the APRN may prescribe to be included in the CPA.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Delegation. The collaborating physician retains responsibility for the NP's prescriptive decisions.

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**NP authorized to Rx controlled substances?** Yes. Controlled substance prescriptive authority for Schedules III–V.

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**If so, what schedules?** Schedules III–V; Schedule III narcotics are limited to 120 hours worth of medication with no refills.

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**NP issued Rx number by state?** APRNs will be required to register with the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD). An RN with the delegated responsibility specified in a collaborative practice arrangement must obtain a Missouri controlled substance registration number (BNDD number) if they wish to dispense or administer when the physician is not present.

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**NP authorized to apply for DEA number?** Yes. After fulfilling obligations to the BON and the BNDD.

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**If so, what is DEA area field office info?:** Not yet available

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes, the collaborating physician.

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**NP name required on Rx bottle?** Yes, for controlled substances.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In the collaborative practice rules.

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**Specified limitations or restrictions on NP drug sampling?** The NP must follow federal laws.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Nothing requiring or prohibiting; as a result, there is variation with insurance carriers and Medicaid reimbursement.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Central Missouri—Warrensburg; (2) Research College of Nursing—Kansas City; (3) Saint Louis University—St. Louis; (4) University of Missouri—Columbia; (5) University of Missouri—Kansas City; (6) Graceland University—Independence; (7) Maryville University of Saint Louis—St. Louis; (8) Southeast Missouri State University—Cape Girardeau; (9) Southwest Missouri State University—Springfield; (10) University of Missouri—St. Louis; (11) University of Phoenix—St. Louis; (12) Barnes-Jewish College—St. Louis; (13) Central Methodist University—Fayette.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Barnes-Jewish College Goldfarb School of Nursing; Graceland University; Maryville University—St. Louis; Missouri State University; Saint Louis University; University of Missouri—Columbia; University of Missouri—Kansas City; University of Missouri—St. Louis

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Missouri Coalition of Nurses in Advanced Practice (MCNAP)

**Organized opposition to NP legislative or regulatory changes?** Yes. From state medical association, osteopathic association, and state anesthesiologist association.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 36

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "F+."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 25 for NPs<sup>†</sup> (6923 in state<sup>‡</sup> results in a **1:277 ratio**)
- 7694 for MDs/DOs/Interns/Residents (25,279 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (6923 in state<sup>†</sup> results in a **0 ratio**)
- **1691 for MDs/DOs/Interns/Residents** (25,279 in state<sup>†</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Medical malpractice actions must be brought within 2 years from the date of the occurrence. Claimants must file an affidavit stating that a legally qualified healthcare provider determined that the defendant failed to use reasonable care and was directly responsible for or contributed to the damages. A claimant’s recovery of noneconomic damages is limited to \$500,000 from any one defendant (adjusted for inflation). There is no requirement for an arbitrator.

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**Recent state malpractice liability tort reform?** 2007–2013: None. 2006: None. 2005: A statute exempts manufacturers, sellers, marketers, or advertisers of food when the claim is for weight gain, obesity, or a health condition associated with weight gain or obesity. Collateral source rule reform: modifies to allow the actual amount of paid medical expenses to be introduced into evidence rather than the amount billed. Joint and several liability reform: provides that joint and several liability applies if a defendant is 51% or more at fault. Medical liability reform/expressions of sympathy: prohibits statements, writings, or benevolent gestures expressing sympathy by medical providers from being admitted into evidence. Medical liability reform/noneconomic damages: limits noneconomic damages in medical liability cases to \$350,000 regardless of the number of defendants in the case. Medical liability reform/statute of limitations for minors: specifies that actions against physicians and other healthcare providers for malpractice must be brought within 2 years of a minor’s 18th birthday.

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## THE PEARSON REPORT

**STATE:** MONTANA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 609

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** In BON administrative rules, which use the SOP from the licensee's national professional organization.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes, unless "grandfathered."

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** APRNs are issued a license number as an RN with an APRN endorsement, and then their specialty is noted within that endorsement.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** Yes. For Rx authority applications: 45 hours of CE in the past 3 years (in pharmacotherapeutics within the NP's specialty).

**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** Forty CEUs every 2-year licensing period in the NP's specialty. An additional 10 CEUs (in pharmacotherapeutics within the NP's specialty) are required every 2-year licensing period if the NP has Rx authority.

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**BON mechanism for others to verify NP license?** Yes. Call the BON or “Lookup Licenses Individual” at [http://bsd.dli.mt.gov/license/bsd\\_boards/nur\\_board/board\\_page.asp](http://bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp)

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** No.

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**Internet address for Nurse Practice Act:** [http://bsd.dli.mt.gov/license/bsd\\_boards/nur\\_board/board\\_page.asp](http://bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp)

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The SOP for Montana nurses is defined by the Montana Code Annotated (MCA), the Administrative Rules of Montana (ARM), and the BON rules.

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#### NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No. The NP must have a method of quality assurance where a physician and/or an APRN peer of the same specialty (with Rx authority) is identified as part of the plan. The quality assurance method must include 15 charts or 5% of all charts handled by the NP, which must be peer reviewed quarterly using preestablished patient outcome criteria specific to the NP’s patient population with written evaluation of review and steps for corrective action if indicated. NPs must file any proposed change in the quality assurance method with the BON and any change is subject to BON approval.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Denver Division Office, 115 Inverness Drive, East Englewood, Colorado 80112; p: 1-800-326-6900

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Board administrative rule

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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**NP REIMBURSEMENT REALITIES/LIMITATIONS**

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**Legislative language permits NP reimbursement by third party or HMO?** Legislation grants APRNs third-party reimbursement for all areas and services for which a policy would reimburse a physician; HMOs are not included in the indemnity insurance law.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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**OTHER FACTORS RELATED TO NP PRACTICE**

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**Number and listing of NP schools in state:** (1) Montana State University—Bozeman

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Montana State University—Bozeman

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Council on Advanced Practice (CAP), through the Montana Nurses Association (p: 1-406-442-6710)

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**Organized opposition to NP legislative or regulatory changes?** No recent opposition.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 93

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

**\*Pearson Report 2014 update: state still deserves high ranking of "A."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **10 for NPs<sup>†</sup>** (609 in state<sup>†</sup> results in a **1:61 ratio**)
- **1644 for MDs/DOs/Interns/Residents** (4174 in state<sup>†</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (609 in state<sup>†</sup> results in a **0 ratio**)
- **217 for MDs/DOs/Interns/Residents** (4174 in state<sup>†</sup> results in a **1:19 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Medical malpractice allegations of personal injury or wrongful death must be brought within 3 years from the date of injury or from when first discovered. Medical malpractice actions not subject to an arbitration agreement must be first reviewed by the state medical legal panel prior to the complaint filing. The panel decides whether there is substantial evidence that the alleged acts occurred, constitute malpractice, and caused the injury.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Medical liability reform/expressions of sympathy: provides that statements of sympathy, apology, etc. by medical providers are inadmissible as evidence of liability in medical liability cases. Medical liability reform/expert witness standards: provide that an expert witness must be a licensed healthcare provider in at least one state; routinely treat or have routinely treated within the previous 5 years the subject matter of the malpractice claim; and demonstrate a familiarity with the standards of care and practice as related to the subject matter of the malpractice claim.

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## THE PEARSON REPORT

**STATE:** NEBRASKA

**NP title(s) used in this state:** APRN-NP (Advanced Practice Registered Nurse-Nurse Practitioner)

**Number of NPs in state:** 1141

**NP specialties legislatively specified?** Yes. In BON R&R: FNP, ANP, SNP, PNP, GNP, Psychiatric/Mental Health NP, ACNP, WHNP, NNNP.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Within regulation.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** No. APRNs are licensed and regulated by the Department of Health and Human Services, Division of Public Health, which is advised by the APRN Board (separate from the BON, which has responsibility for RNs and LPNs) on all issues related to the regulation of APRNs. The APRN Board has sole regulatory responsibility for APRNs (i.e., NPs, CRNAs, CNMs, CNSs). Under the Department, the APRN Board is charged with establishing standards for Integrated Practice Agreements (IPAs) between APRN-NPs and collaborating physicians, monitoring APRN SOPs, and approving R&R to implement the APRN act and the APRN-NP, APRN-CRNA, APRN-CNM, APRN-CNS acts for adoption and promulgation by the Department.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** The members of both the BON and the APRN Board are appointed by the Board of Health. The APRN Board membership includes one NP, one CRNA, one CNM, one CNS, three physicians, and two consumers. The BON has one advanced practice position on the 12-member board.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Collaboration, supervision, consultation, and direction of NP activities as outlined in the Integrated Practice Agreement (IPA).

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Separate APRN-NP license issued by the Department of Health and Human Services, Division of Public Health.



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**Supervised practice hours required before full NP practice autonomy?** Yes. APRN-NPs must have completed a minimum of 2000 hours of practice under the supervision of a physician.

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**Supervised practice hours required before full NP prescribing autonomy?** No. NPs are required to have their own DEA numbers if prescribing controlled substances; they are not required to have cosignatures or physicians' names on Rxs, even during their 2000 hours of supervised practice.

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**Additional pharmacology hours required for prescribing?** No. An APRN applicant must have completed a minimum of 30 contact hours of education in pharmacotherapeutics and a minimum of 45 contact hours in pharmacotherapeutics, advanced health assessment, and pathophysiology to practice without jointly approved protocols as requirements for licensure. Prescriptive authority is not obtained separately from NP licensure; all licensed NPs have prescriptive authority.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Documentation of 40 contact hours of CE in the clinical specialty area within the previous 2 years, 10 hours of which must be in pharmacotherapeutics.

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**BON mechanism for others to verify NP license?** Yes. Information can be accessed through the APRN Board, separate from the BON. Licenses may be verified online.

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**Current listing of all active NP licenses maintained by BON?** Yes. Maintained by the APRN Board.

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**Current listing of authorized NP prescribers maintained by BON?** All licensed APRN-NPs have prescriptive authority.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. LB 788, which allows NPs to order respiratory services, and LB 1042, which authorizes NPs to sign death certificates, were both signed into law March 2012. Legislation enacted in May 2013 (LB 243) adds the term "acute" to the type of conditions listed in the provisions governing an NP's authorized practice stipulations.

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**Legislative/administrative plans for state?** (1) To work with legislators and the medical association to remove the IPA requirement; (2) to prevent passage of any legislation that would impede NPs' right to practice in a primary care role; (3) to support legislation that provides a malpractice cap for NPs.

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**Internet address for Nurse Practice Act:** [http://dhhs.ne.gov/publichealth/Pages/crl\\_nursing\\_aprn\\_aprn3.aspx](http://dhhs.ne.gov/publichealth/Pages/crl_nursing_aprn_aprn3.aspx)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes. The physician, NOT the BOM.

---

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Collaboration, supervision, and direction of NP activities as per the IPA, under which the NP and physician have both individual and

joint responsibility for management of patient health care. The collaborating physician is responsible for supervision through readily available consultation and direction of the activities of the NP within the NP's defined SOP to ensure the quality of health care provided to patients. NPs must also maintain liability insurance (\$200,000 per incident and \$600,000 aggregate per year).

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes. But if after diligent effort an NP is unable to obtain an IPA with a physician, the APRN Board may waive the requirement (if the NP has demonstrated proper course work, has a master's degree or higher in nursing, has completed 2000 hours under the supervision of a physician, and will practice in a geographic area where there is a shortage of healthcare services).

---

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** Yes. With the APRN Board. The collaborating physician and NP must notify the APRN Board/Department of Health and Human Services, Division of Public Health, upon termination of the IPA agreement.

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**If so, is agreement required to be kept/stored/updated?** Yes. The IPA is filed with the Department, and new ones are to be sent in as changes are made.

---

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Only for NPs who have not completed 2000 hours of supervised practice and either have not earned at least a master's degree or cannot demonstrate 45 contact hours of specified separate course work (in pharmacotherapeutics, advanced health assessment, and pathophysiology or psychopathology) from an approved program. If required, the jointly approved protocols must be created and/or approved by the NP and collaborating physician to guide the NP practice.

---

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** Yes. The NP is required to have an attestation of jointly approved protocols on file with the APRN Board/Department of Health and Human Services, Division of Public Health.

---

**If so, are protocols required to be kept/stored/updated?** No.

---

**Any legislative prohibitions against NP hospital privileges?** No.

---

**Additional limitations/clarifications/expansions to NP practice?** NPs may order respiratory services and are authorized to sign death certificates.

---

## NP SCOPE OF PRACTICE—PRESCRIBING

---

**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** Collaboration, supervision, and direction of NP activities as per the IPA, under which the NP and physician have both individual and joint responsibility for management of patient health care. Prescriptive authority is defined in the scope within the NP Practice Act.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** If the physician wishes to limit the prescribing of Schedule II drugs, this must be recorded in the IPA.

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**If so, what words are used to characterize involvement?** Any limitation on the prescribing authority of the NP for controlled substances listed in Schedule II of NEB. REV. STAT. § 28-405 shall be recorded in the established IPA pursuant to NEB. REV. STAT. § 38-2310.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** St. Louis Division Office, United Missouri Bank Building, 7911 Forsyth Boulevard, Suite 500, St. Louis, MO 63105; p: 1-888-803-1179

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** NP Practice Act

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**Specified limitations or restrictions on NP drug sampling?** Yes. Per the NP Practice Act the NP may dispense, incident to practice only, samples of medications that are provided by the manufacturer at no charge to the patient.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** No.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Not addressed in statute.

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OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Creighton University—Omaha; (2) University of Nebraska Medical Center—Omaha, Lincoln, Kearney, and Scottsbluff; (3) Clarkson College—Omaha.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Creighton University; University of Nebraska Medical Center College of Nursing; Clarkson College (begins 2014); Nebraska Methodist College (begins 2014)

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Nebraska Nurse Practitioners ([www.nebraskanp.org](http://www.nebraskanp.org)); NNP is also a member of the statewide Nebraska Nurses Association ([www.NebraskaNurses.org](http://www.NebraskaNurses.org)).

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**Organized opposition to NP legislative or regulatory changes?** Physician groups are strongly in favor of collaborative practice agreements and many NPs in the state want to have this requirement removed. The medical association has opposed proposed legislation to remove the requirement for an IPA during the last two sessions.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 61

**Descriptive ranking:** Grade D. The state restricts patient choice.

**\*Pearson Report 2014 update: state now deserves a higher ranking of "C-"**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **6 for NPs<sup>†</sup>** (1141 in state<sup>‡</sup> results in a **1:190 ratio**)
- **2068 for MDs/DOs/Interns/Residents** (8607 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **3 for NPs<sup>†</sup>** (1141 in state<sup>‡</sup> results in a **1:380 ratio**)
- **329 for MDs/DOs/Interns/Residents** (8607 in state<sup>‡</sup> results in a **1:26 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Any action to recover damages for negligence actions must begin within 2 years of the purported negligence, or within 1 year after the discovery of the alleged negligence and at least within 10 years of the act. If a plaintiff's negligence is equal to or greater than the total negligence of all defendants, the claimant's damages are reduced in proportion to his share of negligence. There is no statute specifically dealing with expert testimony in medical malpractice cases and there are generally no limits on the amount recoverable as compensatory damages in medical malpractice actions. An excess liability fund is available for qualified healthcare providers if they file proof of financial responsibility and pay a surcharge. All malpractice claims must be reviewed by a medical review panel unless the review privilege is waived by the claimant. The review panel determines whether the defendants acted or failed to act within the appropriate standards of care and whether damages were caused by a failure to act within relevant standards of care; the panel's decision is nonbinding but is admissible in court.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** NEVADA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse—as of July 1, 2013)

**Number of NPs in state:** 880

**NP specialties legislatively specified?** No. But specialties are in the process of being written into the BON regulations.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Defined by regulation, national certification, and education.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. But only for APRNs without a BSN or MSN who completed their program between 1992 and June 1, 2005. New legislation will require all APRNs to be nationally certified by 2014.

**BON sole state authority over NPs?** Yes. For practice. A Board of Pharmacy certificate is required to prescribe.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No. Only for those APRNs who have not yet met the practice requirement and who are prescribing Schedule II controlled substances.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** If the APRN has practiced as an APN for more than 2 years or more than 2000 clinical hours, the APRN is no longer required to have a formal written collaborative agreement with a physician. If an APRN has practiced clinically for less than 2 years or 2000 hours and the APRN's practice includes the prescribing of Schedule II controlled substances, then the APRN is required to have a formal written collaborative agreement with a physician with written protocols. If the APRN (who has practiced less than 2000 hours or has practiced less than 2 years) is not prescribing Schedule II controlled substances, then the APRN is not required to have a formal written collaborative agreement with a physician with written protocols.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The APRN certificate of recognition is issued separately from the RN license. All APRNs must first have an active RN license. These both lapse on the same date.

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**Supervised practice hours required before full NP practice autonomy?** In most cases, no. However, supervised practice may be required after a certain period of inactivity.

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**Supervised practice hours required before full NP prescribing autonomy?** In most cases, no. However, supervised practice may be required after a certain period of inactivity.

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**Additional pharmacology hours required for prescribing?** All prescribing APRNs must have successfully completed an advanced course in pharmacotherapeutics.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Renewal requirements are that the APRN must have completed at least 800 hours of collaborative practice (under the supervision of a physician or an APRN) in the past 5 years and a total of 45 hours of nursing-related CE in the previous 24 months (which includes 15 hours in their specialty).

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes. Visit the BON website to purchase a mailing list or verify licensure/certification.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes. The list of prescribing APRNs can be purchased separately.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. On June 3, 2013, the Governor signed AB 170, which changed the title from APN to APRN, changed the APRN certificate to a APRN license, authorizes the BON to require an APRN to maintain a policy of professional liability insurance in accordance with BON regulations, and deleted the requirement for a collaborative agreement with a physician.

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**Legislative/administrative plans for state?** The goal is to include NPs in the definition of Primary Care Providers.

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**Internet address for Nurse Practice Act:** <http://nevadanursingboard.org/>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** Yes. However, only if the APRN has practiced less than 2 years or has less than 2000 clinical hours and the practice includes the prescribing of Schedule II controlled substances. In this case, the APRN must maintain current protocols that he/she and the collaborating physician have agreed upon as a basis for their practice within their ongoing collaborative relationship.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No (unless the APRN has practiced less than 2 years or 2000 hours).

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**If so, what words are used to characterize involvement?** If the APRN has practiced as an APRN for more than 2 years or more than 2000 clinical hours, the APRN is not required to have a formal written collaborative agreement with a physician to prescribe Schedules II–V controlled substances. If the APRN has practiced clinically for less than 2 years or 2000 hours and the APRN's practice includes the prescribing of Schedule II controlled substances, then the APRN is required to have a formal written collaborative agreement with a physician with written protocols.

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**NP authorized to Rx controlled substances?** *See above.*

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** APRNs receive a prescribing number from the BOP.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Los Angeles Division Office, 255 East Temple Street, 20th Floor, Los Angeles, CA 90012; p: 1-888-415-9822

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The BON issues a certificate to dispense controlled substances, poisons, and dangerous drugs and devices to APRNs who successfully complete an examination administered by the BON on Nevada law relating to pharmacy and who submit proof to the BON that they have received a certificate of registration from the BOP.

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**Specified limitations or restrictions on NP drug sampling?** No. Samples may be distributed by APRNs who have been granted prescribing privileges by the BON and BOP.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Not addressed in statute.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Nevada—Reno; (2) University of Nevada—Las Vegas

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Touro University; University of Nevada—Las Vegas; University of Nevada—Reno

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The Advanced Practice Nurse/Special Practice Group (APN/SPG) is associated with the Nevada Nurses Association (<http://www.nvnurses.org/>).

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**Organized opposition to NP legislative or regulatory changes?** The Nevada Board of Medical Examiners and both state medical associations were opposed to AB 170 and have already commenced organized opposition to the APRNs' success in the 2013 legislative session for autonomous practice.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 73

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state now deserves ranking of "A."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

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Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

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- 13 for NPs<sup>†</sup> (880 in state<sup>‡</sup> results in a **1:68 ratio**)
  - 2689 for MDs/DOs/Interns/Residents (7613 in state<sup>‡</sup> results in a **1:3 ratio**)
- 

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license

recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **5 for NPs<sup>†</sup>** (880 in state<sup>†</sup> results in a **1:176 ratio**)
- **498 for MDs/DOs/Interns/Residents** (7613 in state<sup>†</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Personal injury or wrongful death malpractice action must be brought within 4 years from the date of injury or 2 years from the obvious known date of injury. Medical malpractice plaintiffs must show expert proof of deviation from the standard of care. There is no compensation fund for medical malpractice claimants, nor is there a requirement for physicians to carry professional liability insurance. Prior to filing a complaint, medical malpractice claims must be reviewed by a screening panel, which decides whether they believe malpractice occurred and the probable cause of injury. A claimant may still file in court, but if the panel did not find malpractice and the plaintiff loses, the claimant must pay defendant costs. If the panel determines a likelihood of malpractice and the case is filed in court, then both parties must attend a settlement conference before the case proceeds.

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**Recent state malpractice liability tort reform?** 2003–2013: None. 2002: Medical liability reform limits noneconomic damages to \$350,000, except in cases of “gross malpractice” or a judge determination that there is “clear and convincing evidence” that the noneconomic award should exceed the cap.

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## THE PEARSON REPORT

**STATE:** NEW HAMPSHIRE

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 1675

**NP specialties legislatively specified?** The BON recognizes four categories of APRN (CRNA, CNM, CNS in psychology only, and NP). APRNs only need to pay a single licensing fee, regardless of the number of categories in which they are certified.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The SOP for APRNs is defined in the Nurse Practice Act. All APRNs must practice within guidelines set forth by their national specialty organizations.

**NP title protection?** APRN is defined in the Nurse Practice Act, but there is no definition specific to “nurse practitioner.”

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. Or graduated before July 1, 2004 from an APRN education program accredited by a national accrediting body.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g. collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Licensed by BON as an APRN; there are separate RN and APRN licenses.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for controlled substance prescribing?** APRN applicants who graduated from a BON-recognized APRN program 2 or more years prior to date of application must document 30 educational contact hours pertinent to the requested category within 2 years immediately prior to date of application. There is no specific requirement for a course to relate to controlled substances.

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**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** Thirty hours for RN licensure; 30 additional hours specific to the area of advanced practice specialization, 5 of which must be related to pharmacology. Current certification in a specialty must meet the requirements for 30 CE hours for RN licensure.

**BON mechanism for others to verify NP license?** Yes. Online verification is available through the BON website ([www.nh.gov/nursing](http://www.nh.gov/nursing)). Hard copy verification for initial licensure is available to a licensee applying for endorsement in another state.

**Current listing of all active NP licenses maintained by BON?** Yes. In the database that includes all licensees.

**Current listing of authorized NP prescribers maintained by BON?** All APRNs have the authority to prescribe.

**If so, is this a separate list from all active NP licenses?** N/A

**Recent legislative/regulatory changes affecting NP practice?** No.

**Legislative/administrative plans for state?** The APRN community is collaborating with the NH BON to update language in the Nurse Practice Act so that it aligns closely with the national APRN consensus model. It is anticipated that these changes will create title protection for three APRN roles: CNP, CNM, and CRNA.

**Internet address for Nurse Practice Act:** <http://www.nh.gov/nursing/index.htm>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No. Although there are some federal requirements in critical access hospitals.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** No.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No. APRNs have plenary authority to possess, compound, prescribe, administer, dispense, or distribute controlled and uncontrolled drugs.

**NP/physician prescriptive agreement required?** No.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** No.

**If so, what words are used to characterize involvement?** N/A

**NP authorized to Rx controlled substances?** Yes.

**If so, what schedules?** Schedules II–V

**NP issued Rx number by state?** No.

**NP authorized to apply for DEA number?** Yes.

**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Building, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131; p: 1-617-557-2200

**DEA number required for nonscheduled as well as scheduled Rx?** No.

**NP name on Rx pad?** Yes.

**Physician name required on Rx pad?** No.

**NP name required on Rx bottle?** Yes.

**Authority to receive/dispense drug samples spelled out?** Yes.

**If so, where (e.g., statute, rules, opinion)?** In the Nurse Practice Act.

**Specified limitations or restrictions on NP drug sampling?** No.

**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Rivier College—Nashua; (2) University of New Hampshire—Durham; (3) Massachusetts College of Pharmacy—Manchester

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** None

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The NH NP Association is very active and is affiliated with the AANP and ACNP (<http://www.npweb.org/>).

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**Organized opposition to NP legislative or regulatory changes?** None at this time.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 95

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

**\*Pearson Report 2014 update: state now deserves higher ranking of "A+."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **14 for NPs<sup>†</sup>** (1675 in state<sup>‡</sup> results in a **1:120 ratio**)
- **1618 for MDs/DOs/Interns/Residents** (6230 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **2 for NPs<sup>†</sup>** (1675 in state<sup>‡</sup> results in a **1:838 ratio**)
- **364 for MDs/DOs/Interns/Residents** (6230 in state<sup>‡</sup> results in a **1:17 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** The medical statute of limitations for 2 years was held unconstitutional. The general statute of limitations for personal injury or wrongful death is 3 years, unless the injury was or could not have been discovered. There is no

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patient compensation fund or state-sponsored program of liability insurance for physicians and there is no requirement for binding arbitration. Injury compensatory damages are limited to \$250,000 per claimant and \$2 million per occurrence.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Medical liability reform/pretrial screening panels creates a pretrial screening panel requiring that all medical liability cases go before a three-person panel composed of a judge, an attorney, and a healthcare practitioner of the same or similar specialty as the defendant.

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## THE PEARSON REPORT

**STATE:** NEW JERSEY

**NP title(s) used in this state:** APN (Advanced Practice Nurse)

**Number of NPs in state:** 6800 (total APN population includes NPs, NAs, and CNSs)

**NP specialties legislatively specified?** No. APN regulations (adopted by NJ Register June 16, 2008) eliminated categories of specialization and require that the APN be nationally certified in an APN specialty by a recognized national certifying agency. Those APNs who were certified by the BON in the past in a specialty where national certification is no longer available will continue to be able to renew their certification in the state.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. With the exception that those APNs certified in the state prior to the adoption of new APN regulations on June 16, 2008 will not be required to submit proof of national certification in an APN specialty when renewing their APN state certification.

**BON sole state authority over NPs?** Yes. For practice. Prescribing requires a joint protocol with a collaborating physician. The exception is for Nurse Midwives, who are under the authority of the BOME.

**MSN required for practice?** Yes. A minimum of a master's degree in nursing is required for all APNs (can be an MSN, an MN, or an MA, depending upon the nursing program). Some of the schools have gone to PhD, which would be accepted by the BON.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** The joint protocol required for prescribing must conform to the standards established by the Director of the Division of Consumer Affairs; the joint protocol was developed by a joint committee of the BON with the BOME, but the BON alone maintains regulatory authority over APNs.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** For prescribing purposes only, an APN and physician must engage in collaboration, which means an ongoing process consistent with agreed upon parameters of their respective practice using a joint protocol (i.e., an agreement or contract between an APN and a collaborating physician). In general, the joint protocol relates to the prescription of drugs and devices only and not to practice.

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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** BON issues certification.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Each applicant shall have successfully completed at least 39 hours in pharmacology during the APN graduate education program. In addition, an applicant shall have completed 6 contact hours in pharmacology related to controlled dangerous substances (CDS), including pharmacologic therapy and addiction prevention and management. If the graduate program has folded the CDS content into the graduate pharmacology course (bringing it to 45 hours total), the applicant is not required to take a separate CDS course; in this case, the applicant must submit a description of the pharmacology course indicating that CDS content was covered as required when submitting materials for certification to the BON.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** APNs must obtain 30 contact hours of CE appropriate to their specialty every 2 years. The BON does not specify that these contact hours include pharmacology. The BON randomly audits APNs to ensure compliance.

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**BON mechanism for others to verify NP license?** Yes. The BON operates a verification line (1-973-273-8090) for RN and APN licenses and publishes a list of licensees on the BON website. The verification telephone information is updated within 48 hours of a change to the licensing database and the licensing database is updated in real time.

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**Current listing of all active NP licenses maintained by BON?** Yes. Listed by name and town (not addresses).

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**Current listing of authorized NP prescribers maintained by BON?** All APNs are authorized to prescribe.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** Yes. Legislative changes: (1) Bill S 2197, addressing the use of physician orders for life-sustaining treatment forms, includes APNs in the definition of physician and requires physicians and APNs to pursue continuing education in end-of-life care; passed. (2) Bill S 2443 establishes a pilot accountable care organization in Medicaid; the bill includes APNs among recognized providers and it passed. (3) S 2947 includes NPs among providers who can authorize IDs and handicapped parking placards for disabled persons; it passed. (4) P.L. 2013, CHAPTER 71, approved June 27, 2013, Senate, No. 1912, AN ACT concerning the health of student-athletes, includes an APN as able to conduct the school physical along with a physician and PA. The APN can also determine if the student should participate in sports. Regulations adopted: (1) NJ ADMIN. CODE § 10:44B-1.4d, Manual of Standards for Community Care Residences, adds APNs to health professionals who can complete and sign forms for the annual medical examination

of developmentally disabled living in private residences. (Adopted May 19, 2013); (2) NJ ADMIN. CODE § 13:42A, Division of Consumer Affairs, Certified Psychoanalysts Committee, changed rules on adoption to include Psychiatric APNs among those who can, if they meet the committee's requirements, provide psychoanalysis in the state of NJ. They pointed out that APNs who had met with them to discuss this explained it was an oversight in the rules on their part. (Adopted July 2, 2013). DHSS removed the regulatory requirement in hospital rules that APNs using anesthesia must be supervised by an anesthesiologist, replacing it with language that requires "presence" of an anesthesiologist during "induction, emergence, and critical changes in status." NJANA appealed this rule change in the NJ courts but lost.

**Legislative/administrative plans for state?** NJSNA is working on a long-term plan as per the mandate of the NJSNA membership to remove statutory and regulatory barriers to APN practice. NJSNA is building relationships with non-nurse groups to broaden support and to help the community better understand the role of APNs and the tremendous unmet need for primary care and nursing specialties in the community. Pending legislation/regulations: (1) S 1598/A 1097 legislation pending (the bill passed in February 2012 but was vetoed by the Governor; it was then reintroduced) permits an attending APN to determine cause of death and execute death certification when a physician is not available. (2) S 2354/A 3512, titled "Consumer Access to Health Care Act," eliminates the requirement of a joint protocol with a physician for APNs to prescribe medication; it was introduced in October 2012 and NJSNA continues to work with the legislature on passage. (3) NJ ADMIN. CODE § 10:79A, ACO Demonstration Project, adds APNs to the definition of Primary Care Providers (consistent with the ACO statute); proposed May 6, 2013. (4) NJ ADMIN. CODE § 10:191-1.21e, Department of Children and Families, permits Psychiatric APNs to supervise care plans of emotionally challenged youths in partial care programs; proposed November 5, 2012.

**Internet address for Nurse Practice Act:** [http://www.njconsumeraffairs.gov/nursing/nur\\_rules.htm](http://www.njconsumeraffairs.gov/nursing/nur_rules.htm)

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No. In fact, APNs may serve as “clinical practitioners” according to hospital licensing standards and conduct admission physical exams, obtain informed consent, and evaluate the patient.

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**Additional limitations/clarifications/expansions to NP practice?** APNs are permitted to order laboratory and diagnostic tests (including radiologic tests), to prescribe and order treatments, to perform specific procedures within the SOP of an APN, to order transfusions and procedures related to the collection or donation of blood and blood products, to pronounce death in all clinical settings (though not the pronouncement of brain death or certifying cause of death), and to implement advanced directives for the mentally ill. The DHHS Division of Addiction Services permits APNs to serve as directors of substance abuse counseling centers (those certified), to complete physical examinations of patients, and to prescribe medications. The DHSS Public Health Services regulations authorize APNs (along with physicians and psychologists) to ‘sign the statement of a report related to a diagnosed physical or mental condition likely to result in developmental delay and to issue a proposal for the types and amounts of services that are appropriate through the Early Intervention System.’ APNs can serve as the Primary Care Provider of a lead-burdened child and they are recognized as a choice of provider for hospice patients. APNs are recognized as PCPs who may provide diagnosis supporting the need for custom-made prosthetic and orthotic appliances. APNs are recognized by the Juvenile Justice Commission as providers under medical services, and Psychiatric APNs are authorized to recommend placement in a behavior accountability unit, as are psychiatrists and psychologists. Regulations pertaining to the use of physician orders for life-sustaining treatment forms include APNs in the definition of physician and require physicians and APNs to pursue continuing education in end-of-life care. An APN may order a handicapped placard for a person who is disabled. An APN may determine the health of student-athletes and may complete the school physical along with a physician and PA. The APN can also determine if the student should participate in sports.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. A joint protocol is required for prescribing only. The APN and physician must engage in collaboration (an ongoing process consistent with agreed upon parameters of their respective practice) using a joint protocol (i.e., an agreement or contract between an APN and a collaborating physician). The joint protocol must be cooperatively reviewed, signed, and updated at least annually by both providers.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** APNs (who seek to Rx or order medications or devices) and the collaborating physician must develop a written joint protocol signed by both and maintained on the premises of every office in which the APN practices and updated at least annually to reflect changes in the practice, skills, and reference materials

containing practice guidelines or accepted standards of practice. The joint protocol must contain the nature of the practice, the patient population and settings, the recordkeeping methodology, a list of categories of medications prescribed, specific requirements for recording information and refills, and any rules for direct consultation that may be electronic in nature. A template for this joint protocol is available online from NJNSA (<http://www.njsna.org/displaycommon.cfm?an=1&subarticlenbr=33>).

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**NP authorized to Rx controlled substances?** Yes. Law passed in 2004 authorizes APNs to initiate controlled substances according to a joint protocol. APNs are required to revise their joint protocol to explicitly address whether or not they must consult with the collaborating physician prior to prescribing or ordering controlled substances. All APNs must complete a course with 6 contact hours in controlled substance prescribing. This course need only be taken once. The BON will randomly audit APNs on renewal and will request a copy of course completion from those so audited.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. Only for CDS prescribing. The APN must have a NJ CDS before applying for a federal DEA number (contact the Enforcement Bureau, Drug Control Unit, PO Box 45045, 124 Halsey Street, 3rd floor, Newark, NJ 07101). This number is not required to be printed or recorded on the Rx pad.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Newark Division Office, 80 Mulberry Street, Newark, NJ 07102; p: 1-888-356-1071

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. Additionally, a new regulation requires the NPI number to be preprinted on the pad.

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**Physician name required on Rx pad?** Yes (but not physician's DEA number).

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g. statute, rules, opinion)?** NJ ADMIN. CODE § 13:37-7.10

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. The Department of Banking and Insurance, Division of Insurance Health Benefits, plan changed the language from “primary care physician” to “primary care provider” to acknowledge that APNs are authorized by statute to serve as Primary Care Providers and as such to obtain copays from patients enrolled in health plans. HMO law includes NPs/CNSs among those that health plans “may” recognize as Primary Care Providers. A pilot accountable care organization in Medicaid includes APNs among recognized providers.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. Assisted living standards include APNs in the list of providers patients have a “right to choose”; disability regulations allow APNs to be chosen as PCPs and provide primary care; and DHHS added APNs to the Division of Medical Assistance and Health Services Administration manual among those PCPs or specialists who can collect the copay on Medicaid-insured patients. APNs are included as PCPs on adoption forms.

#### OTHER FACTORS RELATED TO NP PRACTICE

**Number and listing of NP schools in state:** (1) Felician College—Lodi; (2) Monmouth University—West Long Branch; (3) Seton Hall University—South Orange; (4) The College of New Jersey—Ewing; (5) University of Medicine & Dentistry of New Jersey—Newark; (6) Fairleigh Dickinson University—Teaneck; (7) Rutgers, The State University of New Jersey—Newark; (8) Saint Peter’s College—Jersey City; (9) Seton WorldWide, Seton Hall University—Online; (10) William Paterson University—Wayne.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Fairleigh Dickinson University; Felician College; Monmouth University; Rutgers, The State University of New Jersey; Saint Peter’s College; Seton Hall University; University of Medicine and Dentistry of New Jersey; William Paterson University. *\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Forum of Nurses in Advanced Practice of the NJ State Nurses Association ([www.njsna.org](http://www.njsna.org)). The Society of Psychiatric Advanced Practice Nurses of NJ (SNA), founded in 1972, was the first professional nursing body in the country to certify clinical nurse specialists in psychiatric nursing (<http://psychapn.org/>).

**Organized opposition to NP legislative or regulatory changes** Yes. The AMA, NJ Medical Society, and NJ Family Practice Association are opposing S 2354/A 3215, “Consumer Access to Health Care Act” (which eliminates the requirement for a joint protocol with a physician for APNs to prescribe medication).

**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 81

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of “B.”*

#### **Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 50 for NPs<sup>†</sup> (6800 in state<sup>‡</sup> results in a **1:136 ratio**)
- 16,000 for MDs/DOs/Interns/Residents (35,152 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license



recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **2 for NPs<sup>†</sup>** (6800 in state<sup>‡</sup> results in a **1:3400 ratio**)
- **2570 for MDs/DOs/Interns/Residents** (35,152 in state<sup>‡</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All personal injury actions must be brought within 2 years from the date the cause of action began. A claimant’s action is barred if his negligence exceeds the combined negligence of all defendants (i.e., the doctrine of modified comparative negligence) or the recovery is lessened in proportion to the claimant’s percentage of negligence. No defendant is liable for any punitive damages greater than \$350,000. Personal injury claims less than \$20,000 are referred to an arbitrator.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** NEW MEXICO

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner), NP (Nurse Practitioner)

**Number of NPs in state:** 1341

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** By national specialty certification as approved by the BON.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is the NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Qualified CNPs receive a CNP designation on their RN license, along with a separate NP number.

**Supervised practice hours required before full NP practice autonomy?** Yes. Graduate NPs, prior to receiving national nursing certification, must practice under the direct supervision of a physician or state-authorized CNP or CNS in the same specialty. No postgraduate/certification supervised practice hours are required.

**Supervised practice hours required before full NP prescribing autonomy?** Graduate NPs may Rx medications only under the direct supervision of a licensed CNP, CNS, or physician.

**Additional pharmacology hours required for prescribing?** No additional requirements beyond that of the NP program.

**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** The CNP must accrue 50 contact hours of CE every 2 years; at least 5 of these contact hours must meet NP specialty requirements and 15 of these shall be in pharmacology, with 5 in the area of noncancer pain management.

**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** All NPs by definition are prescribers.

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**If so, is this a separate list from all active NP licenses?** The BOP keeps a list of those with DEA numbers and state controlled substances licenses.

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**Recent legislative/regulatory changes affecting NP practice?** House Bill 77 (2011) addressed the epidemic of mortality associated with prescription medication overdoses in the state. Changes by the BON took effect in November 2012, including: (1) CE in noncancer pain management specifically; (2) a requirement to register with the Board of Pharmacy prescription monitoring program (PMP) and to participate regularly in PMP activities; and (3) changes in the rules used by the BON to determine whether a CNP's prescriptive practices are consistent with the appropriate treatment of pain. Legislation passed in the 2013 session allows nurses (including CNPs) to continue to perform ultrasound procedures, with the exception of "diagnostic ultrasound."

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**Legislative/administrative plans for state?** The New Mexico NP Council (NMNPC) has a lobbyist monitoring the yearly introduction of the state medical society's proposed bill, which would authorize a board (being commonly called a "super board" and headed by a physician) to oversee all SOP changes in any healthcare profession. This proposed board would be composed of members from various healthcare professions and the public. NMNPC is opposed to this bill and works actively each year to see that it is defeated.

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**Internet address for Nurse Practice Act:** <http://nmbon.sks.com/uploads/files/New%20Mexico%20Nursing%20Practice%20Act.pdf>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs are authorized to declare death and sign death certificates. Legislation passed in 2013 allows nurses (including

CNPs) to continue to perform ultrasound procedures, with the exception of “diagnostic ultrasound.”

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

**NP/physician prescriptive agreement required?** No.

**NP Rx from state authorized formulary required?** Yes.

**If so, explain specifics of formulary.** It is the CNP’s responsibility to maintain a formulary of dangerous drugs and controlled substances that may be prescribed; the only drugs to be included in the formulary are those relevant to the CNP’s specialty and practice setting. The BON reserves the right to audit the formulary of the CNP.

**BOM/physician involvement in NP prescribing?** No.

**If so, what words are used to characterize involvement?** N/A

**NP authorized to Rx controlled substances?** Yes.

**If so, what schedules?** Schedules II–V

**NP issued Rx number by state?** Yes. If the NP indicates on the BON affidavit that they wish to Rx/distribute controlled substances the BON will send a letter to the BOP authorizing the NP to apply for a state controlled substance and DEA registration.

**NP authorized to apply for DEA number?** Yes.

**If so, what is DEA area field office info?:** Houston Division Office, 1433 West Loop South, Suite 600, Houston, TX 77027; p: 1-800-743-0595

**DEA number required for nonscheduled as well as scheduled Rx?** No. However, some pharmacies ask for it.

**NP name on Rx pad?** Yes.

**Physician name required on Rx pad?** No.

**NP name required on Rx bottle?** Yes.

**Authority to receive/dispense drug samples spelled out?** Yes.

**If so, where (e.g., statute, rules, opinion)?** BON rules

**Specified limitations or restrictions on NP drug sampling?** No.

**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) New Mexico State University—Las Cruces; (2) University of New Mexico—Albuquerque; (3) University of St. Francis—Albuquerque.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** New Mexico State University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** NM Nurse Practitioner Council (NMNPC) ([www.nmnp.org](http://www.nmnp.org))

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**Organized opposition to NP legislative or regulatory changes?** The state Medical Society continues to be against any legislative gains in NP autonomy.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 91

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

**Pearson Report 2014 update: state still deserves a high ranking of "A."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **28 for NPs<sup>†</sup>** (1341 in state<sup>‡</sup> results in a **1:48 ratio**)
- **2950 for MDs/DOs/Interns/Residents** (8504 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **3 for NPs<sup>†</sup>** (1341 in state<sup>‡</sup> results in a **1:447 ratio**)
- **551 for MDs/DOs/Interns/Residents** (8504 in state<sup>‡</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All medical malpractice actions for injury or wrongful death must be brought within 3 years from when the alleged malpractice occurred with the exception of pediatric patients. A claimant's negligence will never bar recovery and will only reduce proportionately the recovery (i.e., pure form of comparative negligence). NPs are NOT covered by the state law that limits malpractice settlements (namely, there is a \$600,000 limit on damages except for punitive damages or those for medical expenses).

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** **NEW YORK**

**NP title(s) used in this state:** NP (Nurse Practitioner)

**Number of NPs in state:** 16,390

**NP specialties legislatively specified?** Yes. Specialties are required, but the specialties are not legislated; they are determined by the program diploma and state board category list.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** NPs are certified to practice (by the Office of the Professions, NY State Education Department Board of Regents) in a specialty area. Current specialty areas are: acute care, adult health, college health, community health, family health, gerontology, holistic care, neonatology, obstetrics/gynecology, oncology, pediatrics, palliative care, perinatology, psychiatry, school health, women's health.

**NP title protection?** Yes.

**National certification required for recognition/practice?** No.

**BON sole state authority over NPs?** Yes. This authority is within the umbrella context of the Board of Regents' jurisdiction.

**MSN required for practice?** No.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Certified NPs may diagnose illness and physical conditions and perform therapeutic and corrective measures exclusively within their specialty area, as long as a collaborative agreement with a physician qualified to collaborate in the same specialty or subspecialty is in place.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. But per the general business law statute, if an NP uses the term "Doctor" when offering to perform health services, he or she must indicate the profession in which they hold a doctorate.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** A "certificate" is awarded by the state education department.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** No.



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**CE requirements for NP practice?** No.

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes. All licensees are listed on the Office of the Professions' website ([www.op.nysed.gov](http://www.op.nysed.gov)).

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**Current listing of all active NP licenses maintained by BON?** Yes. All licensees are listed on the Office of the Professions' website ([www.op.nysed.gov](http://www.op.nysed.gov)).

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**Current listing of authorized NP prescribers maintained by BON?** Yes. Any listed NP with an "F" before their number has prescriptive privileges.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Chapter 274 of the Laws of 2013 (bill numbers S4881A/A7324A) was enacted, with support from the Nurse Practitioner Association (NPA), allowing NPs to issue non patient-specific orders for pharmacists to administer meningococcal disease immunizing agents.

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**Legislative/administrative plans for state?** The NPA introduced legislation for the 2013 session (S4611A/A4846A, The Nurse Practitioner Modernization Act) in both the state Senate and Assembly to eliminate statutory collaboration. This bill passed only in the assembly in 2012 and was reintroduced for 2013. The bills finished the legislative session in the higher education committees of each house. The NPA also introduced (S2672/A4381) to authorize NPs to sign forms relating to activities within their SOP whenever a statute authorizes a physician to do so. The intent of this bill is to rectify those instances in the laws of NY where even though an NP is clearly acting within their SOP they are precluded by statute or regulation from signing certain documents. In addition, the NPA introduced legislation (A4886A/S3280A) authorizing NPs to admit patients to inpatient mental health units. They are currently not authorized to do so by the state's mental hygiene law.

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**Internet address for Nurse Practice Act:** [www.thenpa.org](http://www.thenpa.org)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** NPs must function in collaboration with a physician pursuant to a written practice agreement and written practice protocols. The written practice agreement must include explicit provisions for resolving disagreements regarding a matter of diagnosis or treatment that is within the SOP of both parties. To the extent the practice agreement does not so provide, then the collaborating physician's diagnosis and treatment shall prevail.

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**Required physician record/chart review?** Yes. Each written practice agreement shall provide for a review of a sample of patient records by the collaborating physician at least every 3 months. No minimum number of charts is specified. The names of the NP and the collaborating physician shall be clearly posted in the practice setting of the NP.

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**Required NP/physician practice agreement?** Yes. Practice agreements shall include provisions for referral and consultation, coverage for emergency absences of either the NP or collaborating physician, and resolution of disagreements between the NP and collaborating physician regarding matters of diagnosis and treatment.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?**

Only the first such written practice agreement must be filed with the BON. Thereafter it is not required.

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**If so, is agreement required to be kept/stored/updated?** Yes. Practice agreements and practice protocols shall be maintained in the practice setting of the NP and collaborating physician and shall be available to the department for inspection.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes. NPs and physicians list a state education department–approved protocol text (that is selected from a standard publication list) to serve as protocols that relate to the certificate to practice. Any other protocols germane to the practice setting may be developed jointly or individually by the practitioners and are not part of the actual collaborative agreement. Protocol texts not already specified and approved by the department may be submitted to the department for approval.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** The department (i.e., a practice and protocol committee designated by the Deputy Commissioner for the Professions) in its discretion or upon request of an NP or collaborating physician may review practice protocols for the purpose of ensuring that they are in compliance with accepted medical and nursing practice and state statutes and regulations governing the practice of medicine, nursing, and the prescribing of drugs.

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**If so, are protocols required to be kept/stored/updated?** The protocols must be filed with the department within 90 days of the beginning of practice. The protocol is a signed document verifying that the NP has a written collaborative practice agreement with a physician that includes an approved protocol text related to the specialty area as designated on the NP certificate. A sample collaborative practice agreement can be obtained from the BON. Such protocols may be updated periodically. Following the first practice protocol, it is required only that the NP and collaborating physician have the collaborative agreement with attached protocol kept onsite for inspection.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs may write home health personal aid services, may conduct the medical exam and complete the report required prior to admission to an assisted living residence or an adult care facility, may act as medical inspector in school districts, may order respiratory therapy, may obtain limited test site permits under CLIA, may declare an emergency in relation to ordering utilities turned back on after “shutoff” action, and may prescribe non patient-specific orders (i.e., certain immunizations, anti-anaphylactic agents, PPD tests, and rapid HIV tests). The NY Department of Motor Vehicles (DMV) now accepts NP signatures on their certifications for bus driver physicals

and medical certification forms for drivers who experience a “loss of consciousness” event. NPs are granted authority to sign death certificates. NPs are included in the DMV online vision registry. NPs may issue non patient-specific orders for pharmacists to administer meningococcal disease immunizing agents.

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### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. NPs who have satisfied all requirements for certification may be authorized to issue prescriptions after completing instruction satisfactory to the department relating to prescriptions and recordkeeping. Prior to prescribing, NPs must obtain a certificate from the department. The certificate states whether the NP has successfully completed an appropriate pharmacology component or equivalent necessary to be authorized to prescribe. NPs may Rx drugs, devices, and immunizing agents in accordance with the practice agreement and practice protocols. However, if an NP comes from another state, he or she must take the pharmacy law course (online).

**NP/physician prescriptive agreement required?** Yes. The practice agreement and protocols govern the prescribing of drugs. The law authorizes NPs to prescribe drugs for treatment of patients within their specialty area of practice. In terms of controlled substances, NPs may order drugs from Schedules II–IV without restriction. Drugs, immunizing agents, tests, devices, and procedures ordered by NPs do not require a cosignature from the collaborating physician.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** Yes. But only related to the written practice agreement and practice protocols.

**If so, what words are used to characterize involvement?** Collaboration within the written practice agreement and practice protocols.

**NP authorized to Rx controlled substances?** Yes.

**If so, what schedules?** Schedules II–IV

**NP issued Rx number by state?** No.

**NP authorized to apply for DEA number?** Yes.

**If so, what is DEA area field office info?:** New York Division Office, 99 Tenth Ave, New York, NY; p: 1-877-883-5789

**DEA number required for nonscheduled as well as scheduled Rx?** No.

**NP name on Rx pad?** Yes. The Rx pad is now issued only from the NY Department of Health to all authorized providers.

**Physician name required on Rx pad?** No.

**NP name required on Rx bottle?** Yes.

**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Pharmacy statute R&R.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**

Yes. In 2011, The Nurse Practitioner Association, New York State, succeeded (after nearly 10 years of advocacy) in getting NPs included in the New York State Health Insurance Program's Empire Plan for state and local government employees. The Public Employees Federation and the Civil Service Employees Association now permit NPs to apply for credentialing with the Empire Plan health insurance program. The two unions have a combined total of approximately 122,000 members. This will permit NPs thus credentialed to receive reimbursement for service as per those contracts. In other words, once NPs are credentialed they can receive direct reimbursement. The Empire Plan will look to first credential those NPs who are engaged in NP-owned practices as NPs in non-NP owned practices are already being reimbursed through those practices.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Adelphi University—Garden City; (2) Binghamton University, SUNY Binghamton; (3) College of Mount Saint Vincent—Riverdale; (4) Columbia University—New York; (5) D'Youville College—Buffalo; (6) Pace University—New York; (7) SUNY Institute of Technology—Utica; (8) University at Buffalo—Buffalo; (9) University of Rochester—Rochester; (10) Daemen College—Amherst; (11) Dominican College—Orangeburg; (12) Hunter-Bellevue College of the City University of New York—New York; (13) Keuka College—Keuka Park; (14) Long Island University, C.W. Post—Brookville; (15) Long Island University—Brooklyn; (16) Molloy College—Rockville Centre; (17) Mount Saint Mary College—Newburgh; (18) Nazareth College of Rochester—Rochester; (19) New York University—New York; (20) Saint John Fisher College—Rochester; (21) Stony Brook University—Brockport; (22) SUNY College at Brockport—Brockport; (23) SUNY Downstate Medical Center at Brooklyn—Brooklyn; (24) SUNY Upstate Medical University—Syracuse; (25) The College of New Rochelle—New Rochelle; (26) The Sage Colleges, Department of Nursing—Troy; (27) Wagner College—Staten Island; (28) Mercy College—Dobbs Ferry.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Binghamton University; Columbia University; Daemen College; D'Youville College; Hunter College of CUNY; New York University; Pace University; St. John Fisher College; Stony Brook University; University at Buffalo; University of Rochester; Upstate Medical University.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The NP Association, NY State (NPA; [www.thenpa.org](http://www.thenpa.org))

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**Organized opposition to NP legislative or regulatory changes?** Opposition tends to depend upon the issue; there is strong resistance from the medical society to increasing NP autonomy and/or reimbursement.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 85

**Descriptive ranking:** Grade B. State partially supports patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "B."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **164 for NPs<sup>†</sup>** (16,390 in state<sup>‡</sup> results in a **1:100 ratio**)
- **48,608 for MDs/DOs/Interns/Residents** (84,474 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **59 for NPs<sup>†</sup>** (16,390 in state<sup>‡</sup> results in a **1:278 ratio**)
- **7103 for MDs/DOs/Interns/Residents** (84,474 in state<sup>‡</sup> results in a **1:12 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All medical malpractice actions must be brought within 2 ½ years from the act or omission. A claimant's negligence, no matter how great, will not bar recovery (i.e., a pure comparative negligence state), but the recoverable damages will be proportionately reduced. There is no limit to the amount of recoverable damages, there is no patient compensation fund, and physicians are not required to carry liability insurance. There is a procedure for defendants to concede liability in exchange for an agreement to arbitrate damages.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** NORTH CAROLINA

**NP title(s) used in this state:** NP (Nurse Practitioner)

**Number of NPs in state:** 4634

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Defined by national certification and education.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** No. NP rules are developed by the Joint Subcommittee (JSC) of the BON and the NC Medical Board (NCMB) and then must be approved by both boards. The JSC also recommends disciplinary actions.

**MSN required for practice?** Yes.

**Requirement for advanced practice nurse member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** The JSC, composed of three members each of the BON and NCMB, develops rules to govern the performance of “medical acts” and recommends disciplinary actions. The BON and BOM have the responsibility for securing compliance with these rules.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** “Approval to practice” is defined as authorization by the BON and BOM for an NP to perform “medical acts” within her/his area of educational preparation and certification under a collaborative practice agreement (CPA) with an NC-licensed physician for ongoing supervision, consultation, collaboration, and evaluation of the medical acts performed. Such medical acts are in addition to those nursing acts performed by virtue of RN licensure.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** “Approval to practice” is separate from the RN licensure. Formal notice that an NP has been granted approval to practice is issued by the BON.

**Supervised practice hours required before full NP practice autonomy?** During the first 6 months of the initial collaborative practice agreement, the NP and primary supervising physician are required to hold monthly “quality improvement process” meetings. After this initial period, the NP and primary supervising physician must hold these meetings at least every 6 months.



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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** No.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** N.C. ADMIN. CODE tit. 21, r. § 36.0807 states that the NP shall earn 50 contact hours of CE each year. At least 20 of these hours must be those for which approval has been granted by the American Nurses Credentialing Center, the Accreditation Council on Continuing Medical Education, or other national credentialing bodies or practice-relevant courses in an institution of higher learning.

NPs may choose to obtain formal CE credits from these bodies for the full 50 hours or they may choose to complete the following activities for all or any part of the 30 hours that do not have to meet the formal criteria.

1. Clinical Presentations (5 hours): Designing, developing, and conducting an educational presentation or presentations for health professionals totaling a minimum of 5 contact hours
  2. Preceptor Hours (up to 30 hours): With validation from educational program
  3. Author (5 hours): On a journal article or book chapter published during the renewal year
  4. Primary or Secondary Author (15 hours): For a book published during the renewal year
  5. Research Project (10 hour): Completion of an institutional review board (IRB)–approved research project related to the NP’s certification specialty
  6. Professional Volunteer Service (5 hours): Completed during the renewal year with an international, national, state, or local healthcare-related organization in which the NP’s certification specialty expertise is required. Examples of accepted volunteer activities include sitting on boards of directors, committees, editorial boards, review boards, or task forces.
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**BON mechanism for others to verify NP license?** Yes. Online verification is available on the BON and BOM websites.

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**Current listing of all active NP licenses maintained by BON?** Yes. The BON maintains a database of those “approved to practice” as NPs.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No. All active NPs with current approval to practice are authorized to prescribe.

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**Recent legislative/regulatory changes affecting NP practice?** *Refresher course requirement:* Effective January 1, 2013, the time out of practice before an NP is required to complete a refresher course decreased from 5 years to 2 years. Therefore, effective January 1, 2013, NPs who have been out of practice for longer than 2 years are required to complete the Board-approved NP refresher course before they can be approved to practice. Visit the BON website ([www.ncbon.com](http://www.ncbon.com)) to access information on NP refresher course requirements. Additionally, the BON and NCBM recently approved a proposed addition that is currently in the rulemaking process.

It would allow an NP to obtain approval to practice that would be limited to activities required by the refresher course. This would facilitate NPs obtaining clinical placements and individual malpractice insurance.

**NP prescribing rule:** Effective December 1, 2012, NPs shall not prescribe controlled substances, as defined by the state and federal controlled substances acts, for the NP's own use or that of an NP's supervising physician, or that of a member of the NP's immediate family, which shall mean a spouse, parent, child, sibling, or parent-in-law, son- or daughter-in-law, brother- or sister-in-law, step-parent, stepchild, step-siblings, or any other person living in the same residence as the licensee; or anyone with whom the NP is having a sexual relationship or has a significant emotional relationship.

**Legislative/administrative plans for state?** Senate Bill 555 was introduced at the request of the NCNA on April 1, 2013. This bill was designed to move regulation of NPs under the sole jurisdiction of the BON and would have eliminated the JRS. Although SB 555 garnered a lot of support, the bill was essentially stuck in the back of the line behind many significant policy issues being considered by legislators this session. NCNA intends to renew efforts at getting this legislation passed at the next opportunity.

**Internet address for Nurse Practice Act:** <http://www.ncbon.com/dcp/i/news-resources-online-services-forms-applications>

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** Yes.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Primary supervising physician means the licensed physician who, by signing the NP application, shall provide ongoing supervision, collaboration, consultation, and evaluation of the medical acts performed by the NP as defined in the collaborative practice agreement (CPA). The primary supervising physician shall assure both boards (BON and BOM) that the NP is qualified to perform those medical acts described in the CPA.

**Required physician record/chart review?** Cosigning of charts is not required. The primary supervising physician and the NP shall develop a process for the ongoing review of the care provided in each practice site, including a written plan for evaluating the quality of care provided for frequently encountered clinical problems. The plan must include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified timeframe. The quality improvement process shall include scheduled meetings between the primary supervising physician and the NP: monthly for the first 6 months and then at least every 6 months thereafter. Documentation of such meetings must be kept onsite for 5 years and be available for review by members or agents of either board.

**Required NP/physician practice agreement?** Yes.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No. However, the CPA is maintained at the practice site and must be available for inspection by member or agents of either board.

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**If so, is agreement required to be kept/stored/updated?** The CPA shall be reviewed at least yearly. This review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the NP, appended to the CPA, and available for inspection by members or agents of either board.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs are authorized to sign death certificates.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** No. However, prescribed/ordered drugs, devices, and tests must be included in the CPA.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Prescribing, ordering, and dispensing are allowed as long as the drug or device is included in the CPA.

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**NP authorized to Rx controlled substances?** Schedules II, II-N, III, III-N, IV, and V, as defined by the state and federal controlled substances acts, may be procured, prescribed, or ordered as established in the CPA, provided all of the following requirements are met: the NP has an assigned DEA number that is entered on each prescription for a controlled substance; dosage units for Schedules II, II-N, III, and III-N are limited to a 30-day supply; and the supervising physician(s) possesses the same schedule(s) of controlled substances as the NP's DEA registration.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No. The number is issued by the BON.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Atlanta Division Office Registration, 75 Spring Street SW, Room 740, Atlanta, GA 30303; p: 1-888-219-8689

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** Not required, but most pharmacies place the NP name on the bottle as the authorized prescriber (and not the physician's name).

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The BON and BOM regulations and on the Board of Pharmacy website.

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**Specified limitations or restrictions on NP drug sampling?** No. An NP may dispense sample medications without a pharmacy permit but must comply with dispensing laws for labeling, education, and recordkeeping.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Third-party reimbursement legislation passed in 1993 mandates direct reimbursement to NPs for any plan-covered service within their SOP when reimbursable to another provider. The managed-care patients' bill of rights legislation passed in 2001 includes antidiscrimination language. NPs who want to apply for MCO empanelment must be allowed to do so (although this does not guarantee panel inclusion). Once added to panels, billing may be done under the NP's name.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. NPs may be listed in provider directories if requested by their employing physician. The managed-care patients' bill of rights legislation passed in 2001 includes antidiscriminatory language. NPs who want to apply for MCO empanelment must be allowed to do so (although this does not guarantee panel inclusion).

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Duke University—Durham; (2) East Carolina University—Greenville; (3) Gardner-Webb University; (4) University of North Carolina—Chapel Hill; (5) University of North Carolina—Greensboro; (6) University of North Carolina—Charlotte; (7) University of North Carolina—Wilmington; (8) Western Carolina University—Cullowhee; (9) Winston-Salem State University—Winston-Salem.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** \*Duke University, \*Gardner Webb University. Note: In February 2013, the UNC System's Board of Governors approved the DNP program at six public campuses: East Carolina University—Greenville; University of North Carolina—Chapel Hill; University of Nursing Carolina—Charlotte; University of North Carolina—Greensboro; Winston-Salem State University—Winston-Salem; and Western Carolina University—Cullowhee.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The NC Nurses Association has an NP Council (<http://www.ncnurses.org/>).

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**Organized opposition to NP legislative or regulatory changes?** Yes. The NC Medical Board, the NC Medical Society, the NC Academy of Family Physicians, and BCBS have been vocal in their opposition to NPs who are seeking full practice authority and reimbursement.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 57

**Descriptive ranking:** Grade F. The state severely restricts patient choice.

**\*Pearson Report 2014 update: state still deserves a ranking of "F."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **71 for NPs<sup>†</sup>** (4634 in state<sup>‡</sup> results in a **1:65 ratio**)
- **6817 for MDs/DOs/Interns/Residents** (33,213 in state<sup>‡</sup> results in a **1:5 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **40 for NPs<sup>†</sup>** (4634 in state<sup>‡</sup> results in a **1:116 ratio**)
- **1760 for MDs/DOs/Interns/Residents** (33,213 in state<sup>‡</sup> results in a **1:19 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Senate Bill 33 was ratified by the General Assembly on June 13, 2011. Although it was subsequently vetoed by Governor Perdue, the General Assembly overrode the veto and thus the provisions of this bill took effect on October 1, 2011. One of the most publicized provisions of this bill is that in medical malpractice cases, there is now a cap (\$500,000) on noneconomic damages except where the jury finds

that death or serious injury was caused by the defendant's gross negligence (more than mere negligence). Also, changes to the expert witness review requirement in the NC Rules of Civil Procedure (a requirement that medical malpractice cases be reviewed by an expert prior to a complaint being filed with the court) now requires the expert to review *all* medical records, favorable and unfavorable to the plaintiff. Finally, the burden of proof was raised in actions where the treatment at issue was for an "emergency medical condition." Malpractice suits must be brought within 3 years from the date of the cause of action or within 1 year of the date when the injury occurred. If a claimant contributed to negligence, recovery is barred completely; a patient's unreasonable failure to follow the defendant's medical advice can be considered contributory negligence—adequate to bar recovery; there is no limit on potential recoverable compensatory economic damages; however, compensatory noneconomic damages will be capped at \$500,000 unless gross negligence is found. Punitive damages will be limited to a maximum of \$250,000. Physicians/NPs are not required to carry liability insurance.

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**Recent state malpractice liability tort reform?** 2012–2013: None. 2011: See above. 2005–2010: None.

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## THE PEARSON REPORT

**STATE:** NORTH DAKOTA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), NP (Nurse Practitioner)

**Number of NPs in state?** 540 NPs

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Specialty program and national certification as approved by the BON.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes. Effective August 1, 2013, one APRN must be a member.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** An APRN may be granted an advanced practice license by the BON, an NP number that is the same as the RN number.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** Yes. APRNs with Rx authority must complete 15 hours of CE related to pharmacology during each 2-year renewal period.

**CE requirements for NP practice?** Yes.

**If so, what are the specifics?** All individuals renewing a license must meet or exceed 400 hours of nursing practice in the preceding 4 years. Additionally, all applicants must complete 12 contact hours within the preceding 2 years; these hours may be included in the 15 contact hours for pharmacology.

**BON mechanism for others to verify NP license?** Yes.



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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** No. The 2013 session did not impact practice.

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**Legislative/administrative plans for state?** Not at this time.

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**Internet address for Nurse Practice Act:** [https://www.ndbon.org/nurse\\_practices\\_act.asp](https://www.ndbon.org/nurse_practices_act.asp)

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#### NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Chicago Division Office, 230 S. Dearborn Street, Suite 1200, Chicago, IL 60604; p: 1-312-353-9166

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. However, many scripts are submitted electronically.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In the BON's administrative R&R.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**  
Yes. NPs are now recognized by all third-party payers, Medicare, and Medicaid as Primary Care Providers.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) North Dakota State University—Fargo; (2) University of Mary—Bismarck; (3) University of North Dakota—Grand Forks.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** North Dakota State University; University of North Dakota will offer a postmaster's DNP in fall of 2013; University of Mary will offer a DNP in the fall of 2013.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** North Dakota Nurse Practitioners Association (NDNPA)  
<http://ndnpa.org/>

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**Organized opposition to NP legislative or regulatory changes?** Not prominent at this time.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 76

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state now deserves higher ranking of "A."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **5 for NPs<sup>†</sup>** (540 in state<sup>‡</sup> results in a **1:108 ratio**)
- **943 for MDs/DOs/Interns/Residents** (3477 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **1 for NPs<sup>†</sup>** (540 in state<sup>‡</sup> results in a **1:540 ratio**)
- **278 for MDs/DOs/Interns/Residents** (3477 in state<sup>‡</sup> results in a **1:13 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice claimants must bring action within 2 years from the date the cause of action. The state has adopted a doctrine where the plaintiff’s action is barred if his fault equals or exceeds the combined fault of all potential defendants and the recovery is lessened to his degree of fault (i.e., modified comparative negligence). There is a \$500,000 cap on noneconomic damages. The North Dakota Medical Malpractice Mutual Insurance Company creates a cap on the liability of its policyholders with limits of at least \$500,000 per occurrence and \$1 million in the aggregate. The claimant’s attorney must inform the claimant (before initiating a claim) about all alternative dispute

resolution options available to him and the defense counsel must inform the healthcare provider about the alternatives; both parties must make a good faith effort to resolve the dispute before a lawsuit is filed.

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**Recent state malpractice liability tort reform?** 2008–2013: None. 2007: Clarifies that a statement or any kind of gesture or conduct from a healthcare provider or their employee that expresses apology or any type of sympathy is not admissible as evidence of liability. 2006: None. 2005: Exempts from civil liability producers, manufacturers, sellers, etc. of food for claims arising out of weight gain, obesity, or health conditions.

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## THE PEARSON REPORT

**STATE:** OHIO

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner), APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 6671

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** SOP is defined by the state's laws and rules, as well as national certifying bodies.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. This is verified through primary source verification.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. An earned graduate degree with a major in a nursing specialty or in a related field that qualifies the applicant to sit for a national certifying organization examination.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Collaboration. NPs can only practice in collaboration with a physician or podiatrist whereby the NP has a written standard care arrangement (SCA) in place prior to practicing with one or more collaborating physicians or podiatrists and who is/are continuously available to communicate with the NP via some form of telecommunication. Direct supervision and indirect supervision are required only as they relate to the initial prescribing experience (certificate to prescribe—externship, CTP-E).

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** Nothing in the Ohio nursing laws and rules prohibits a nurse from using the term “Dr.”; the regulations require the nurse to display their applicable APRN title or communicate the applicable title during telephonic communications with a patient. The medical law and rules (OHIO REV. CODE § 4731.34) do prohibit the use of this title or similar titles if used to represent the person as engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any branches. Several other disciplines, such as Doctor of Physical Therapy (DPT), Doctor of Psychology (PsyD), and Doctor of Pharmacy (PharmD) use the title “Dr.” in the state of Ohio.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** An individual must have a separate RN license issued prior to being authorized to practice as an NP by the BON. They must keep RN and the certificate of authority current and renew at same time every 2 years. No paper copy is issued; verification of licensure is online ([www.nursing.ohio.gov/Verification.htm](http://www.nursing.ohio.gov/Verification.htm)).

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. The CTP-E. A prescribing NP has full prescriptive authority during an externship, the initial period of prescribing. However, there is enhanced NP/physician oversight for 1500 hours (maximum of 1800 hours). During the externship, 500 of the 1500 hours must be direct supervision (physician must be onsite); 200 of these 500 hours may be with a prescribing APRN who has a CTP and who is not in a CTP-E. During the externship, the NP's prescribing activities are reviewed and evaluated by a supervising professional (i.e., a physician or APRN authorized by the BON to prescribe and who has an SCA with the supervising physician). The SCA between the collaborating physician and NP specifies the frequency of the review needed for appropriate oversight but must occur more frequently than for those NPs not in an externship.

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**Additional pharmacology hours required for prescribing?** Yes. To be eligible for a CTP-E, an applicant shall complete a minimum of 45 BON-approved contact hours (within 3 years immediately preceding the application) on content that ensures preparation for the safe prescribing of drugs and devices including Schedule II controlled substances. NPs moving to Ohio who meet the requirements for an exempt or a reduced externship due to the passage of SB 89 will need to complete 2 contact hours specific to prescribing in Ohio.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** NPs, as Ohio RNs, are required to obtain 24 contact hours every 2 years, including 1 contact hour related to Ohio nursing law and rules. Holders of certificates to prescribe require documentation of having completed during the previous 2 years at least 12 hours of additional CE in advanced pharmacology, which includes instruction that is specific to controlled substances, or, if the certificate has been held for less than a full renewal period, at least 6 hours of approved CE in pharmacology, which includes instruction specific to controlled substances. The NP must also remember to keep current with the CE requirements related to his/her NP specialty certification board.

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**BON mechanism for others to verify NP license?** Yes. Available online at the BON website ([www.nursing.ohio.gov/Verification.htm](http://www.nursing.ohio.gov/Verification.htm)).

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No (online with NP certificate of authority list).

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**Recent legislative/regulatory changes affecting NP practice?** Yes. SB 83, effective June 8, 2012, expanded Schedule II drug prescriptive authority. Unfortunately, concessions had to be made, and only 14 places of service were accepted. HB 253, effective March 24, 2013, expanded the SOP of APRN's and Physician Assistants to declare death in certain situations. Death may be pronounced if an individual is not being artificially sustained or resides in a nursing home, residential care facility, home for the aging, county home, district home, or residential facility, or are under a hospice care program. This legislative change does not allow for any completion of the death certificate. HB 303, also effective March 24, 2013, is a technical bill that updated terminology and modified a few items in the Nurse Practice Act. Modifications included: adoption of Advanced Practice Registered Nurse title, or APRN, as a permissive title; definition of NP now includes "...provides services for acute illnesses"; and certificate to prescribe externship extension period changed to 2 years instead of 1.

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**Legislative/administrative plans for state?** The Ohio Action Coalition, partially sponsored by the Robert Wood Johnson Foundation, is actively working on the recommendations cited in the IOM's *Future of Nursing* report. The Ohio Association of Advanced Practice Nurses (OAAPN), in concert with the AANP, has activated a full scope committee to change legislative barriers to practice. Following are a few current active initiatives. HB 104: Planned amendment to obtain authorization for certain APRNs to mandate an emergent mental health exam for patients who plan to cause harm to others or self. HB 139: To permit certain APRNs and Physician Assistants to admit patients to hospitals. Expand delegation of medication administration to unlicensed healthcare workers: The inability for APRNs to delegate medication administration to Medical Assistants remains an obstacle for improved provider efficiency and patient flow. OAAPN worked with the Ohio Nurses Association to find common ground.

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**Internet address for Nurse Practice Act:** [http://www.nursing.ohio.gov/Law\\_and\\_Rule.htm](http://www.nursing.ohio.gov/Law_and_Rule.htm)

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Collaboration. An NP may practice only in accordance with an SCA entered into with one or more collaborating physicians or podiatrists.

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**Required physician record/chart review?** As specified in the SCA, but at least annually. NPs with prescriptive authority must have prescriptive reviews at least semi-annually and more frequently during the CTP-E.

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**Required NP/physician practice agreement?** Yes.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** The SCA must be signed annually by the APRN and physicians or podiatrists who are a party to it. Effective February 1, 2011, BON administrative rules were adopted to permit the use of a physician's designated representative to sign on the other physician's behalf if certain criteria are met. The signed SCA must be kept current and be available upon request at each practice site. The BON must be notified of any



change in the collaborating physician/podiatrist and/or contact info/address within 30 days of the change.

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** Yes. Hospital admitting privileges (see initiative to change with HB 139 discussed earlier).

**Additional limitations/clarifications/expansions to NP practice?** CNPs may give orders for physical therapy, may supervise services provided by a home health agency if included in the SCA, and may legally sign to issue handicap placards and plates for their qualified clients. NPs are not permitted to delegate medication administration to unlicensed persons (e.g., Medical Assistants). Death may be pronounced if an individual is not being artificially sustained or resides in a nursing home, residential care facility, home for the aging, county home, district home, or residential facility, or is under a hospice care program. This legislative change does not allow for any completion of the death certificate.

#### NP SCOPE OF PRACTICE—PRESCRIBING

**NP Rx authority granted separate from practice authority?** Yes. A certificate to prescribe issued by the BON authorizes the NP to Rx drugs and therapeutic devices in collaboration with one or more physicians or podiatrists. The APRN prescriber may not prescribe Schedule II controlled substances in collaboration with a podiatrist.

**NP/physician prescriptive agreement required?** Yes. A physician or podiatrist must enter into an SCA with an NP (i.e., being continuously available to communicate with the NP in person or via other forms of communication).

**NP Rx from state authorized formulary required?** Yes.

**If so, explain specifics of formulary.** The Committee on Prescriptive Governance under the auspices of the BON establishes a formulary that is reviewed at least annually and is available on the BON website. Drugs are categorized as “may prescribe,” “may not prescribe,” “physician consultation” (where the NP must initiate the medication after direct consultation with the collaborating physician), or “physician initiation” (where the NP may physically write the first initial prescription but the collaborating physician must personally examine and evaluate the patient before therapy is initiated). Other restrictions within the formulary that limit NP prescribing include the practice setting or the collaborating physician’s specialty.

**BOM/physician involvement in NP prescribing?** Yes.

**If so, what words are used to characterize involvement?** APRN prescribing must be in accordance with the BON formulary; APRNs must prescribe as agreed to and stated in the SCA. The NP needs to consult the physician to initiate a medication when the formulary indicates such for a particular drug or category of drug. The formulary contains many drugs and drug categories that require no physician consultation prior to the NP initiating the drug.

When applicable, the NP documents the consultation in the patient's record, noting the consulting physician's name and the date the consultation took place. The NP and collaborating physician must conduct a periodic review, at least semiannually, of a representative sample of prescriptions written by the NP (and more frequently for those in the prescribing externship period). The NP must not prescribe outside or above that of the collaborating physician.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V. The NP may Rx Schedule II only for a patient with a “terminal condition” (as defined by law in the OHIO REV. CODE) and only if the NP's collaborating physician initially prescribed the medication for the patient; the NP may only refill the medication for an amount necessary for a 24-hour period unless the patient is located in one of 14 sites outlined in the law. If practicing in one of the newly authorized practice sites, NPs may prescribe Schedule II medications with minimal restrictions. APRNs may not prescribe a Schedule II controlled substance in a convenience care clinic.

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**NP issued Rx number by state?** Yes. The certificate to prescribe is issued by the BON.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Detroit Division Office, 431 Howard Street, Detroit, MI 48226; p: 1-800-230-6844). There are also several local resident offices.

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. Along with the certificate to prescribe number; the NPI number is also recommended.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes. An NP with a certificate to prescribe issued by the BON may furnish a sample of a drug or therapeutic device as long as it is within the formulary and the sample amount does not exceed a 72-hour supply (or the smallest commercially available sample size).

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**If so, where (e.g., statute, rules, opinion)?** OHIO REV. CODE § 4723.481

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**Specified limitations or restrictions on NP drug sampling?** Yes. An NP with a certificate to prescribe issued by the BON may furnish a sample of a drug or therapeutic device as long as it is within the formulary, is limited to antibiotics, antifungals, scabicides, contraceptives, prenatal vitamins, antihypertensives, drugs and devices for the treatment of diabetes, drugs and devices for the treatment of asthma, and drugs used for the treatment of dyslipidemia. Samples may only be provided from locations of a city or county health department, or general health district, a nonprofit healthcare clinic, or a federally funded comprehensive primary care clinic. The sample amount cannot exceed a 72-hour supply (or the smallest commercially available sample size).

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** There is legislative language that identifies all APRNs as eligible providers under Medicaid. The vast majority of the Medicaid managed-care insurance companies also contract with all APRN types. Only PCP APRNs are noted on the insurance card. There are no limitations on NP reimbursement.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** The vast majority of commercial payers in Ohio credential and contract with NPs and most payers recognize NPs as PCPs. In addition, payers have started to contract with APRNs in freestanding nurse-owned practices. Ohio participates in the AANP Multi-State Reimbursement Alliance and has successfully initiated and participated in negotiations with commercial insurers, resulting in improved commercial contracting across state lines and regions.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Case Western Reserve University—Cleveland; (2) Cedarville University—Cedarville; (3) Franciscan University of Steubenville—Steubenville; (4) Kent State University—Kent; (5) Malone College—Canton; (6) Mount Carmel College—Columbus; (7) Ohio University—Athens; (8) The Ohio State University—Columbus; (9) Otterbein University—Columbus; (10) University of Akron—Akron; (11) University of Cincinnati—Cincinnati; (12) University of Toledo—Toledo; (13) Ursuline College—Pepper Pike; (14) Wright State University—Dayton; (15) Xavier University—Cincinnati; (16) Youngstown State University—Youngstown.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Case Western Reserve University; College of Mount Saint Joseph; Kent State University; The Ohio State University; Otterbein University; The University of Akron; University of Cincinnati; University of Toledo; Ursuline University; Walsh University; Wright State University.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** The Ohio Association of Advanced Practice Nurses ([www.oaapn.org](http://www.oaapn.org)) represents all APRNs in Ohio and serves as the lead organization for legislative and reimbursement advancement. The Northeast Ohio Nurse Practitioners ([www.neonp.org](http://www.neonp.org)), the Ohio chapter of the National Association of Pediatric Nurse Practitioners (NAPNAP; [www.ohio-napnap.org](http://www.ohio-napnap.org)), and the Ohio chapter of the Gerontological Advanced Practice Nurses Association (GAPNA; <https://ohiogapna.enpnetwork.com>) are also active in Ohio.

**Organized opposition to NP legislative or regulatory changes?** Ohio State Medical Association (OSMA) opposes increasing autonomy for NPs.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 71

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "C."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **19 for NPs<sup>†</sup>** (6671 in state<sup>‡</sup> results in a **1:351 ratio**)
- **17,842 for MDs/DOs/Interns/Residents** (41,644 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **10 for NPs<sup>†</sup>** (6671 in state<sup>‡</sup> results in a **1:667 ratio**)
- **5132 for MDs/DOs/Interns/Residents** (41,644 in state<sup>‡</sup> results in a **1:8 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions must be brought within 1 year after the cause of action. A claimant’s contributing negligence will prevent recovery of damages if his negligence is greater than all the potential defendants (i.e., modified form of comparative negligence). There are no caps on either compensatory or punitive damages. There is no patient compensation fund or a general program of state-sponsored liability insurance for physicians. The law allows, but does not require, the use of an arbitration board.

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**Recent state malpractice liability tort reform?** 2005–2013: None. 2004: Established medical requirements (based on AMA guide to the evaluation of permanent impairment) for filing asbestos and silicosis claims. Limited noneconomic damages in cases involving noncatastrophic injuries to the greater of \$250,000 or three times economic damages up to \$350,000, per plaintiff, with a maximum limit of \$500,000 per occurrence.

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## THE PEARSON REPORT

**STATE:** OKLAHOMA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 1389

**NP specialties legislatively specified?** Yes. Specialties are listed in the BON R&R. Effective January 1, 2016, the Oklahoma Nursing Practice Act (ONPA) requires certification in one of six population foci.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Requirements for practice as a CNP are defined in the Oklahoma Nursing Practice Act (ONPA) and Rules. The BON approves a list of national certifying bodies and national certification examinations that meet the requirements identified in the ONPA and Rules for APRN licensure and the APRN practices in accordance with the standards for advanced practice nurses as identified by the certifying body and approved by the BON.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. For initial application for Rx authority. Initial applicants for CNP recognition are not required to hold an MSN or higher, if they completed a program that had oversight by a nursing education program accredited by an approved national nursing accrediting agency. Effective January 1, 2016, it is included in the ONPA that all APRNs applying for initial licensure or licensure by endorsement must hold a graduate degree from an accredited APRN education program.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** The Oklahoma State Medical Association and the Oklahoma Osteopathic Association appoint physicians to the Formulary Advisory Council, which has the power to select appropriate drugs for an exclusionary formulary. The BON may accept or reject the Council recommendations, but the BON may not amend the exclusionary formulary without the approval of the Council.

**Physician involvement required for any aspect of practice?** Yes. For Rx authority.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** A physician must supervise the CNP with prescriptive authority by overseeing and accepting responsibility for the ordering and transmission of written telephonic, electronic, or oral prescriptions for drugs and other medical supplies subject to a defined formulary. A written statement is required between the CNP and the physician

supervising prescriptive authority, which identifies mechanisms for (1) appropriate referral, consultation, and collaboration between the advanced practice nurse and physician supervising prescriptive authority and (2) availability of communication between the advanced practice nurse and physician supervising prescriptive authority.

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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Legislation passed in 2009 (HB 1569) amended the previous Medical Practice Act restrictions to allow providers to use the term “doctor” providing they are listed specifically as one of nine classes of persons who can use the term “physician” or they “...designate the authority under which the title is used or the college or honorary degree that gives rise to use of the title.” Such provider “shall identify through written notice, which may include the wearing of a name tag, the type of license under which the doctor is practicing, utilizing the designations provided...” (HB 1569) and shall “utilize appropriate, accepted, and easily understood words or letters that clearly show and indicate the branch of the healing arts in which the person is licensed to practice and is engaged in” (HB 1569).

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON issues licenses for applicants who have been approved for initial licensure as a CNP; the RN pocket license card indicates the CNP recognition on the front of the card and whether the CNP has prescriptive authority by the designation “Rx” next to CNP.

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**Supervised practice hours required before full NP practice autonomy?** No. But CNPs may not practice or be employed without initial licensure. If the CNP applicant is not a graduate of master’s-level or higher preparation in nursing in a program accredited by or holding preliminary approval or candidacy status with the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE), the applicant’s education program has to meet the following requirements: (1) be based on measurable objectives that related directly to the SOP for the specialty area; (2) include theoretical and clinical content directed to the objectives; (3) be equivalent to at least 1 academic year. A preceptorship that is part of the formal program is included as part of the academic year; (4) be university based or university affiliated with oversight by a nursing program accredited by an approved national nursing accrediting agency. Effective November 1, 2011, temporary recognition of APRNs was removed from the Nurse Practice Act. Current information technology allows for quicker processing for licensure.

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**Supervised practice hours required before full NP prescribing autonomy?** No. But the APRN must be a graduate of a master’s-level or higher advanced practice program accredited by or holding preliminary approval or candidacy status with ACEN or CCNE.

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**Additional pharmacology hours required for prescribing?** The CNP must submit proof of 45 contact hours or 3 academic credit hours of education in pharmacotherapeutics, clinical application, and use of pharmacological agents in the prevention of illness, and in the restoration and maintenance of health in a program beyond basic nursing preparation applicable to the SOP for the CNP. The pharmacology hours must have been obtained within 3 years immediately



preceding the date of the application for Rx authority. The 3 years may be waived if the CNP has graduated from an advanced practice educational program within a time period of 3 years immediately preceding the date of application for Rx authority and if the CNP applicant submits appropriate documentation, as defined in the BON rules.

**CE requirements for NP practice?** Renewal of APRN licensure shall be congruent with 2-year licensure renewal as an RN. Effective January 1, 2014, each licensee shall demonstrate evidence of continuing qualifications for practice. One option for meeting the qualifications includes the completion of contact hours. In addition, APRNs also have a CE requirement for prescriptive authority recognition.

**If so, what are the specifics?** Renewal for Rx authority requires proof of at least 15 hours or 1 academic credit hour of education in pharmacotherapeutics applicable to the SOP within the 2-year period immediately preceding the effective date for renewal of Rx authority.

**BON mechanism for others to verify NP license?** Yes, online through the BON website (<https://www.ok.gov/nursing/verify/index.php>).

**Current listing of all active NP licenses maintained by BON?** Yes.

**Current listing of authorized NP prescribers maintained by BON?** Yes.

**If so, is this a separate list from all active NP licenses?** Yes.

**Recent legislative/regulatory changes affecting NP practice?** Proposed amendments to the ONPA were approved by the Governor and implemented on November 1, 2013. The amendments include a requirement for fingerprint criminal history search for APRNs, as is currently required for RNs and LPNs and endorsement of APRN prescriptive authority, allowing those APRNs who have been practicing with prescriptive authority in other states who meet identified criteria to endorse prescriptive authority.

**Legislative/administrative plans for state?** No plans are being formulated at this time.

**Internet address for Nurse Practice Act:** <http://www.ok.gov/nursing/actwp.pdf>

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.



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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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**NP SCOPE OF PRACTICE—PRESCRIBING**

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. The written statement defines appropriate referral, consultation, and collaboration between the APRN and the supervising physician.

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**NP Rx from state authorized formulary required?** Yes. The BON exclusionary formulary.

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**If so, explain specifics of formulary.** The Formulary Advisory Council, consisting of 12 members, created an exclusionary formulary that lists drugs or categories of drugs that are not prescribed by APRNs. The APRN with Rx authority may submit to the Formulary Advisory Council a written request for an amendment to the exclusionary formulary with documentation verifying a practice-specific situation. The exclusionary formulary is reviewed annually and recommendations are submitted to the BON. The BON may accept or reject the Council's recommendations, but the BON may not amend the formulary without the approval of the Council. The Council is composed of four physicians appointed by the physician associations (three from the Oklahoma State Medical Association and one from the Oklahoma Osteopathic Association), four pharmacists appointed by the Oklahoma Pharmaceutical Association, and four APRNs, one of whom shall be a CNP appointed by the BON and one of whom shall be a current member of the BON.

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** A CNP, in accordance with the SOP of the CNP, is eligible to obtain recognition as authorized by the BON to prescribe, as defined by the rules promulgated by the BON, pursuant to the statutes and subject to the medical direction of a supervising physician.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V. The CNP may not Rx more than a 30-day supply for these drugs and must Rx in accordance with the exclusionary formulary.

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**NP issued Rx number by state?** Yes. A state registration is required prior to obtaining a DEA number.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Dallas Division Office, 10160 Technology Boulevard East, Dallas, TX 75220; p: 1-214-366-6900

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The ONPA. The BON grants authorization that does not include dispensing drugs, but does not preclude the receipt of, the signing for, or the dispensing of professional samples to patients within the CNP's area of specialization.

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**Specified limitations or restrictions on NP drug sampling?** Yes. Drugs must not be listed as an excluded drug on approved exclusionary formulary.

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**Restrictions on out-of-state NP Rx being filled in this state?** Yes. According to the Board of Pharmacy and the ONPA and Rules, only APNs recognized by BON for Rx authority and who are supervised by an OK-licensed physician can have a patient's Rx filled in the state.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** No.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** No.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Oklahoma—Oklahoma City and Tulsa; (2) Oklahoma City University—Oklahoma City.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** The University of Oklahoma

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Oklahoma NP organization (ONP; [www.npofoklahoma.com](http://www.npofoklahoma.com))

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**Organized opposition to NP legislative or regulatory changes?** Heavy opposition to NP SOP from organized medicine. NP SOP is continually legislatively attacked with an attempt to further restrict NPs' existing autonomy.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 63

**Descriptive ranking:** Grade D. The state restricts patient choice.

*\*Pearson Report 2014 update: state now deserves a higher ranking of "C+."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 137 for NPs<sup>†</sup> (1389 in state<sup>‡</sup> results in a **1:10 ratio**)
- 4341 for MDs/DOs/Interns/Residents (12,416 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- 124 for NPs<sup>†</sup> (1389 in state<sup>‡</sup> results in a **1:11 ratio**)
- 1001 for MDs/DOs/Interns/Residents (12,416 in state<sup>‡</sup> results in a **1:12 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice action must be brought within 2 years from the date when the alleged injury was discovered (or should have been). Under this doctrine, a claimant’s action is not barred unless his negligence is greater than the combined negligence of all defendants (i.e., modified comparative negligence). There is no patient compensation fund, physicians are not required to carry professional liability insurance, and arbitration is not required.

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**Recent state malpractice liability tort reform?** 2012–2013: None. 2011: Reduced the limit on the amount of noneconomic damages arising from a claim of bodily injury from \$400,000 to \$350,000 (not impacting lost wages, medical expenses with exceptions in cases of gross negligence, reckless disregard, intentional actions, or malicious conduct). 2010: None. 2009: Many changes. (1) The “rule of joint and several liability” provided that unless a defendant is

more than 50% at fault the defendant will be charged its proportionate share of the injury award. (2) "Noneconomic damages" provided that in any civil action arising from a claimed bodily injury, the amount of compensation that a trier of fact may award a plaintiff shall not exceed \$400,000 except under certain circumstances. (3) Provided that prejudgment interest does not begin to accrue until 2 years after the beginning of a lawsuit and the interest rate charged is reduced. (4) "Appeal bond reform" limited the amount a defendant can be required to pay to secure the right to appeal to \$25 million and eliminated the bonding requirement to appeal a punitive damages judgment. 2008: None. 2007: Allows healthcare providers providing charitable professional services gratuitously to be exempt from legal liability. 2005–2006: None. 2004: Act limits noneconomic damages to \$300,000 (adjusted for inflation) provided the defendant made an offer of judgment and the amount of the verdict is less than one-and-a-half times the amount of the final offer of judgment; this limit does not apply to wrongful death action.

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## THE PEARSON REPORT

**STATE:** OREGON

**NP title(s) used in this state:** NP (Nurse Practitioner)

**Number of NPs in state:** 2761

**NP specialties legislatively specified?** The BON R&R define the following accepted categories of NP: ACNP, ANP, NMNP (Nurse Midwife NP), FNP, GNP (terminating in 2015), NNP, PNP, PMHNP, and WHCNP.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Specialty (now population) categories of NPs are certified by the BON based upon completion of an NP program specific to the population category, national board certification, and pharmacology requirements. The SOP is in the administrative rule and is also articulated through BON communication, consultation, and policy.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes. For all new licensees as of January 1, 2011.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes (with some exceptions for those educated before 1986).

**Requirement for APN member on BON?** Yes. The member must be an NP.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. HB 2610 passed in the 2009 legislative session; the bill permits a licensed health professional to use the title doctor if they hold a doctoral degree in their field of practice, provided that they designate in any written or printed material the field in which the doctorate was earned.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** NPs are credentialed with a certificate issued by the BON; there is a separate number for NP. “PP” on the license indicates prescriptive privileges, while “DP” on the license indicates dispensing privileges.

**Supervised practice hours required before full NP practice autonomy?** Supervised practice is only required for persons not meeting the BON practice or prescribing requirements (needing reentry). Renewing the certification requires a minimum of 960 hours of practice in an expanded

specialty role within the 5-year period immediately preceding renewal, 192 hours of practice in the 2 years prior to renewal, or graduation from an NP program within 1 year of renewal. Those who do not meet the practice requirement must complete a Board-supervised practicum of 150–1000 hours in addition to relevant coursework. A prescribing practicum is required for those who have never prescribed or do not meet currency in practice.

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**Supervised practice hours required before full NP prescribing autonomy?** *See above.*

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**Additional pharmacology hours required for prescribing?** Prescribing privileges require completion of 45 hours of pharmacology instruction related to the specialty SOP within the 2 years prior to the application date. An exception may be made to the 2-year rule if an applicant has demonstrated a working knowledge of pharmacotherapeutics through prior practice such as prescriptive authority in another state or student clinicals. Persons not meeting the practice requirement who endorse in or have been out of practice may be required to take an additional pharmacology course and do supervised prescribing hours.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** One hundred clock hours of CE obtained through independent learning activities, unstructured learning activities, and structured learning activities every 2 years; 50% of those hours must be CE or CME. National certification now counts for 50% of the total CE requirement.

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**BON mechanism for others to verify NP license?** Yes. Online verification is available through the BON website ([www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)). In addition, there is a phone verification system.

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**Current listing of all active NP licenses maintained by BON?** Yes. The list can be purchased from the BON website (updated monthly); lists can also be requested by area of population focus.

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**Current listing of authorized NP prescribers maintained by BON?** Yes. The list is available by specialty, geographic location, and other variables; there is also a list of NPs with dispensing authority available.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** Oregon is currently in legislative session. Proposed bills include payment parity for NPs in independent practice. CCOs and medical homes are being implemented by the Oregon Health Authority; some include NPs in their model.

Passed in 2013 legislative session: SB 8 removes certain restrictions on the authority of NPs to dispense prescription drugs; SB 533 extends the timeframe within which an NP can provide medical services and authorize temporary disability benefits to 180 days.

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**Legislative/administrative plans for state?** Monitoring and working with current legislative session as above.

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**Internet address for Nurse Practice Act:** <http://www.oregon.gov/OSBN/Pages/index.aspx>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No. However, legislation (OR. REV. STAT. § 441.064 regarding “use of facilities by licensed NPs; rules regarding admissions and privileges”) is permissive of NPs getting admitting privileges but restricts it to the medical staff process. There is still the problem of NP autonomy.

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**Additional limitations/clarifications/expansions to NP practice?** NPs have been added to most statutes that previously were physician specific; NPs (for the most part) are not excluded as providers.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. BON-authorized NPs with Rx authority may Rx all over-the-counter drugs and “appliances and devices” (i.e., an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or accessory, which is required under federal or state law to be prescribed by a practitioner and dispensed by a pharmacist) in addition to Rx drugs that are FDA approved. Exceptions to FDA approval exist for grandfathered, off-label, and some compounded medications.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** There is no separate NP Rx number; the designation “PP” on the end of the prescribing number indicates prescriptive privileges, while “DP” indicates dispensing privileges.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Seattle Division Office, 400 Second Avenue West, Seattle, WA 98119; p: 1-888-219-4261

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** BON R&R specify that NPs must file for the authority to dispense prescription drugs, which documents that the NP has reviewed each of a list of references on drugs and prescribing, affirms that pharmacy services are not readily available (e.g., the patient lives outside the boundaries of a metro area, lives 30 or more miles from the closest hospital, and receives services from a health safety net), and affirms that granting the NP authority to dispense Rx drugs would correct the lack of access. The ADPD forms are located in Division 56 and applications are on the BON website.

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**Specified limitations or restrictions on NP drug sampling?** No. The Nurse Practice Act R&R specify that any NP who has Rx writing authority may receive prepackaged complimentary samples of drugs included in the formulary and distribute these samples to clients. SB 8 (passed in 2013) removes certain restrictions on the authority of NPs to dispense prescription drugs.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Also, in 2007, NPs were added to the Medical Malpractice Reinsurance Program, a state program that provides malpractice coverage relief.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. CCOs and medical homes are currently being implemented by the Oregon Health Authority; some include NPs in their model.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Oregon Health and Science University—Portland; (2) University of Portland—Portland.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Oregon Health & Science University; University of Portland.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** NP of Oregon (NPO); state Pediatric NP Association (OPNPA); ADNOM Oregon Chapter; APNA Oregon Chapter.

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**Organized opposition to NP legislative or regulatory changes?** The Oregon House and Senate are supportive of NP practice and care delivery. The primary opposition to NP payment parity is from the professional association for DOs.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 92

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

**\*Pearson Report 2014 update: state now deserves higher ranking of "A+."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **77 for NPs<sup>†</sup>** (2761 in state<sup>‡</sup> results in a **1:36 ratio**)
- **3615 for MDs/DOs/Interns/Residents** (13,992 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **37 for NPs<sup>†</sup>** (2761 in state<sup>‡</sup> results in a **1:75 ratio**)
- **1088 for MDs/DOs/Interns/Residents** (13,992 in state<sup>‡</sup> results in a **1:13 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice action must commence within 2 years from the date the injury is discovered (or should have been discovered) or in the exercise of reasonable care should have been discovered. The claimant's recovery is diminished in proportion to his percentage of fault and his action is barred if his fault exceeds all defendants (i.e., modified comparative negligence). The legislature established a \$500,000 cap on damages for noneconomic loss in bodily injury and death cases, but the state Supreme Court ruled it to be unconstitutional under most circumstances. Punitive damages are not allowed against individual health practitioners such as physicians and nurses. Malpractice claims are not required to be heard by an arbitration panel, although a compulsory, nonbinding arbitration is required for claims less than \$25,000 or \$50,000.

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**Recent state malpractice liability tort reform?** 2010–2013: None. 2009: SB 311 increases the damage limits recoverable under the OTCA (Oregon Tort Claims Act); the cap had previously been \$200,000. The cap increases to \$500,000 for most entities; however, for the State of Oregon, Oregon Health and Science University, SAIF, and the Oregon Utility Notification Center the cap is \$1.5 million. Although only government entities are impacted by this cap, it seems as if they are requiring providers who contract with them to carry higher liability limits such as \$2 million per occurrence (rather than the typical \$1 million). There is a built-in annual increase of \$100,000 through 2015 for the four areas noted and an annual increase of \$33,000 for all other public entities. 2006–2008: None. 2005: Exempts from civil liability persons involved in the selling of food for a claim of injury or death caused by the consumption of food.

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## THE PEARSON REPORT

**STATE:** PENNSYLVANIA

**NP title(s) used in this state:** CRNP (Certified Registered Nurse Practitioner)

**Number of NPs in state:** 8397 CRNP's (5926 of which hold prescriptive authority)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The Nurse Practice Act states that while functioning in the expanded role as a professional nurse, a CRNP shall practice within the SOP of the particular clinical specialty area in which the nurse is certified by the BON.

**NP title protection?** Yes (as a CRNP).

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes. For CRNPs.

**MSN required for practice?** Yes. For new applicants.

**Requirement for APN member on BON?** No. But three of the RN members must hold a minimum of a master's degree.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The Nurse Practice Act defines "collaboration" as "A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP's expertise. The process includes all of the following: 1) immediate availability of the licensed physician... through direct communication by radio, telephone, or telecommunications. 2) A predetermined plan for emergency services. 3) A physician available ... on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics, and cosigning records when necessary to document accountability by both parties." The Act also states that a "CRNP may perform acts of medical diagnosis in collaboration with a physician and in accordance with regulations promulgated by the board" and "a CRNP may prescribe medical therapeutic or corrective measures if the nurse ... is acting in collaboration with a physician as set forth in a written agreement..."

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. But as specified in Chapter 21 of State Board of Nursing:

### § 21.286. Identification of the CRNP.

- (a) A CRNP shall comply with State, Federal, and facility regulations regarding identification of personnel.
- (b) The listing of a CRNP in an advertisement or publicly displayed sign shall identify CRNPs who use the designation “Dr.” as CRNPs by using the title CRNP following the individual’s name.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON issues a CRNP certification separate from the RN license.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. The Nurse Practice Act requires successful completion of at least 45 hours of coursework specific to advanced pharmacology.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Certifications are renewable every 2 years and require 30 hours of CE to be completed in the immediate 2-year period prior to renewal. CRNPs with prescriptive authority must provide evidence that at least 16 of these Board-approved 30 hours were in pharmacology.

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**BON mechanism for others to verify NP license?** Yes. Verification of CRNP state certification and prescriptive authority can be viewed online through the state’s website (<http://www.mylicense.state.pa.us/>).

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**Current listing of all active NP licenses maintained by BON?** Yes. A list can be requested by phone (1-717-772-2244).

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. Act 68 of 2012 grants NPs signatory authority for death certificates.

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**Legislative/administrative plans for state?** The PA Coalition for NPs (PACNP) is actively planning for implementation of full practice authority to align state practice with the National Council of State Boards of Nursing Consensus Model Act. See PACNP’s white paper for more information; [www.pacnp.org](http://www.pacnp.org)). PACNP has strived to remove practice barriers so CRNPs can function to the top of their license. Implementation of full practice authority is not an expansion of the CRNP scope, but rather will remove outdated and burdensome mandates that limit access to high-quality care delivered by APRNs.

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**Internet address for Nurse Practice Act:** <http://www.pacode.com/secure/data/049/chapter21/chap21toc.html>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The CRNP may perform acts of medical diagnosis in collaboration with a physician licensed in PA and in accordance with regulations promulgated by the BON. “Collaboration” is defined in Section 2(13) of the Nurse Practice Act to mean, “a process in which a certified registered nurse practitioner works with one or more physicians to deliver health care services within the scope of the certified registered nurse practitioner’s expertise...”

**Required physician record/chart review?** The collaborating physician must be available ‘on a regularly scheduled basis for ....review of standards of medical practice incorporating consultation and chart review, and co-signing of records when necessary to document accountability by both parties.’

**Required NP/physician practice agreement?** Yes.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

**If so, is agreement required to be kept/stored/updated?** The written and signed collaborative agreement (CA) is not provided to the Board (unlike the prescriptive authority collaborative agreement), but rather kept at the primary practice location for anyone that requests to view it. The CRNP and collaborating physician must review and update the CA at least once every 2 years or whenever the agreement is changed.

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** A 2007 law includes the following for CRNP SOP: (1) ordering home health and hospice care; (2) ordering durable medical equipment; (3) issuing oral orders to the extent permitted by the healthcare facility’s bylaws, rules, regulations, or administrative policies and guidelines; (4) making PT, dietitian, respiratory, and OT referrals; (5) performing disability assessments for the Temporary Assistance for Needy Families (TANF) program; (6) issuing homebound schooling certifications; (7) performing and signing the initial assessment of methadone treatment evaluations provided that any order for methadone treatment shall be made only by a physician. A 2012 law allows CRNPs to sign death certificates.

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

**NP/physician prescriptive agreement required?** Yes. CRNPs in PA may apply for prescriptive authority if they have (1) successfully completed at least 45 hours of coursework specific to advanced pharmacology at a level above that required by a professional nursing education

program, and (2) are acting within the authority set forth in a CRNP collaborative agreement for prescriptive authority between the CRNP and the collaborative physician, a copy of which is provided to the BON. The agreement must identify the specialty area of practice in which the CRNP is certified, detail the categories of drugs from which the CRNP may prescribe and dispense, and specify the circumstances and how often the collaborating physician will personally see the patient. The CRNP collaborative agreement for prescriptive authority must be reviewed and updated by the parties at least once every 2 years or whenever the agreement is changed. CRNPs who meet the requirements for prescriptive authority are issued prescriptive authority numbers unique to the specific collaborating physicians.

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**NP Rx from state authorized formulary required?** Yes.

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**If so, explain specifics of formulary.** The BON adopted the American Hospital Formulary Service Pharmacologic–Therapeutic Classification to identify drugs that the CRNP may prescribe and dispense.

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Collaborative per the written signed agreement. Additionally, a drug review committee is charged with approving or disapproving any changes proposed by the BON to the categories from which NPs may prescribe.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** CRNPs authorized to prescribe and dispense shall register with the DEA. Controlled substances may be prescribed and dispensed per the prescriptive authority agreement, limiting Schedule II drugs to up to a 30-day supply and Schedules III and IV drugs to up to a 90-day supply.

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**NP issued Rx number by state?** Yes. An approval number is issued when prescriptive authority is granted by the BON.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Philadelphia Division Office, William J. Green Federal Building, 600 Arch Street, Room 10224, Philadelphia, PA 19106; p: 1-888- 393-8231

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes. Prescription pads used by CRNPs must contain the name, title, PA certificate number and, when appropriate, the NPI number.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** CRNPs with prescriptive authority are authorized to receive and dispense drug samples without limitation.

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**If so, where (e.g., statutes, rules, opinion)?** § 21.284a. Prescribing and dispensing drugs.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCP)?**

Yes. But the statutory language makes this optional rather than mandated.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Drexel University—Philadelphia; (2) Duquesne University—Pittsburgh; (3) Gwynedd-Mercy College—Gwynedd Valley; (4) University of Pennsylvania—Philadelphia; (5) University of Pittsburgh—Pittsburgh; (6) Widener University—Chester; (7) Bloomsburg—Bloomsburg; (8) Gannon University—Erie; (9) La Salle University—Philadelphia; (10) Millersville University—Millersville; (11) Neumann College—Aston; (12) Pennsylvania State University—University Park; (13) Temple University—Philadelphia; (14) The University of Scranton—Scranton; (15) Thomas Jefferson University—Philadelphia; (16) Clarion University—Clarion; (17) Edinboro University—Clarion; (18) Villanova University—Villanova; (19) Carlow College—Pittsburgh; (20) Misericordia College—Dallas; (21) DeSales University—Center Valley; (22) Robert Morris University—Moon Township; (23) York College of Pennsylvania—York.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Carlow University; Chatham University; DeSales University; Drexel University; Duquesne University; La Salle University; Robert Morris University; Temple University; Thomas Jefferson University; University of Pittsburgh; Villanova University; Waynesburg University; Widener University; Wilkes University; York College of Pennsylvania.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** PA Coalition of NPs ([www.pacnp.org](http://www.pacnp.org))

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**Organized opposition to NP legislative or regulatory changes?** PACNP continues to encounter opposition from organized medicine to regulatory and statutory changes.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 78

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "C."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- 95 for NPs<sup>†</sup> (8397 in state<sup>‡</sup> results in a **1:88 ratio**)
- 30,071 for MDs/DOs/Interns/Residents (54,248 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains

the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **49 for NPs<sup>†</sup>** (8397 in state<sup>‡</sup> results in a **1:171 ratio**)
- **3894 for MDs/DOs/Interns/Residents** (54,248 in state<sup>‡</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Effective September 2007, a new section of the Nurse Practice Act requires CRNPs to maintain a level of professional liability coverage for a nonparticipating healthcare provider (at least \$1 million per occurrence and \$3 million annual aggregate) obtained from an insurer licensed or approved by the PA Insurance Department or from a self-insurance plan approved by the Insurance Department. Malpractice actions must be brought within 2 years; the time does not begin until the injured party reaches age 18 and/or discovers or reasonably should have discovered he or she was injured. A plaintiff’s recovery is barred only if his or her contributory negligence is greater than the negligence of the defendants (i.e., modified rule of comparative negligence). All physicians and hospitals are required to obtain a specified amount of “basic insurance coverage,” and to obtain excess coverage from the state MCARE Fund, paid for by an annual surcharge. Because liability is not capped at the MCARE Fund limits, healthcare providers often purchase additional excess coverage. There is no compulsory arbitration of small claims when more than \$50,000 is at issue. NPs are not covered by, nor do they pay into, the MCARE fund (only physicians and CNMs). A plaintiff suing licensed professionals must file a certificate of merit that a qualified expert has opined that there was a reasonable probability that the defendant’s care fell outside acceptable professional standards of care and that the conduct was the cause of the injury. There is a procedure where a party to a malpractice claim can ask the court to order a settlement conference or mediation before expert reports are exchanged.

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**Recent state malpractice liability tort reform?** 2003–2013: None. 2002: Prohibits a patient from suing for damages that were paid by a health insurer and allows for the periodic payment of future medical costs exceeding \$100,000.

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## THE PEARSON REPORT

**STATE:** RHODE ISLAND

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 784

**NP specialties legislatively specified?** No. Follows Licensure, Accreditation, Certification, and Education (LACE) Consensus Model for APRN Regulation, using population-specific language.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification, BON administrative regulations, and the Nurse Practice Act.

**NP title protection?** Yes (for APRN-CNP).

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes. Also required on APRN advisory committee to the BON.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No. The Advanced Nurse Practice Council is charged with improving patient care, reviewing complaints regarding APNs, and reporting periodically to the BON regarding advanced practice. The Council is made up of two CNPs, two CRNAs, two Psychiatric and Mental Health CNSs, and one physician. The new APRN legislation contains no supervisory or collaborative language.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** There is a separate NP license.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. To prescribe, the CNP needs to complete 30 hours of pharmacology within the 3 years prior to application.

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**CE requirements for NP practice?** Yes. Requirement of 30 pharmacology hours every 6 years.

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**If so, what are the specifics?** To maintain Rx privileges, NPs need to complete 30 hours of CE in pharmacology every 6 years. Beginning March 2006, all licensed applicants for renewal of their RN license must provide evidence of 10 CE hours within the preceding 2 years.

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**BON mechanism for others to verify NP license?** Yes. Available on BON website ([www.health.ri.gov](http://www.health.ri.gov)).

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. The new APRN law, effective as of June 2013, creates consistency in titling, licensing, certification, and education policies for APRNs.

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**Legislative/administrative plans for state?** Goals are to continue to work with the third-party payers for NP parity as Primary Care Providers.

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**Internet address for Nurse Practice Act:** <http://webserver.rilin.state.ri.us/Statutes/TITLE5/5-34/INDEX.HTM>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No. The Nurse Practice Act allows for the global signature authority of the CNP (i.e., whenever any provision of the general or public law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit, or endorsement by a CNP, provided that nothing shall be construed to expand the SOP of the CNP).

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V. New language in the Nurse Practice Act states that CNP’s “may prescribe Schedule I.”

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**NP issued Rx number by state?** All prescribers of controlled substances must register with the state as well as with the DEA. The RI Board of Nurse Registration and Nursing Education form for RI Uniform Controlled Substance Act Registration must be obtained prior to applying for DEA registration.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Building, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131; p: 1-617-557- 2200

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**DEA number required for nonscheduled as well as scheduled Rx?** Yes. Required by pharmacy board as ID.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Pharmacy Rules and Regulations

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**

In October 2009, a bill passed the Senate and House mandating that all third-party payers allow NPs to be listed as Primary Care Providers. However, Blue Cross is refusing to recognize this and is still requiring that physicians supervise (they call it collaborate) NP practice if the NP wants to be credentialed as a provider. The state nursing association and the BON are working to “define” collaboration in the rules and regulations to satisfy Blue Cross’s concerns.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Rhode Island—Kingston (FNP, AGNP, ACNP); (2) Rhode Island College (ACNP only).

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Rhode Island—Kingston

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** The RISNA NP Council (affiliated with the ANA); Nurse Practitioner Alliance of RI. Both are group members of the AANP.

**Organized opposition to NP legislative or regulatory changes?** No.

**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 88

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state now deserves a higher ranking of “A.”*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports  
(9/1/1990–3/30/2013):

- **13 for NPs**<sup>†</sup> (784 in state<sup>‡</sup> results in a **1:60 ratio**)
- **1718 for MDs/DOs/Interns/Residents** (4306 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **4 for NPs<sup>†</sup>** (784 in state<sup>‡</sup> results in a **1:196 ratio**)
- **321 for MDs/DOs/Interns/Residents** (4306 in state<sup>‡</sup> results in a **1:13 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice personal injury or wrongful death action must begin within 3 years of the incident or when it should have been known. The award is lessened in proportion to the plaintiff’s negligence, but there is no amount of his negligence that would bar recovery (i.e., pure form of comparative negligence). Expert witnesses must be experts in the field of the alleged malpractice. There is no patient compensation fund and physicians are not required to carry malpractice insurance. There is no mandate for binding arbitration.

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**Recent state malpractice liability tort reform?** 2012: Medical liability evidence reform expands the type of medical services and expenses that can be introduced into evidence without the provider being required to testify in court. 2005–2011: None.

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## THE PEARSON REPORT

**STATE:** **SOUTH CAROLINA**

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), NP (Nurse Practitioner)

**Number of NPs in state:** 4152 (all APRNs, which includes NPs, CNMs, CNSs, and CRNAs)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification by BON-approved certifying body.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes. Additional acts that constitute delegated medical acts must be agreed to jointly by the BON and the Board of Medical Examiners (BOM) and must be promulgated by the BON; the collaborative protocol practice agreement stipulates the aspect of practice privileges, such as performing procedures.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Supervision by a physician who delegates medical acts as outlined in collaboratively developed written protocols that are subject to joint BON–BOM approval. Supervision is conducted by electronic means and within a 45-mile radius.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Except as clarified in statute S.C. CODE ANN. §40-1-20. (1976), Definitions, the “Practice of Medicine” includes “using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination of these in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in this State that is applicable to the clinical setting.”

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** There is a separate APRN license.

**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. Requirement of 45 pharmacology hours with initial application for Rx authority, at least 15 hours of which must be related to controlled substances if including request to prescribe scheduled drugs in application. NPs must have 20 hours of continuing education in pharmacotherapeutics every 2 years for renewal of prescriptive authority and 2 of these hours must be specific to controlled substances if prescribing them.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** The APRN must maintain certification or recertification by a national certifying body recognized by the BON. For biennial renewal of prescriptive authority, 20 pharmacology hours are required, at least 2 of which must be related to controlled substances if Rx authority includes scheduled drugs.

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**BON mechanism for others to verify NP license?** Yes. BON verification is available online or by written request.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** HB 3372 has passed the House and now sits in the Senate. This bill will authorize NPs to sign a certificate to allow patients to apply for a handicapped placard through the Department of Motor Vehicles.

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**Legislative/administrative plans for state?** The APRN groups and South Carolina Nurses Association have convened a group, called the Coalition for Access to Healthcare. This group is interested in removing barriers to care in order to improve access to care.

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**Internet address for Nurse Practice Act:** <http://www.scstatehouse.gov/code/t40c033.php>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Supervision by a physician who delegates medical acts as outlined in collaboratively developed written protocols that are subject to joint BON–BOM approval. NPs who perform delegated medical acts must have a supervising physician or dentist who is readily available for consultation. When an application is made for more than three NPs to practice with one physician or when an NP is performing delegated medical acts at a practice site farther than 45 miles from the supervising physician, the BON and BOM shall each review the application to determine if adequate supervision exists. The BON agrees to interpret adequate supervision as three at any given time.

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** Yes. The annual protocol practice agreement.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, is agreement required to be kept/stored/updated?** Yes.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** Yes. "Approved written protocols" are defined by the joint BON-BOM rulemaking as specific statements developed collaboratively by a physician or the medical staff and an NP that establish physician delegation for medical aspects of care, including the prescribing of medications.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** No.

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**If so, are protocols required to be kept/stored/updated?** The original protocol and any amendments must be reviewed at least annually and dated and signed by the NP and physician; they must be available for BON review within 72 hours of request. A nurse consultant for practice performs random audits.

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No. As long as tests are listed in the written protocols kept by the NP.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. Prescribing by NP must be within the approved written protocols that establish physician delegation for prescribing of medications.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Authority to prescribe is delegated by the supervising physician as outlined in collaboratively developed protocols that are subject to joint BON-BOM approval. Authorized prescriptions are limited to drugs and devices utilized to treat common well-defined medical problems within the NP's specialty.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V

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**NP issued Rx number by state?** Yes.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Atlanta Division Office Registration, 75 Spring Street SW, Room 740, Atlanta, GA 30303; p: 1-888-219-8689

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**DEA number required for nonscheduled as well as scheduled Rx?** Yes.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** The Nurse Practice Act

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**Specified limitations or restrictions on NP drug sampling?** Yes. Sampling is limited to those classifications of drugs listed in the NP's approved protocols.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** N/A

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**  
It is not specified in the law either way.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Clemson University—Clemson; (2) Medical University of South Carolina—Charleston; (3) University of South Carolina—Columbia; (4) Francis Marion University

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Medical University of South Carolina; University of South Carolina.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The Advanced Practice Registered Nurse Council, which is affiliated with the SC Nurses Association (<http://www.scnurses.org/>)

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**Organized opposition to NP legislative or regulatory changes?** Yes. The medical associations oppose the expansion of APRN SOP and APRN independent practice. They oppose the changes proposed by the Advanced Practice Committee's White Paper (<http://www.scnurses.org/associations/10047/files/BON%20APC%20White%20Paper%20Aug%202011%20approved%20by%20the%20APC%20Aug%2012%202011%20doc.pdf>).

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 59

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**Descriptive ranking:** Grade F. The state severely restricts patient choice.

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*\*Pearson Report 2014 update: state still deserves a ranking of "F."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **35 for NPs<sup>†</sup>** (4152 in state<sup>‡</sup> results in a **1:119 ratio**)
- **4203 for MDs/DOs/Interns/Residents** (14,824 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **17 for NPs<sup>†</sup>** (4152 in state<sup>‡</sup> results in a **1:244 ratio**)
- **816 for MDs/DOs/Interns/Residents** (14,824 in state<sup>‡</sup> results in a **1:18 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice claim must begin within 3 years of when the occurrence was or should have been discovered, and at least within 6 years. A plaintiff may recover damages if his or her negligence is less than all the defendants, but his or her award is reduced proportionately (i.e., modified doctrine of comparative negligence). Claimants are not required to have an expert affidavit, but the case must demonstrate the defendant did not perform under the appropriate standard of care. There is no damage cap. The state has a patient compensation fund to benefit licensed healthcare providers. The fund pays for that portion of any judgment or settlement that exceeds \$100,000 per incident and \$300,000 in the annual aggregate. All healthcare providers have the option of participating in the fund if they pay an annual fee. Malpractice claims are not required to go to an arbiter or screening prior to the filing.

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**Recent state malpractice liability tort reform?** 2012–2013: None. 2011: Established procedures to claim punitive damages where the complaint may not specify an amount; where a bifurcated process to determine punitive damages (awarded only if the plaintiff proves that harm was the result of willful, wanton, or reckless conduct) is based upon 11 factors (e.g., defendant's degree of culpability). 2006–2010: None. 2005: (1) Expert witness standards reform in an action against a professional increases the standard for admitting expert witness testimony by defining an expert witness as one who is qualified, licensed, and board certified with actual professional knowledge. (2) Requires that prior to filing an action, the plaintiff must file a Notice of Intent to File Suit and the parties must participate in a court-supervised mediation. (3) Medical malpractice reform/ noneconomic damages limits noneconomic damages in medical liability cases to \$350,000 per provider, with an overall aggregate limit of \$1.05 million.

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## THE PEARSON REPORT

**STATE:** **SOUTH DAKOTA**

**NP title(s) used in this state:** CNP (Certified Nurse Practitioner)

**Number of NPs in state:** 564

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Each applicant must pass one of the standardized qualifying certification examinations prepared by specified listed organizations in South Dakota's Administrative Rules. It must be specific to the NP applicant's educational preparation in the advanced specialty role.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** No.

**MSN required for practice?** Yes. A graduate degree in nursing.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes. Practice as an NP is subject to the joint control and regulation of the BON and the South Dakota Board of Medical and Osteopathic Examiners (BOM). The joint boards may license, supervise the practice of, and revoke or suspend licenses or otherwise discipline any person applying for or practicing as an NP. The BON shall appoint an APN advisory committee composed of two CNMs and four CNPs. Committee members shall meet annually and shall assist the boards in evaluating standards of advanced practice nursing care and the regulation and rule setting for NPs and Nurse Midwives.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** An NP may perform the overlapping scope of advanced practice nursing and medical functions only under the terms of a required collaborative agreement with a physician. Collaboration may be by direct personal contact, or by a combination of direct personal contact and indirect contact via telecommunication, as may be required by the BON and BOM.

**Statutory restriction against NP with doctorate being addressed as "Dr."?** No. Except that per S.D. CODIFIED LAWS § 36-4-23 "No person practicing any of the healing arts shall use the title 'doctor' or any contraction thereof, in connection with his business or profession, or any written or printed material, or in connection with any advertising, unless he add after his name the recognized abbreviation or specification of the branch of the healing art in which he is licensed to practice and is engaged." A violation of this section is a Class 1 misdemeanor.



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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** A separate license is issued identifying title “Certified Nurse Practitioner” along with the CNP’s specialty.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** No.

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**CE requirements for NP practice?** Nothing required beyond maintaining national certification.

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes. Licenses can be verified online through the BON website ([www.nursing.sd.gov](http://www.nursing.sd.gov)).

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** No. The SD Department of Health registers and maintains a list of NPs with DEA numbers.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** Not at this time.

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**Internet address for Nurse Practice Act:** <http://doh.sd.gov/Boards/Nursing/nurseact.aspx>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** A CNP may perform overlapping SOP of advanced practice nursing and medical functions, including initial medical diagnosis and institution of plan of therapy or referral as delineated in the collaborative agreement with a licensed SD physician.

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**Required physician record/chart review?** Chart or record review is not required in SD’s Nurse Practice Act. CNPs are required to collaborate with a physician by direct personal contact no less than twice each month unless a modification request to have one of the twice monthly meetings be held by telecommunications is approved by the joint boards. Direct personal contact means that both the collaborating physician and the CNP are physically present onsite and available for purposes of collaboration.

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**Required NP/physician practice agreement?** Yes. A collaborative agreement defines or describes the agreed upon overlapping scope of advanced practice nursing and medical functions that may be performed and contains such other information as is required by the BON and BOM.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** A copy of each collaborative agreement shall be maintained on file with and be approved by the BON and BOM prior to performing any of the acts contained in the agreement.

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**If so, is agreement required to be kept/stored/updated?** Yes. A collaborative agreement must be written and signed by the CNP and the physician. If a CNP intends to alter practice status by reason of a change in setting, modification, or expansion of the functions the NP is authorized to perform, or for any other reason, the CNP must submit a new or amended collaborative agreement to the BON and BOM for approval before any change may be permitted.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** Yes.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** A CNP may prescribe medications as a function of overlapping scope of medical functions only with an approved collaborative agreement on file with the BON and BOM. The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II for one period of not more than 30 days, for treatment of causative factors and symptoms, is permitted.

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**NP authorized to Rx controlled substances?** Yes. (*See above.*)

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**If so, what schedules?** Schedules II–IV (SD's controlled substances schedules are I–IV), but Schedule II substances limited to one period of not more than 30 days.

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**NP issued Rx number by state?** Yes. NPs who want to Rx controlled substances have two options: (1) they may act as an agent of an institution, utilizing the institution's registration number to prescribe, dispense, or administer controlled substances; the Rx must include the institution's DEA number followed by the unique identification number assigned to the NP by the institution; or (2) they may seek a state controlled substances registration from the Department of Health and apply for a DEA number; prescriptions must include the NP's DEA number.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Chicago Division Office, 230 S. Dearborn Street, Suite 1200, Chicago, IL 60604; p: 1-312-353-9166

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Nurse Practice Act and S.D. CODIFIED LAWS § 36-9A

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**Specified limitations or restrictions on NP drug sampling?** Yes. NPs may request, receive, and provide drug samples and provide a limited supply of labeled medications. Medications or sample drugs provided to patients shall be in accordance with the written collaborative agreement and accompanied with written administration instructions; appropriate documentation shall be entered in the patient's medical record.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**  
Not legislatively specified.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) South Dakota State University—Brookings;  
(2) Mount Marty College—Yankton/Sioux Falls.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** South Dakota State University

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** NP Association of South Dakota (NPASD; <http://www.npasd.org/>)

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**Organized opposition to NP legislative or regulatory changes?** Yes. Historically from both the state medical society and the state pharmaceutical association.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 63

**Descriptive ranking:** Grade D. The state restricts patient choice.

*\*Pearson Report 2014 update: state still deserves ranking of "D"*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports  
(9/1/1990–3/30/2013):

- 13 for NPs<sup>†</sup> (564 in state<sup>†</sup> results in a **1:43 ratio**)
- 733 for MDs/DOs/Interns/Residents (3624 in state<sup>†</sup> results in a **1:5 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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### **Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **8 for NPs<sup>†</sup>** (564 in state<sup>‡</sup> results in a **1:71 ratio**)
- **161 for MDs/DOs/Interns/Residents** (3624 in state<sup>‡</sup> results in a **1:23 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A malpractice action must begin within 2 years from date of occurrence. Contributory negligence by a claimant does not prevent recovery if his or her negligence was “slight” in comparison to the defendant’s negligence (i.e., modified form of comparative negligence). The total cap for awarded damages for noneconomic injury such as pain and suffering may not exceed \$500,000. There is no patient compensation fund, and physicians are not required to carry liability insurance. A voluntary arbitration panel can provide an opinion about whether there was liability and can determine the amount of damages to be awarded.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Limitation on damages for medical malpractice provides that in any action for damages for personal injury or death alleging malpractice against any licensed healthcare provider (including a CNP) or against the practitioner’s corporate limited liability partnership, or limited liability company employer based upon the acts or omissions of the practitioner, whether taken through the court system or by binding arbitration, the total general damages that may be awarded may not exceed the sum of \$500,000. There is no limitation on the amount of special damages that may be awarded. 2004: Law exempts manufacturers, sellers, and retailers of any food or drink from claims based on the individual’s weight gain, obesity, or a health condition related to weight gain or obesity resulting from the individual’s long-term consumption of a food or drink.

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## THE PEARSON REPORT

**STATE:** **TENNESSEE**

**NP title(s) used in this state:** APN (Advanced Practice Nurse)

**Number of NPs in state:** 7039

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** BON-approved programs and national certification.

**NP title protection?** The umbrella APN credential issued upon BON certification is expressly protected, but that protection may be inferred to extend to the specific titles covered by the APN designation (e.g., NPs, CNMS, CRNAs, and CNSs).

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes. However, prescribing NPs are under rules that were jointly adopted by the BON and the Board of Medical Examiners (BME). Under these rules, physicians supervising NP prescriptive practice are regulated by the BME, while NPs are regulated by the BON.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** Yes. The rules governing the practice of NP prescribing are jointly adopted by the BME and the BON.

**Physician involvement required for any aspect of practice?** Yes. For prescribing NPs.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The supervising physician in a collaborative NP–physician practice shall be responsible for ensuring compliance with the applicable standard of care outlined in jointly developed and approved protocols. Additionally, the supervising physician shall develop clinical guidelines in collaboration with the NP to include a method for documenting consultation and referral, and shall supervise, control, and be responsible for the prescriptive services rendered by the NP.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** BON-issued APN certificate is separate from the RN license.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. Three quarter-hours or their equivalent.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** The state legislature mandates evidence of continued competence by the BON using educationally sound methods to promote learning and assess outcomes pertinent to contemporary standards of nursing practice. Acceptable proof includes a minimum of a 1 contact hour course addressing controlled substance prescribing practices offered through a CE provider approved by any nationally certifying board of an advanced practice nurse (if prescribing) and initial or continuing national certification and one of the following: satisfactory employer evaluation, written self-evaluation based on the standards of competence, 5 contact hours of CE.

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**BON mechanism for others to verify NP license?** Yes.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

---

**If so, is this a separate list from all active NP licenses?** No.

---

**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** To continue working with the state legislature regarding the use of provider-neutral language; to remove unwanted and unnecessary restrictions of existing federal or state SOP barriers; to monitor closely the legislative introduction of any medical association bills that would seek to restrict NP SOP.

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**Internet address for Nurse Practice Act:** <http://www.state.tn.us/sos/rules/1000/1000.htm>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. NPs meeting requirements to practice but who do not include prescribing documentation with their application to practice and who do not request prescriptive authority are issued an APN certificate without prescriptive writing privileges.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** NPs have the same authority as a physician has to issue certified statements of disability or deafness to accompany the application of disabled or deaf persons to obtain registration, license plates, placards, and decals from the Motor Vehicle Department, if such authority is expressly included in the written protocol developed jointly by the supervising physician and NP.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. Qualified applicants who submit prescribing documentation with their application to practice are issued an APN certificate with prescription writing privileges (COF). Qualifications to prescribe include current RN licensure, a master's degree in a nursing clinical specialty area, 3 quarter-hours of pharmacology, national certification, and evidence of specialized practitioner skills. Once the NP has a COF, establishes joint protocols, and files a notice of formulary and the name of a supervisory physician with the BON, the NP is authorized to prescribe and/or issue legend drugs.

---

**NP/physician prescriptive agreement required?** The written guidelines for prescriptive management are developed jointly by the supervising physician and prescribing NP; the guidelines outline and cover the applicable standard of care specific to the population seen, and account for all protocol drugs by appropriate formulary. The NP must maintain a copy of the guideline/protocol he or she is using at the practice location and shall make the protocol available upon request by the BON, BME, or authorized agents of either board. In addition to being kept at the practice site, the protocol must be reviewed and updated biennially (i.e., every 2 years).

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**NP Rx from state authorized formulary required?** Yes.

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**If so, explain specifics of formulary.** The APN COF holder must submit a notice of a formulary to the BON. Protocols are not required to be submitted. The APN must file a notice and formulary form with the BON containing information about the supervising physician and a check mark beside the class of drugs intended to be prescribed. The listed class of drugs includes such categories as 'analgesics, anticonvulsants, anti-hypertensives, arthritis medications, Schedule II, Schedule III,' etc.

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** Supervision, control, and responsibility. Under the BME rules, the supervising physician must sign (minimum of 20% of charts) the NP's chart documentation within 30 days for any patient for whom the NP prescribes a controlled drug.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** The NP who holds a COF is authorized to prescribe and/or issue controlled substances listed in Schedules II–V upon joint adoption of physician supervisory rules concerning controlled substances.

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Atlanta Division Office Registration, 75 Spring Street SW, Room 740, Atlanta, GA 30303; p: 1-888-219-8689

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Statute

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes.

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OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Belmont University—Nashville; (2) Carson-Newman University—Jefferson City; (3) East Tennessee State University—Johnson City; (4) Tennessee State University—Nashville; (5) University of Memphis—Memphis; (6) University of Tennessee—Knoxville; (7) University of Tennessee—Memphis; (8) Vanderbilt University—Nashville; (9) Southern Adventist University—Collegedale; (10) Union University—Jackson; (11) University of Tennessee—Chattanooga; (12) King University; (13) Lincoln Memorial University; (14) Austin Peay State University; (15) Middle Tennessee State University; (16) Tennessee Technological University.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Union University; University of Tennessee Health Science Center; Vanderbilt University; East Tennessee State University; University of Tennessee Chattanooga; University of Tennessee Knoxville; Belmont University.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Tennessee Nurses Association Council on Advanced Practice (<http://www.tnaonline.org/>)

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**Organized opposition to NP legislative or regulatory changes?** General opposition by organized medicine.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 75

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state now deserves a ranking of "C+."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **143 for NPs<sup>†</sup>** (7039 in state<sup>‡</sup> results in a **1:49 ratio**)
- **5516 for MDs/DOs/Interns/Residents** (21,356 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **105 for NPs<sup>†</sup>** (7039 in state<sup>‡</sup> results in a **1:67 ratio**)
- **1463 for MDs/DOs/Interns/Residents** (21,356 in state<sup>‡</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions must be initiated within 1 year after injury discovery and never more than 3 years after date of negligent act or omission. Expert witnesses must be physicians licensed in the same specialty that caused the alleged malpractice. There is no damage cap on malpractice cases and the state allows but does not mandate arbitration for malpractice claims.

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**Recent state malpractice liability tort reform?** 2011: Limited noneconomic damages to \$750,000 per occurrence in medical liability actions and provided for a limit of \$1 million if the injury or loss is catastrophic in nature; limited punitive damages to two times compensatory damages or \$500,000 (whichever is greater). Also prohibited the award of punitive damages against the sellers of products, drugs, or devices (with certain exceptions) that were manufactured in accordance with relevant federal law (with certain exceptions). 2006–2010: None. 2005: Exempts from civil liability manufacturers, distributors, sellers, or advertisers of food [as defined in Section 201(f) of 21 U.S.C. § 321(f)] when the claim is for weight gain, obesity, or other conditions resulting from the long-term consumption of food.

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## THE PEARSON REPORT

**STATE:** **TEXAS**

**NP title(s) used in this state:** NP (Nurse Practitioner; must include one of the nine BON-approved population foci, for example, FNP, PNP, etc.); APRN (Advanced Practice Registered Nurse; this is the name on the advanced nursing license, but it is not a title; rules may change in 2014.)

**Number of NPs in state:** 11,025

**NP specialties legislatively specified?** No. Population foci are identified in BON rules, which specify nine NP titles.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The SOP is defined in the BON rule; based on advanced practice nursing education, continued advanced practice experience, and the accepted SOP as defined by the professional specialty organizations recognized by the BON. NPs must practice in the role and population focus/specialty appropriate to their educational preparation.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No joint regulation. But the BOM regulates physicians who delegate prescriptive authority. APRNs and physicians must register delegation of the prescriptive authority with the BOM.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** Delegation of authority to provide medical aspects of patient care, including medical diagnosis and prescribing. Protocols or other written authorization are required to provide medical aspects of patient care. A prescriptive authority agreement is required in order to prescribe medications or devices, including durable medical equipment, effective November 2013). The Medical Practice Act includes supervision/quality assurance requirements for physicians who delegate prescriptive authority.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. As long as the NP clarifies the basis of the title, that he or she is an NP, not a physician (per Section 104.004 of Texas Occupations Code related to “Other Persons Using Title Doctor”).

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The NP's role and population focus area are noted on the RN license. APRN and RN licenses are renewed at the same time. The BON is considering issuing a separate APRN license number, but this is not done at this time.

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**Supervised practice hours required before full NP practice autonomy?** No. However, applicants who complete NP or clinical nurse specialist (CNS) programs on or after January 1, 2003 must demonstrate evidence of completion of a minimum of 500 clinical hours within the advanced educational program. APRNs must also have a minimum of 400 hours of current practice within the preceding biennium unless they graduated from an appropriate program within the last 2 years.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. To be BON approved for licensure and Rx authority the APRN must have successfully completed a separate, dedicated graduate-level course in pharmacotherapeutics.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** Requirement of 20 contact hours of CE in the advanced role and population focus recognized by the BON every 2 years or proof of national certification or recertification in the same advanced practice role and population focus. APRNs with prescriptive authority must take 5 additional hours of CE in pharmacotherapeutics specific to their clinical specialty every 2 years. Those prescribing controlled substances must take 3 additional hours specific to those drugs.

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**BON mechanism for others to verify NP license?** Yes. Online through the BON website (<https://www.bon.state.tx.us/olv/apninq.html>).

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**Current listing of all active NP licenses maintained by BON?** Yes. An electronic file of all APRNs is available for purchase (<http://www.bon.texas.gov/olv/verification.html>).

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**Current listing of authorized NP prescribers maintained by BON?** Yes. The electronic file of APRNs identifies those with an Rx authority number issued by the BON. Rx authority can be verified for individual NPs on the Web.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** SB 406 amends the site-based prescriptive authority requirements. Prescriptive authority can be delegated by a physician via a prescriptive authority agreement between the APRN and physician provided neither party is prohibited from entering a prescriptive authority agreement by their respective licensing boards. The bill extends the limit on the number of APRNs with whom a physician can have a prescriptive authority agreement to seven full-time employees. Medically underserved and facility-based practices are exempt from the seven full-time employees restriction. Periodic face-to-face meetings between the APRN and physician are required based

on the schedule provided. The BON and BOM are required to share information regarding investigations of licensees and final disposition of cases related to prescriptive authority agreements. The BON and BOM are required to work together to develop FAQs regarding prescriptive authority agreements. SB 406 also expands NP authority to prescribe controlled substances in Schedule II for patients in hospital and hospice settings only. The BON is granted explicit authority to issue an APRN license. The bill requires managed-care organizations contracted with the Texas Health and Human Services Commission to consider APRNs at the same level as Primary Care Physicians with regard to selection and assignment as Primary Care Providers and for inclusion in the primary care network and in the network directory, effective November 2013.

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**Legislative/administrative plans for state?** The Texas legislature will not meet in 2014. The professional organizations will discuss statutory changes needed to improve practice and monitor any problems associated with implementing SB 406. Professional APRN organizations will continue helping APRNs meet with legislators to continue educating them about APRNs during the interim.

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**Internet address for Nurse Practice Act:** <http://www.bon.texas.gov/nursinglaw/npa.html>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Physician involvement includes delegation of diagnosis, but the Medical Practice Act contains no specific reference to this. BOM Rule 193.6(a) states protocols may authorize diagnosis of the patient's condition or treatment. A prescriptive authority agreement is required to order or prescribe medications, devices, or durable medical equipment, effective November 2013.

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**Required physician record/chart review?** Yes. The number of charts to be reviewed is to be determined jointly by the APRN and physician; the prescriptive authority agreement must state the number of charts the physician will review as part of the quality assurance plan, effective November 2013.

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**Required NP/physician practice agreement?** Yes. Protocols or other written authorization are required, but only for medical aspects of care. BON rules require that NPs use mechanisms (i.e., protocols/policies/practice guidelines/clinical practice privileges) that provide authority from the physician for medical aspects of care. Such protocols or other written authorization need not describe the exact steps that the NP must take with respect to each specific condition, disease, or symptom. The degree of detail within the protocols or other written authorization may vary in relation to the complexity of the situations covered, the advanced specialty area of practice, the advanced educational preparation of the individual, and the experience level of the individual NP. Prescriptive authority agreements are required to order or prescribe medications or devices, including durable medical equipment. Prescriptive authority agreements meet the requirements for protocols or other written authorization, effective November 2013.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No. However, it must be made available upon request.

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**If so, is agreement required to be kept/stored/updated?** Yes. Prescriptive authority agreements, (effective November 2013), protocols, or other written authorization must be maintained in the APRN's practice setting to verify authority to provide medical aspects of care. They must be reviewed at least annually, and signed and dated by NP(s) and physician(s).

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** Hospital licensing law does not include APRNs as medical staff members who may admit and discharge patients. Another law only allows physicians to perform the admission physical exam and admit patients to psychiatric facilities. Most hospitals grant privileges to APRNs as allied health providers.

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**Additional limitations/clarifications/expansions to NP practice?** APRNs may issue temporary disabled parking placards on the initial request.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. The APRN with a valid Rx authorization number issued by the BON shall: (1) sign Rx drug orders for only those drugs that are authorized by prescriptive authority agreement, (effective November 2013), protocols, or other written authorization for medical aspects of patient care; (2) prescribe for patient populations within the accepted scope of professional practice for the NP's population focus area; and (3) comply with the requirements for the prescriptive authority agreement and face-to-face meetings with the delegating physician.

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**NP/physician prescriptive agreement required?** Yes. Prescriptive authority agreements (effective November 2013) that are agreed upon and signed by the APRN and physician. Rather than listing specific drugs, the physician may state types or categories of drugs that the APRN may or may not prescribe.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The NP prescriptive authority can be delegated by a physician via a prescriptive authority agreement with the APRN, provided neither party is prohibited from entering a prescriptive authority agreement by their respective licensing boards. Supervision must be consistent with what a careful and prudent physician would do, but at a minimum, for NPs who have not been prescribing for the past 5 of 7 years, the physician must have monthly face-to-face meetings with the NP for the first 3 years. For NPs with 5 years of recent prescribing experience, monthly face-to-face meetings must occur for 1 year. Thereafter, frequency reduces to quarterly face-to-face meetings with monthly contact in between. Physicians are limited to delegating prescriptive authority to no more than seven APRNs and/or PAs or the full-time equivalent, except in sites serving medically



underserved populations and licensed hospital facility-based practices where there is no limit on the number. The delegating physician may designate one or more alternate physicians to conduct and document the quality assurance meetings (effective November 2013).

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V, limited to 90 days. Consultation with the delegating physician is required for refills beyond 90 days and for any controlled substance Rx for a patient under the age of 2 years. All controlled substance prescriptions must include the NP's DEA number and the physician's DEA number. Orders or prescriptions for Schedule II medications may be issued in hospital facility-based practices (provided the individual is a patient of the emergency department or has an intended length of stay that is at least 24 hours) and in hospice settings (effective November 2013).

**NP issued Rx number by state?** Yes. The Rx number is issued by the BON. Before prescribing controlled substances, NPs also must have a state controlled substances registration number issued by the Texas Department of Public Safety.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Texas Northern: Dallas Division Office, 10160 Technology Boulevard East, Dallas, TX 75220; p: 1-214-366-6900). South and Central Texas: Houston Division Office, 1433 West Loop South, Suite 600, Houston, TX 77027; p: 1-713-693-3000). Southwest Texas: El Paso Division, 660 Mesa Hills Drive, Suite 2000, El Paso, TX 79912; p: 1-915-832-6000). Toll-free phone numbers are provided online for each field office (<http://www.justice.gov/dea/about/offices.shtml>).

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** Yes.

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**NP name required on Rx bottle?** Yes. (The pharmacist must include the name of the "prescribing practitioner.")

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** BON R&R (22 TEXAS ADMIN. CODE § 222.11) and NPA Texas Occupations Code, § 301.002(2)(F)

**Specified limitations or restrictions on NP drug sampling?** Yes. NPs with a valid prescription authorization number may request, receive, possess, and distribute prescription drug samples provided the prescriptive authority agreement (effective November 2013) authorizes the NP to sign the prescription drug orders and a record of the sample is maintained and properly labeled.

**Restrictions on out-of-state NP Rx being filled in this state?** Yes. Under BOP regulations, an out-of-state prescription is honored as long as an equivalent in-state prescriber may legally prescribe the same drug. Thus, a prescription written by an out-of-state NP for a Schedule II drug prescribed in a location other than a hospital facility-based or hospice setting (effective November 2013), although valid under the NP's state law, could not be filled in TX because NP's in TX may not legally prescribe Schedule II drugs.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. Medicaid reimbursement is 92% of the amount paid to a physician. Insurance code requires HMOs and PPOs to include NPs on provider panels if the collaborating physician is also on the panel. The code also requires insurers to reimburse NPs unless specifically excluded by the insurance policy.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. But only Medicaid managed-care companies must include APRNs as PCPs. Managed-care organizations contracted with the Texas Health and Human Services Commission are to consider APRNs at the same level as PCPs with regard to selection and assignment as PCPs and for inclusion in the primary care network and in the network director (effective November 2013).

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Abilene Intercollegiate—Abilene; (2) Baylor University—Dallas; (3) Midwestern State University—Wichita Falls; (4) Prairie View A&M—Houston; (5) Texas A&M University—Corpus Christi; (6) Texas A&M International University—Laredo; (7) Texas Tech University—Lubbock; (8) Texas State University—San Marcos; (9–11) Texas Woman's University—Dallas, Denton, Houston; (10–19) University of Texas—Arlington, Austin, El Paso, Houston, Medical Branch in Galveston, Pan American in Edinberg, San Antonio, Tyler; (20) University of Houston—Victoria; (21) University of Mary Hardin-Baylor—Belton; (22) West Texas A&M University—Canyon.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Baylor University; Texas Christian University; Texas Tech University Health Sciences Center; Texas Woman's University; University of Texas—Arlington; University of Texas—El Paso; University of Texas Health Science Center at Houston; University of Texas Health Science Center—San Antonio; University of Texas Medical Branch—Galveston; University of the Incarnate Word.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** Texas Nurse Practitioners (<http://www.texasnp.org/>); Coalition for Nurses in Advanced Practice (<http://www.cnaptexas.org/>); Texas Nurses Association (<http://www.texasnurses.org/>); Texas Nurse Practitioner Foundation (<http://www.tnnpfoundation.org/>).

**Organized opposition to NP legislative or regulatory changes?** Any legislative or regulatory action that would increase NP independence is opposed by the Texas Medical Association (TMA; over 41,000 members) and a coalition of TMA and specialty medical societies named "PatientsFIRST."

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 65

**Descriptive ranking:** Grade D. The state restricts patient choice.

**\*Pearson Report 2014 update: state now deserves a higher ranking of "D+."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **101 for NPs<sup>†</sup>** (11,025 in state<sup>‡</sup> results in a **1:109 ratio**)
- **25,191 for MDs/DOs/Interns/Residents** (68,717 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **9 for NPs<sup>†</sup>** (11,025 in state<sup>‡</sup> results in a **1:1225 ratio**)
- **4252 for MDs/DOs/Interns/Residents** (68,717 in state<sup>‡</sup> results in a **1:16 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** A healthcare liability claim must begin within 2 years from the occurrence of the mistake or injury or from the completion of treatment or hospitalization. Malpractice action is barred if a claimant’s “percentage of responsibility” is greater than 50%; if less than 50%, his or her recovery is proportionately reduced (i.e., modified comparative negligence for tort claims). A plaintiff must within 120 days of filing a healthcare liability claim provide expert reports about the liability claimed against the healthcare provider. When there is no expert report the court must dismiss with prejudice and award attorney fees. Experts who testify must have board certification relevant to the claim. Noneconomic damages are limited to a total of \$250,000 from all healthcare providers and a total of \$500,000 from

all institutions. Wrongful death awards are limited to \$500,000 (in 1977 dollars), which is now adjusted to inflation to about \$1.3 million. Use of an arbitrator or screening panel is not mandated; however, pretrial mediation is routine and the legislature has authorized counties to create a dispute resolution system. Healthcare providers cannot require or request that patients sign an agreement to arbitrate liability claims without giving the patient a prescribed form of written notice that the agreement is invalid without the patient's attorney's signature.

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**Recent state malpractice liability tort reform?** 2006–2013: None. 2005: Asbestos/silica litigation reform establishes medical criteria for all pending and future asbestos claims, including a requirement that all claimants submit a qualifying medical report with a pulmonary function test that demonstrates physical impairment. 2005: Bill exempts from civil liability trade associations, livestock producers, manufacturers, sellers, etc. of food for claims arising out of weight gain, obesity, or a health condition. 2003: Law limits the award of noneconomic damages to \$750,000 total (i.e., \$250,000 against all doctors and healthcare practitioners and a \$250,000 per-facility cap against healthcare facilities such as hospitals and nursing homes, with an overall cap of \$500,000 against healthcare facilities).

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## THE PEARSON REPORT

**STATE:** UTAH

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), RNP (Registered Nurse Practitioner), and NP (Nurse Practitioner)

**Number of NPs in state:** 1445 NPs (total APRNs = 2056)

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** SOP is broadly defined in law and rule and relies on the generally recognized scope and standards of the profession, as defined by national certification bodies and professional associations.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes. However, the BON is advisory to the Utah Division of Occupational and Professional Licensing (DOPL), which is the agency that oversees licensure of approximately 60 different occupations and professions.

**MSN required for practice?** Yes (or higher degree). However, if licensed prior to 1987, a BSN is acceptable.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** An APRN who chooses to prescribe Schedule II–III controlled substances must have a completed consultation and referral plan on file at the practice site. The written plan must describe the process of consultation, including how it will be documented and a description of how referrals will be made. The plan can be as vague or as specific as the parties design it; there must be a written plan, but there is no requirement for “consultation.” There is no requirement for physician signature.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Except that UTAH CODE ANN. § 58-67-102, Definitions, specifies “to use, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions in any printed material, stationery, letterhead, envelopes, signs, or advertisements, the designation ‘doctor,’ . . . ‘Dr.’ . . . or any combination of these designations in any manner which might cause a reasonable person to believe the individual using the designation is a licensed physician and surgeon . . . the designation must additionally contain the description of the branch of the healing

the Senate Transparency in Health Care Provider Advertising Act both affirmed that healthcare providers must include information about their license and title so they cannot be mistaken for being a physician (e.g., by writing “Dr. John Doe, Nurse Practitioner”).

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** An individual may only hold one license. Therefore, once the APRN license is issued, the RN license expires (due to the issuance of the greater SOP license). An individual holding an APRN license as of July 1, 1998 who cannot document the successful completion of advanced course work in patient assessment, diagnosis and treatment, and pharmacotherapeutics, may not prescribe and shall be issued an “APRN— without prescriptive practice” license.

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**Supervised practice hours required before full NP practice autonomy?** Practice requirements for APRNs specializing in psychiatric mental health nursing must have supervised clinical practice for a minimum of 4000 hours (1000 hours can be credited from an approved psychiatric mental health nursing education program; the remaining 3000 hours must include a minimum of 1000 hours of mental health therapy with 1 hour of face-to-face supervision for every 20 hours; at least 2000 of these hours must be under the supervision of a qualified APRN). No other APRN specialty requires postgraduate supervised experience hours.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** No. However, NPs must have completed an advanced pharmacotherapeutics course as part of the approved graduate education.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** For renewal of the APRN license the APRN must be currently certified or recertified in their specialty area of practice, or if licensed prior to July 1, 1992, complete 30 hours of approved CE and 400 hours of practice.

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**BON mechanism for others to verify NP license?** Yes. The DOPL has a website ([www.dopl.utah.gov](http://www.dopl.utah.gov)) and publishes all licenses it monitors. Type in the name to ascertain if the person has an active APRN license (also utilize NURSYS to verify RN/LPN licenses).

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** Bills that passed in 2013: (1) SB 147 S1, Sen. Mayne, “Workers’ Compensation and Occupational Safety Amendments,” appropriately names NPs and APRNs as entities who can be billed through workers’ compensation. Language in the original bill listed NPs as “physician extenders.” This language was amended to eliminate the physician extender language. (2) SB 214 S1, Sen. Jones, “Continuing Education for Prescription Drugs,” requires certain controlled substance prescribers to complete at least 4 hours of CE as a requisite for license renewal; requires that at least 3.5 hours of the required CE hours be completed in controlled substance prescribing classes; establishes criteria for controlled substance prescribing classes recognized by the DOPL; directs the DOPL to consult with other applicable departments and associations when determining whether classes



for controlled substance prescribers with a specific license type meet established criteria; grants rulemaking authority to the DOPL.

**Legislative/administrative plans for state?** To work toward obtaining reimbursement from Medicaid for all NPs certifications (in addition to Family and Pediatric NPs) and to work toward eliminating the consultation and referral plan required for the prescription of Schedule II and III controlled substances.

**Internet address for Nurse Practice Act:** <http://www.dopl.utah.gov/licensing/nursing.html> (See “Statutes and Rules.”)

#### NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** NPs may sign death certificates (if they are employed by a healthcare facility). NPs may sign handicapped parking permits. NPs may dispense “cosmetic” medicines or injectable weight loss drugs. All qualified healthcare providers (not just physicians) may evaluate child athletes’ concussions and determine when they can resume play.

#### NP SCOPE OF PRACTICE—PRESCRIBING

**NP Rx authority granted separate from practice authority?** No (for new applicants).

**NP/physician prescriptive agreement required?** Yes. For the APRN who chooses to prescribe Schedule II and III controlled substances. The “consulting physician” is a physician or surgeon who has agreed to consult with this APRN (who must possess a state controlled substance license and a DEA registration number). Physician consultation is not needed for any other prescribing drugs or devices, or for prescribing Schedule IV and V controlled substances.

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** Yes.



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**If so, what words are used to characterize involvement?** The APRN must have a formal consultation and referral plan on file at the practice site if prescribing Schedule II or III controlled substances. There is no requirement to consult on the prescription or for the physician to review charts.

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**NP authorized to Rx controlled substances?** Yes. All prescribers with controlled substance licenses (including NPs) must register with the Controlled Substance Data Base to keep track of controlled substance prescriptions and the patients who take them.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. The DOPL may issue a controlled substance license to manufacture, produce, distribute, dispense, prescribe, obtain, administer, analyze, or conduct research with controlled substances in Schedules I, II, III, IV, or V to qualified persons, including APRNs.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Denver Division Office, 115 Inverness Drive, East Englewood, Colorado 80112; p: 1-800-326-6900

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**DEA number required for nonscheduled as well as scheduled Rx?** No

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** APRNs follow the Utah Controlled Substances Act, which defines the rules for all licensed practitioners allowed to prescribe a controlled substance, other drug, or device that the prescribing practitioner dispenses or administers for use by a patient.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes. However, Utah Medicaid will not reimburse all NP specialties; they only acknowledge FNP and PNP.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. There is an increased number of retail clinics in the state with Intermountain Health Care owned and staffed by NPs.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Brigham Young University—Provo; (2) University of Utah—Salt Lake City; (3) Westminster College—Salt Lake City

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Rocky Mountain University of Health Professions; University of Utah.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Utah NPs (<https://utahnp.enpnetwork.com/>)

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**Organized opposition to NP legislative or regulatory changes?** No. Any opposition tends to be issue specific.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 87

**Descriptive ranking:** Grade B. The state partially supports patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "B."*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **34 for NPs<sup>†</sup>** (1445 in state<sup>‡</sup> results in a **1:43 ratio**)
- **2996 for MDs/DOs/Interns/Residents** (9038 in state<sup>‡</sup> results in a **1:3 ratio**)

<sup>†</sup> NP total includes column count for NP, Adult Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)

(1/1999–3/2013):

- **20 for NPs<sup>†</sup>** (1445 in state<sup>‡</sup> results in a **1:72 ratio**)
- **588 for MDs/DOs/Interns/Residents** (9038 in state<sup>‡</sup> results in a **1:15 ratio**)

<sup>†</sup> NP total includes column count for NP, Adult Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** In general, malpractice actions against any healthcare provider must be initiated within 2 years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the injury, whichever comes first, but not to exceed 4 years after the date of the alleged action, omission, neglect, or occurrence. A plaintiff must file a notice of intent to commence action with the prospective defendant at least 90 days prior to filing a medical malpractice action. Additionally, the plaintiff must properly request a prelitigation panel within 60 days after their notice of intent to commence action. There are no laws requiring an expert opinion in malpractice cases, but the plaintiff must demonstrate that healthcare provider's conduct fell below the standard of care. A prelitigation panel must review cases; the findings are nonbinding and inadmissible in court. The parties may waive the hearing or convert it to binding arbitration. There is no patient compensation fund, and physicians are not required to carry malpractice insurance. A 2003 law exempts manufacturers, distributors, and marketers of food for claims arising from obesity or weight gain resulting from the consumption of food. Physicians may withhold services (except in emergencies) if their patient does not consent to arbitration.

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**Recent state malpractice liability tort reform?** 2013: Medical liability reform regarding arbitration provides that a party in a medical liability action must have an issued certificate of compliance before attempting an allocation of fault to a healthcare provider; it also requires that evidence from a medical review panel remain "unreportable" to a healthcare facility or health insurance plan. 2011–2012: None. 2010: Change in the prelitigation process imposed an affidavit of merit requirement from an appropriate healthcare professional within 60 days of a non-meritorious finding by a prelitigation panel. A certificate of compliance (not issued unless a required affidavit is received in a timely manner) is a condition precedent to filing a medical malpractice action. Additionally, noneconomic damages (those for pain, suffering, and inconvenience) may not exceed \$400,000; for a cause of action arising after May 15, 2010, the amount is \$450,000. 2005–2009: None.

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## THE PEARSON REPORT

**STATE:** VERMONT

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 545

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Completion of a formal education program approved by the BON and certified by a national organization.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** No (although graduate-level course work is required).

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** No.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** Unclear, but there is strong concern. Under VT. STAT. ANN. tit. 26, § 1311; 1314, “A person who advertises or holds himself or herself out to the public as a physician or surgeon, or who assumes the title or uses the words or letters ‘Dr.,’ ‘Doctor,’ ‘Professor,’ ‘M.D.,’ or ‘M.B.,’ in connection with his or her name, or any other title implying or designating that he or she is a practitioner of medicine or surgery in any of its branches, or shall advertise or hold himself or herself out to the public as one skilled in the art of curing or alleviating disease, pain, bodily injuries, or physical or nervous ailments, or shall prescribe, direct, recommend, or advise, give or sell for the use of any person, any drug, medicine or other agency or application for the treatment, cure, or relief of any bodily injury, pain, infirmity, or disease, or who follows the occupation of treating diseases by any system or method, shall be deemed a physician, or practitioner of medicine or surgery” with the penalty for violating any aspect of VT. STAT. ANN. tit. 26, § 1311; 1314 as “imprisonment of not more than three months or fined not more than \$200.00 nor less than \$50.00, or both.”

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** Individuals are licensed as RNs and endorsed as APRNs (with a different license prefix than RNs). When the APRN license is issued, the RN license becomes “inactive.” The APRN license, through Administrative Rule, allows APRNs to also work as RNs if desired.

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**Supervised practice hours required before full NP practice autonomy?** Yes. A collaborative agreement is required during the transition to practice period (2400 hours and 2 years).

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**Supervised practice hours required before full NP prescribing autonomy?** Yes. A collaborative agreement is required for the transition to practice period (2400 hours and 2 years).

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**Additional pharmacology hours required for prescribing?** A graduate-level pharmacotherapeutics course is required. No additional hours are required.

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**CE requirements for NP practice?** No. However, VT has a practice requirement. The NP must have worked 50 days or 400 hours within the 2-year renewal period and maintain national certification (which requires CEUs).

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**If so, what are the specifics?** N/A

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**BON mechanism for others to verify NP license?** Yes. This can be done on the website or by mail.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** No.

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** Goal is for healthcare reform, including possible universal health care with increased public oversight or mandated budgets for hospitals.

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**Internet address for Nurse Practice Act:** <http://vtprofessionals.org>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Not required with a physician during the “transition to practice” period (2400 hours and 2 years); the written collaborative agreement must be with a physician, DO, or APRN (with at least 4 years of experience in the same population focus and field).

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** The APRN acts independently consistent with the practice guidelines. During the transition to practice, graduates with fewer than 24 months and 2400 hours of licensed active advanced nursing practice in an initial role and population focus and those with fewer than 12 months and 1600 hours for any additional role and population focus shall have a formal agreement with a collaborating provider (i.e., with a physician, DO, or APRN with at least 4 years of experience in the same population focus and field). APRNs shall have and maintain signed and dated copies of all required collaborative provider agreements as part of the practice guidelines. An APRN required to practice with a collaborative provider agreement may not engage in solo practice.

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**Required physician record/chart review?** No. Unless specified by the APRN in the required submission of the quality assurance plan. The quality assurance plan is written by the APRN and signed by the APRN and collaborating provider, for the transition to practice period;

it describes the method the APRN will utilize for chart/care review and collaboration and conferencing.

**Required NP/physician practice agreement?** No. Practice guidelines (mutually agreed upon by the APRN and collaborating provider) are reviewed and approved by the BON. Practice guidelines must include: (1) a description of clinical practice, including practice site, focus of care, and general category of clients; (2) an indexed copy of standards for clinical practice, including method of data collection, assessment, plan of care, and criteria for collaboration, consultation, and referral, as well as the name of at least one provider who will be routinely utilized for collaboration, consultation, and referral; and (3) methods of quality assurance.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** BON (and the place of employment).

**If so, is agreement required to be kept/stored/updated?** Practice guidelines must be kept on file in the workplace. Practice guidelines must be updated and sent to the BON for review and approval when there is a change in collaborating provider, location, or clinical practice. Practice guidelines are also reviewed during each biennial renewal period.

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** No.

#### NP SCOPE OF PRACTICE—PRESCRIBING

**NP Rx authority granted separate from practice authority?** No.

**NP/physician prescriptive agreement required?** Not required with a physician. During the “transition to practice” period (2400 hours and 2 years) the written collaborative agreement must be with a physician, DO, or APRN (with at least 4 years of experience in the same population focus and field; included in practice guidelines). Prescriptions may be written and signed by the APRN for those medications appropriately described based upon the practice guidelines. A list of endorsed APRNs will be made available to the BOP (pharmacy).

**NP Rx from state authorized formulary required?** No.

**If so, explain specifics of formulary.** N/A

**BOM/physician involvement in NP prescribing?** No.

**If so, what words are used to characterize involvement?** A collaborating provider agrees to the practice guidelines.

**NP authorized to Rx controlled substances?** Yes.

**If so, what schedules?** Schedules II–V



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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Boston Division Office, JFK Federal Building, Room E-400, 15 New Sudbury Street, Boston, MA 02203-0131; p: 1-617-557-2200

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** No. State law addresses drug samples but is not specific to APRNs.

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**Specified limitations or restrictions on NP drug sampling?** Yes. Based on state law that applies to MDs and APRNs.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** There is no prohibition in the BON R&R or legislative statutes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** There is no prohibition in the BON R&R or legislative statutes.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) University of Vermont—Burlington.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** None

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Vermont NP Association (<http://www.vtnpa.org/>)

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**Organized opposition to NP legislative or regulatory changes?** There has not been active opposition. However, there was organized “concern” from the medical society that could have been considered opposition during the Administrative Rules change in June 2011. The BON worked with the Board of Medical Practice to revise the Administrative Rules statute. The BON continues to collaborate with the Board of Medical Practice on issues involving Vermont healthcare regulation. The BON also is available in a consultant role to stakeholders (e.g., the Vermont Medical Society, the Vermont Nurse Practitioner Association, and the Vermont State Nurses Association).

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**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 77

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state now deserves a ranking of “A-.”*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **1 for NPs<sup>†</sup>** (545 in state<sup>†</sup> results in a **1:545 ratio**)
- **890 for MDs/DOs/Interns/Residents** (3427 in state<sup>†</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **3 for NPs<sup>†</sup>** (545 in state<sup>†</sup> results in a **1:182 ratio**)
- **243 for MDs/DOs/Interns/Residents** (3427 in state<sup>†</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice claims must begin within 3 years from the date of alleged occurrence, within 2 years of when the individual knew or should have known, and in no case longer than 7 years after any injury. A claimant’s recovery is barred if his negligence is greater than the combined negligence of all defendants; his recovery is lessened proportionately based upon the amount of his negligence (i.e., the doctrine of modified comparative negligence). Plaintiffs must show expert testimony that the defendant did not apply an applicable standard of care. There is no damage cap. Malpractice claims must be submitted to an arbitration panel before beginning a trial; the panel’s findings can be appealed unless the parties agree to binding arbitration.

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**Recent state malpractice liability tort reform?** 2005–2013: None.

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## THE PEARSON REPORT

**STATE:** VIRGINIA

**NP title(s) used in this state:** LNP (Licensed Nurse Practitioner), NP (Nurse Practitioner)

**Number of NPs in state:** 7244

**NP specialties legislatively specified?** No. However, the regulations governing the licensure of NPs list categories of NPs accepted by the BON and BOM: APN, FNP, PNP, GNP, CRNA, CNM, NNP, WHNP, ACNP, and Psychiatric NP. NPs licensed prior to March 9, 2005 may retain the specialty category in which they were initially licensed, or if the specialty category has been subsequently deleted and if qualified by certification, be reissued a license in a specialty category consistent with such certification. (See 18 VA. ADMIN. CODE § 90-30-70.)

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Defined in Virginia Code as well as in regulations jointly agreed upon by the Committee of the Joint Boards of Nursing and Medicine (CJBNM). (See VA. CODE § 543.1-2957.01, 18 VA. ADMIN. CODE § 90-30-10 et seq., and VA. ADMIN. CODE § 90-40-10 et seq.) 54.1-3000 Definitions: “Nurse Practitioner” means an advanced practice registered nurse who is jointly licensed by the CJBNM pursuant to VA. CODE § 54.1-2957.

**NP title protection?** No.

**National certification required for recognition/practice?** Initial licensure requires evidence of professional certification that is consistent with the specialty area of the LNP’s educational preparation. License by endorsement also requires evidence of national certification consistent with the specialty area of the LNP’s educational preparation. To renew a license, an LNP shall hold current professional certification in an area of specialty practice from one of the national certifying agencies designated by the CJBNM. LNPs licensed prior to May 8, 2002 must hold current professional certification in an area of specialty practice from one of the national certifying agencies designated by the CJBNM or complete at least 40 hours of continuing education in the area of specialty practice approved by one of the national certifying agencies designated by the CJBNM (18 VA. ADMIN. CODE § et seq.).

**BON sole state authority over NPs?** No. The CJBNM has authority (see VA. CODE § 54.1-2978).

**MSN required for practice?** Yes. 18 VA. ADMIN. CODE § 90-30-80 requires NPs to submit evidence of a graduate degree in nursing or in the appropriate NP specialty from an educational program designed to prepare NPs. 18 VA. ADMIN. CODE § 90-30-85 outlines qualifications for licensure by endorsement and requires NPs provide verification of licensure as an NP or APN in another U.S. jurisdiction with a license in good standing, or if lapsed, eligible for reinstatement.

**Requirement for APN member on BON?** Yes. VA. CODE § 54.1-3002 requires the BON to consist of 13 members, at least one of whom is an LNP.

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**Joint BON/BOM regulation over any aspect of practice?** Yes. The presidents of the BON and BOM respectively shall each appoint three members from their boards to the CJBNM. The purpose of the CJBNM is to administer the regulations governing the licensure of NPs. (See VA. ADMIN. CODE § 90-30-30). The BON and the BOM, in consultation with the BOP, shall promulgate such regulations governing the prescriptive authority of NPs as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. (See VA. CODE § 54.1-2958.01.)

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**Physician involvement required for any aspect of practice?** Yes.

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**If so, what words are used to describe involvement (e.g. collaboration, supervision, direction, authorization, delegation)?** “Collaboration” means “the communication and decision-making process among members of a patient care team related to the treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments; and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources and expertise, problem solving, and arranging for referrals, testing, or studies.” “Consultation” means “the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem solving, and arranging for referrals, testing, or studies.” VA. CODE § 54.1-2901 states that this code does not prevent “any LNP from rendering care in collaboration and consultation with a patient care team physician as part of a patient care team pursuant to 54.1-2957 when such services are authorized by regulations promulgated jointly by the BOM and BON. NPs shall have Rx authority to prescribe Schedule II through VI controlled substances and devices upon the provision to the BOM and the BON of such evidence as they may jointly require that the NP has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the NP.” Virginia Code no longer mandates periodic site visits by physicians at a location other than where the physician regularly practices; site visits are optional and can be specified in the practice agreement. Requirements for the practice agreement are specified in code and regulation. The practice agreement is maintained by the NP and made available to the BON upon request.

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**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. However, Virginia Code requires that any person who is not a physician and uses the title “Dr” in writing or in advertising in connection with his practice, must simultaneously use a clarifying title, initials, abbreviations, or designation or language that identifies the type of practice for which he is licensed.

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**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** There is a separate license.

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**Supervised practice hours required before full NP practice autonomy?** No.

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**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Applicants for prescriptive authority can have completed a graduate course in pharmacology or pharmacotherapeutics, practice no less than 1000 hours plus 15 continuing education units related to the area of practice, or provide evidence of 30 contact hours of pharmacology education acceptable to the CJBNM.

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**CE requirements for NP practice?** Yes. 18 VA. ADMIN. CODE § 90-30-105 requires NPs to complete at least 40 hours of CE in the area of specialty practice approved by a national certifying agency designated by the CJBNM. To maintain Rx authority, LNPs must obtain 8 hours of CE in pharmacology or pharmacotherapeutics every 2 years.

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**If so, what are the specifics?** NPs licensed after May 2002 must maintain certification from one of the national certifying agencies designated by the CJBNM; NPs licensed prior to May 2002 must maintain certification from one of the national certifying agencies designated by the CJBNM, or complete at least 40 hours of CE in the area of specialty practice approved by one of the national certifying agencies designated by the CJBNM. To maintain Rx authority, LNPs must obtain 8 hours of CE in pharmacology or pharmacotherapeutics every 2 years.

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**BON mechanism for others to verify NP license?** Yes. NP licenses can be verified on the BON website, or by telephoning or faxing the BON.

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**Current listing of all active NP licenses maintained by BON?** Yes.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** The list is maintained in a database that can be sorted for those with Rx authority.

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**Recent legislative/regulatory changes affecting NP practice?** Governor McDonnell convened the Virginia Health Reform Initiative (VHRI) in 2010 to address reform needed in anticipation of the Patient Protection and Affordable Care Act. There were six task forces associated with the VHRI. One of them, the Capacity Task Force, included NP representation. Subsequent recommendations led to joint discussions between organized medicine (the Medical Society of Virginia) and the VCNP (the Virginia Council of Nurse Practitioners). A joint consensus bill, HB 346, was submitted to the 2012 legislative session and became law on June 1, 2012. Regulations subsequently promulgated took effect on May 8, 2013. There are both pros and cons to the bill, as follows. PROS: (1) Removed all reference to physician supervision of NPs; (2) defined NPs as APRNs within VA Code; (3) regulations prohibiting the establishment of a separate office for the NP have been deleted; (4) site visits by the physician to a setting where an NP practices are no longer mandatory; (5) requirement for collaboration and consultation may be met via written or electronic practice agreement; and (6) increased physician-to-NP "CJBNM limited ratio" from 4:1 to 6:1. CONS: (1) CJBNM involvement is still included; (2) requires chart review and physician input for complex cases, emergencies, and referrals; (3) statute now describes "physician leadership and management of the health care team"; and (4) physician may require NP to have malpractice insurance.

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**Legislative/administrative plans for state?** To move forward with legislative plans for further incremental progress toward unrestricted NP practice and increased patient access to NP care.

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**Internet address for Nurse Practice Act:** <http://www.dhp.virginia.gov/nursing/>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** Yes.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** Collaboration and consultation within a patient care team—“a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients. A patient care team physician means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.” VA. CODE § 54.1-2901 “Exemptions: The provisions of this chapter shall not prevent or prohibit any licensed nurse practitioner from rendering care in collaboration and consultation with a patient care team physician as part of a patient care team.”

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**Required physician record/chart review?** Yes. The written or electronic practice agreement shall include “provision for” periodic review of patient charts or electronic patient care records by a patient care physician. Frequency or number not specified. Specifics are to be determined by the team members as appropriate.

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**Required NP/physician practice agreement?** Virginia law requires a written or electronic practice agreement. A practice agreement means a written or electronic statement, jointly developed by the collaborating patient care team physician(s) and the licensed NP(s) that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the LNP(s) in the care and management of patients.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** No. The practice agreement shall be maintained by the NP and provided to the CJBNM upon request.

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**If so, is agreement required to be kept/stored/updated?** Any time there are changes in the patient care team physician, authorization to prescribe, or SOP, the NP shall revise and maintain the practice agreement.

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No. The written practice agreement is the only document required.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** VA. CODE § 54.1-2957.02 specifies that whenever a state law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit, or endorsement by a nurse (impacting audiological forms, school forms, Department of Health forms, nursing home forms, Medicaid forms, motor vehicle forms, mining forms, health spa forms, jail forms, tanning salon forms, and assisted living forms). NPs have the authority to sign DNR orders and death certificates.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes.

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**NP/physician prescriptive agreement required?** Yes. Included as part of the practice agreement, which is required for NPs with Rx authority. A practice agreement means a written or electronic agreement jointly developed by the patient care team physician and the NP for the practice of the NP; it also describes the prescriptive authority of the NP.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary** N/A

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**BOM/physician involvement in NP prescribing?** Yes. A licensed NP, other than a CRNA, shall have the authority to prescribe Schedule II–VI controlled substances and devices. The jointly developed practice agreement clearly states the prescriptive practices of the NP and may include restrictions on such prescriptive authority.

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**If so, what words are used to characterize involvement?** Virginia Code requires that a physician who enters into a practice agreement with an NP for Rx authority shall not serve as a patient care physician to more than six NPs with prescriptive authority at any one time.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** Yes. A prescriptive authority number is issued by the CJBNM.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Washington DC Division Office, Techworld Plaza, 800 K Street NW, Suite 500, Washington, DC 20001; p: 1-877-801-7974

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** The NP shall include on each prescription written or dispensed, his or her signature and the DEA number (when applicable). If the practice agreement authorizes prescribing of only Schedule VI drugs and the NP does not have a DEA number, he or she shall include the prescriptive authority number as issued by the CJBNM. The NP shall disclose to patients that he or she is a licensed NP and provide the name, address, and telephone number of the patient care team physician. Such disclosure may be included on a prescription pad or may be given in writing to the patient.

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**Physician name required on Rx pad?** The NP shall disclose to patients at the initial encounter that he or she is a licensed NP. Such disclosure may be included on a prescription pad or may be given in writing to the patient. The NP shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

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**NP name required on Rx bottle?** No.

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**Authority to receive/dispense drug samples spelled out?** Yes. Virginia Code states that an LNP authorized to prescribe controlled substances may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices.

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**Specified limitations or restrictions on NP drug sampling?** Yes. An NP may dispense only those manufacturer samples of drugs that are included in the written practice agreement as is on file with the board.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** There are no statutory prohibitions preventing NPs from independently billing insurers; however, payment is dependent upon individual company policies. Virginia does have a willing provider law, but among APNs only psychiatric CNSs and CNMs are mandated providers. BCBS has a policy of allowing NPs to participate as independent PCPs in its Northern Virginia network and VCNP has a reimbursement task force dedicated to reimbursement equity and empanelment.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** There are no statutory prohibitions.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Hampton University—Hampton; (2) Marymount University—Arlington; (3) Old Dominion University—Norfolk; (4) Radford University—Radford; (5) Shenandoah University—Winchester; (6) University of Virginia—Charlottesville; (7) Virginia Commonwealth University—Richmond; (8) George Mason University—Fairfax; (9) James Madison University—Harrisonburg

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** George Mason University; Marymount University; Old Dominion University; Radford University; Shenandoah University; University of Virginia.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** The Virginia Council of NPs (VCNP; [www.vcnp.net](http://www.vcnp.net))

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**Organized opposition to NP legislative or regulatory changes?** The level and scope of organized opposition to NP legislative or regulatory changes is dependent on the type and nature of the changes proposed.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal): 60**

**Descriptive ranking:** Grade D. The state restricts patient choice.

**\*Pearson Report 2014 update: state now deserves a ranking of "C-."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **110 for NPs<sup>†</sup>** (7244 in state<sup>†</sup> results in a **1:66 ratio**)
- **8162 for MDs/DOs/Interns/Residents** (31,949 in state<sup>†</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **85 for NPs<sup>†</sup>** (7244 in state<sup>†</sup> results in a **1:85 ratio**)
- **2781 for MDs/DOs/Interns/Residents** (31,949 in state<sup>†</sup> results in a **1:11 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>†</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** All malpractice actions for injury (as opposed to death) must begin within 2 years of the date of the injury. A plaintiff's contributory negligence may bar recovery (i.e., doctrine of contributory negligence). For acts or omissions the damage cap is \$2 million; for punitive damages the damage cap is \$350,000. There is no general patient compensation fund that covers all medical malpractice claims, but the no-fault remedy Birth-Related Neurological Injury Compensation Act covers infants who suffer permanent, disabling damage to the brain or spine caused by oxygen deprivation or mechanical injury during labor, delivery, or resuscitation. There is a system of medical malpractice review panels

to review newly filed medical malpractice claims. Either party can request a panel (consisting of two doctors, two lawyers, and a nonvoting judge) to review the claim to determine if the healthcare provider failed to provide the relevant standard of care and whether that failure caused the injury. The panel's findings are nonbinding, the lawsuit can be filed after the finding, and the panel's ruling is admissible in court. The parties can agree in advance to binding arbitration.

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**Recent state malpractice liability tort reform?** 2013: Medical liability reform regarding witness certification provides that the plaintiff must provide certification of expert witnesses, who must then certify that the defendant deviated from the standard of care and that this deviation was the proximate cause of the claimed injuries before the plaintiff may commence malpractice action. 2012: None. 2011: Virginia's medical malpractice cap will increase in \$50,000 annual increments beginning on July 1, 2012 through July 1, 2013. 2010: Two House bills attempted tort reform, but both bills failed. 2009: SB 1389 sought to provide that on and after July 2009 a healthcare provider's personal liability would be limited to \$2 million for any injury to, or death of a patient, and any amount due from a judgment or verdict in excess of \$2 million would be paid from the Patient's Compensation Fund. The bill failed to report. 2008: Defines the term "professional services in nursing homes" in the context of medical malpractice actions. Another law adds nurses to those persons presumed to know the statewide standard of care in the field in which they are qualified or certified for purposes of medical malpractice actions or proceedings before a medical malpractice review panel. Also, healthcare provider liability coverage provides that in the absence of gross negligence or willful misconduct, healthcare providers who respond to a disaster are immune from civil liability for any injury or wrongful death arising from the delivery or withholding of health care. 2007: Clarifies that when a plaintiff requests the service of process against a healthcare provider defendant, there is an expert opinion that the defendant deviated from the applicable standard of care. 2006: None. 2005: (1) Requires an expert witness to certify that the healthcare practitioner deviated from the standard of care and that such deviation is a proximate cause of the injuries claimed before service of process is made; (2) specifies that an expression of sympathy or general sense of benevolence to a patient or patient's relative is not admissible as evidence of an admission of liability; (3) revises the definition of malpractice to limit it to a tort or contract action for personal injuries or wrongful death.

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## THE PEARSON REPORT

**STATE:** WASHINGTON

**NP title(s) used in this state:** ARNP (Advanced Registered Nurse Practitioner)

**Number of NPs in state:** 4212 NPs (5385 ARNPs)

**NP specialties legislatively specified?** Yes (specified in BON Rules): NP, CNM, and CRNA.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** The ARNP BON rules stipulate that the ARNP functions within his or her SOP according to the BON commission-approved certification program and standards of care developed by professional organizations. The rules also specify the activities the ARNP may perform.

**NP title protection?** Yes.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** No. For NPs educated before January 1, 1995, education must have had content that required a minimum of 1 academic year for completion. For NPs educated after January 1, 1995, the educational content must culminate in a graduate degree with a concentration in advanced practice nursing. This allows for the fact that some ARNPs, such as CRNAs, may graduate from a program that is not in a school of nursing. This rule language also allows ARNP graduates of DNP programs to qualify for licensure.

**Requirement for APN member on BON?** Yes. There are two ARNP members on the 15-member Nursing Care Quality Assurance Commission (the Washington equivalent of the BON).

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc)?** A separate ARNP license is issued in addition to the RN license that an individual must maintain.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Yes. ARNPs must provide evidence of completion of 30 contact hours of education in pharmacotherapeutics related to the applicant's scope of specialized and advanced practice. This education must have been obtained within a 2-year time period immediately prior to the date of application for prescriptive authority, unless the applicant has graduated within the past 2 years from a graduate program that meets the requirements for an approved program in Washington.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** For license renewal, the licensee must provide documentation of 30 contact hours of CE during the renewal period and 15 additional contact hours for pharmacotherapeutics for renewal of prescriptive authority. CE must be related to licensee's SOP.

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**BON mechanism for others to verify NP license?** Yes. Via the Health Professions Quality Assurance Lookup system (<https://fortress.wa.gov/doh/providercredentialsearch/>).

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**Current listing of all active NP licenses maintained by BON?** The list is maintained in collaboration with Department of Health staff.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** The list of active licenses contains a designation for NPs with prescriptive authority.

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**Recent legislative/regulatory changes affecting NP practice?** Yes. In 2012, legislation passed allowing pharmacists to fill prescriptions for controlled substances, in addition to legend drugs previously authorized, from NPs in all other states and in the Canadian provinces that border Washington state. In 2012, the Department of Social and Health Services implemented a restrictive rule that no longer allows NPs to establish a disabling impairment; however, the Department may use an evaluation from an ARNP to establish a disabling impairment if the findings are reviewed and adopted by an acceptable medical source. This change was made to align with federal Social Security disability medical evidence rules, which do not allow NPs to establish a disabling impairment (see [http://www.ssa.gov/OP\\_Home/cfr20/416/416-0913.htm](http://www.ssa.gov/OP_Home/cfr20/416/416-0913.htm)).

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**Legislative/administrative plans for state?** Efforts to require all health plans to reimburse NPs at the same rate as physicians for the same service have been thwarted; however, these efforts continue.

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**Internet address for Nurse Practice Act:** <http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79>

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(In addition the ARNP rules are available at <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840>.)

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NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** ARNPs may sign accident reports and certify time loss for labor and industry claims. Psychiatric ARNPs are authorized to admit and manage the care of patients who are involuntarily detained in hospitals and mental health treatment centers; they may also provide legally mandated evaluations for hearings related to issues such as whether there is reason not to allow a patient's right to refuse medications. The Department of Labor and Industries added psychiatric ARNPs to its list of approved providers. ARNPs were included as PCPs in legislation that requires Medicaid, Basic Health, and the Public Employees Benefits Board programs to include provisions in contracts that encourage broad implementation of primary care health homes (SB 5394). ARNPs may certify death, sign forms allowing medication to be given in schools, and may sign change-in-gender designation forms for the Department of Licensing.

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#### NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. Although application for prescriptive authority can be made concurrent with the application for an ARNP license.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes. ARNPs may also recommend medical marijuana.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Seattle Division Office, 400 Second Avenue West, Seattle, WA 98119; p: 1-888-219-1418

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** WASH. REV. CODE § 69.45.050 (Foods, Drugs, Cosmetics, and Poisons) specifies samples may be distributed to practitioners legally authorized to prescribe drugs.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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**NP REIMBURSEMENT REALITIES/LIMITATIONS**

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** Yes. However, one insurance company reimburses ARNPs at 95% of the physician fee schedule, two reimburse at 85% of the physician fee schedule, and the Washington State Department of Labor and Industries reimburses ARNPs at 90% of the physician fee schedule.

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**OTHER FACTORS RELATED TO NP PRACTICE**

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**Number and listing of NP schools in state:** (1) Gonzaga University—Spokane; (2) Pacific Lutheran University—Tacoma; (3) Seattle University—Seattle; (4) Washington State University—Spokane and four other campuses across the state; (5) Seattle Pacific University—Seattle; (6) University of Washington—Seattle.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Seattle University; University of Washington; Washington State University.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** ARNP United of Washington (<http://www.auws.org>); Association of Advanced Practice Psychiatric Nurses (<http://www.aappn.org/>); Washington chapter of NAPNAP (<https://wanapnap.enpnetwork.com/>); Midwives of Washington ([www.midwivesofwa.org](http://www.midwivesofwa.org)).

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**Organized opposition to NP legislative or regulatory changes?** Yes. The state medical association has a history of trying to control or limit ARNP practice.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal): 98****Descriptive ranking:** Grade A. The state is exemplary for patient choice.**\*Pearson Report 2014 update: state now deserves a higher ranking of "A+."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **168 for NPs<sup>†</sup>** (4212 in state<sup>‡</sup> results in a **1:25 ratio**)
- **7159 for MDs/DOs/Interns/Residents** (25,830 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **129 for NPs<sup>†</sup>** (4212 in state<sup>‡</sup> results in a **1:33 ratio**)
- **1890 for MDs/DOs/Interns/Residents** (25,830 in state<sup>‡</sup> results in a **1:14 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Action must be brought within 3 years of the alleged malpractice action that caused the injury or 1 year after discovery; action for wrongful death must be brought within 3 years after death. A claimant's award is lessened proportionately to the claimant's fault, but no amount of fault will completely bar recovery (i.e., pure doctrine of comparative negligence). The state Supreme Court decided that a statutory cap on noneconomic damages is unconstitutional.

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**Recent state malpractice liability tort reform?** 2007–2013: None. 2006: Legislation limits the amount that can be required to pay to secure the right to appeal to \$100 million; also permits the admissibility of evidence of collateral source payments in medical liability cases. 2005. None. 2004: Law exempts from civil liability all manufacturers, marketers, or sellers of food or nonalcoholic beverages when the claim is based upon weight gain, obesity, or health conditions related to the long-term consumption of food or nonalcoholic beverages. 2003: None. 2002: Act bars a defendant's apology to a plaintiff from being admissible evidence in support of a plaintiff's case.

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## THE PEARSON REPORT

**STATE:** WEST VIRGINIA

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse), CNP (Certified Nurse Practitioner), and designated role titles (e.g., NP, WHNP, etc.).

**Number of NPs in state:** 1013 NPs (total number recognized for advanced practice is 1540)

**NP specialties legislatively specified?** Yes. An APRN is a Registered Nurse who has acquired advanced clinical knowledge and skills preparing him or her to independently provide direct and indirect care to patients, who has completed a BON-approved graduate-level education program, and who has passed a board-approved national certification examination.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** Within the Nurse Practice Act R&R, the BON states that the competencies of NP specialists include but are not limited to the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health.

**NP title protection?** No. However, “Registered Professional Nurse” and “Nurse” are title protected.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. A graduate-level education program is required; a nursing degree and a master’s are no longer mandated to be in the field of nursing, however, is recommended in the national LACE model.

**Requirement for advanced practice nurse member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** The APRN applying for limited prescriptive authority must provide written verification of an agreement for a collaborative relationship with a licensed physician for prescriptive writing privileges.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** There is a separate APRN license.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

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**Additional pharmacology hours required for prescribing?** Prior to application to the BON for approval for limited prescriptive authority, the applicant shall successfully complete an accredited course(s) of instruction in pharmacology during undergraduate study and an advanced pharmacotherapy graduate-level course approved by the board of not less than 45 pharmacology contact hours, provide documentation of the use of pharmacotherapy in clinical practice in the education program, and provide evidence of 15 pharmacology contact hours in advanced pharmacotherapy completed within the 2 years prior to the application.

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**CE requirements for NP practice?** Yes.

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**If so, what are the specifics?** RNs must complete 12 contact hours of CE every year. For renewing Rx approval, the applicant shall maintain national certification as an APRN as required for initial authorization for limited prescriptive privileges and during the 2 years prior to renewal complete a minimum of 8 contact hours of pharmacology education that have been approved by the BON.

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**BON mechanism for others to verify NP license?** Renewal, confirmation, and applications can be viewed online; an individual can also call the BON. Official verification is available by request at a \$30 fee.

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**Current listing of all active NP licenses maintained by BON?** Yes. The BON can generate listings of those NPs who have an APRN license with the BON.

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**Current listing of authorized NP prescribers maintained by BON?** Yes.

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**If so, is this a separate list from all active NP licenses?** Yes.

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**Recent legislative/regulatory changes affecting NP practice?** APRNs were defined in the law in 2012 (Chapter 30-07 et seq.), and rule in 2013 (Title 19-07 et seq.) to include CNPs, CNMs, CRNAs, and CNSs. An APRN license is required for APRNs in the state effective July 01, 2013 (Title 19-07). CNPs are required for accessing the WV Controlled Substance Monitoring Program Database initially upon prescribing or dispensing any pain-relieving substances for a patient and at least annually thereafter should the prescriber or dispenser continue to treat the patient with controlled substances (Title 19-14). APRNs shall not prescribe from the following categories of drugs: Schedule I and II of the Uniform Controlled Substances Act, antineoplastics, radio-pharmaceuticals, general anesthetics, and MAO inhibitors, except when in a collaborative agreement with a psychiatrist. Drugs listed under Schedule III and benzodiazepines are limited to a 72-hour supply without refills. The APRN may prescribe drugs from Schedules IV and V in a quantity necessary for up to a 90-day supply, with only 1 refill, and shall provide that the prescription expires in 6 months, with the following exceptions: prescriptions for phenothiazines shall be limited to up to a 30-day supply and be nonrefillable; prescriptions for noncontrolled substances of antipsychotics and sedatives prescribed by the APRN shall not exceed the quantity necessary for a 90-day supply, shall provide for no more than 1 prescription refill, and shall expire in 6 months (Title 19-08). APRNs with limited prescriptive authority may prescribe an annual supply of any drug with the exception of controlled substances that is prescribed for the treatment of a chronic condition, other than chronic pain management (Title 19-08). In 2010, the BOM wrote a policy statement entitled

“Guidelines for Physicians in Collaborative Relationships with APRN or CNMs: Standards of Practice.” This document added restrictions to APN and CNM practice in many ways, specifically by disciplining the physicians who do not comply with conduct sanctions (including the limitation on the number of APNs or CNMs a physician may enter into and participate in a collaborative agreement with). The nurses association successfully defeated this language in legislative code in 2009 and 2010. The BOM decided to declare it an internal policy of the regulatory BOM, however, thus insulting the legislative process. In 2012, there was a victory for collaborating physicians; the BOM revised their policy to a recommendation and “guidelines that are NOT sanctionable since they are NOT in code.”

**Legislative/administrative plans for state?** The current barriers APRNs face in providing care include, but are not limited to, the written collaborative regulatory requirements, restrictions on medication prescribing, loss of autonomy, and the inability to sign certain healthcare documentation for patients currently under their care. Modernizing the current regulatory requirements via retirement of these barriers is necessary to allow APRNs to provide timely, high-quality, cost-effective, and patient-centered care.

**Internet address for Nurse Practice Act:** <http://www.wvrnboard.com/>

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

**Additional limitations/clarifications/expansions to NP practice?** APRNs may be leads of the medical home project as long as allowed by the federal payer.

## NP SCOPE OF PRACTICE—PRESCRIBING

**NP Rx authority granted separate from practice authority?** Yes.

**NP/physician prescriptive agreement required?** Yes.

**NP Rx from state authorized formulary required?** Yes. Certain drugs are excluded.

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**If so, explain specifics of formulary.** The APRN may not Rx from the following categories of drugs: Schedules I and II controlled substances, antineoplastics, radio-pharmaceuticals, general anesthetics, or MAO inhibitors, except when in a collaborative agreement with a psychiatrist. Drugs listed under Schedule III and benzodiazepines are limited to a 72-hour supply without refills. Additionally, APRNs have the following restrictions on their prescribing: (1) may prescribe drugs from Schedules IV through V in a quantity necessary for up to a 90-day supply, may provide for only 1 refill, and shall provide that the prescription expires in 6 months; (2) prescriptions for phenothiazines shall be limited to up to a 30-day supply and shall be nonrefillable; (3) prescriptions for noncontrolled substances of antipsychotics and sedatives prescribed by the APRN shall not exceed the quantity necessary for a 30-day supply, shall provide for no more than 5 prescription refills, and shall expire in 6 months. The maximum dosage of any drug, including antidepressants, prescribed by the APRN shall be consistent with industry prescribing guidelines specific to the ANP's or CNM's area of practice and these guidelines shall be included in the collaborative agreement. APRNs shall not prescribe other prescription drugs or refills for a period exceeding 6 months (provided that this limitation shall not include contraceptives).

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** The APRN applying for limited prescriptive authority must submit a voided sample of their prescription form and written verification of an agreement for a collaborative relationship with a licensed physician to the BON. The APRN must certify that their collaborative agreement includes: (1) agreed upon written guidelines or protocols; (2) statements describing the individual and shared responsibilities of the APRN and the physician; (3) provision for the periodic and joint evaluation of the prescriptive practice; and (4) provision for the periodic and joint review and updating of the written guidelines or protocols.

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules III–V. The APRN must file any restrictions on Rx authority that are agreed to within the written collaborative agreement and the collaborating physician(s) with the BON.

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**NP issued Rx number by state?** Yes. The BON notifies the BOM, the Board of Osteopathy, the DEA, and the BOP of the APRN prescriber's identification number on the approved list of the APRNs.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Washington DC Division Office, Techworld Plaza, 800 K Street NW, Suite 500, Washington, DC 20001; p: 1-410-962-7580. West Virginia contact: U.S. Department of Justice, Drug Enforcement Administration, 200 Street Paul Place, Suite 2222, Baltimore, MD 21202.

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** Nurse Practice Act R&R

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**Specified limitations or restrictions on NP drug sampling?** Yes. The APRN approved for limited prescriptive authority by the BON is authorized to sign for, accept, and provide to patients samples of drugs received from a drug company representative.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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#### NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**  
There are no prohibitions against this.

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#### OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Marshall University—Huntington; (2) Wheeling Jesuit University—Wheeling; (3) West Virginia University—Morgantown; (4) West Virginia Wesleyan College—Buckhannon.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** West Virginia University

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** West Virginia Nurses Association, APRN Congress (WVNA APRN) is parent with the AANP as the APRN associate within the organization.

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**Organized opposition to NP legislative or regulatory changes?** Yes. The BOM and the Board of Osteopathic Medicine continue to lobby against legislation that removes current barriers to APRN practice, including removal of written collaborative agreements for prescriptive authority, restrictions on medication prescribing, loss of autonomy, and the inability to sign certain healthcare documentation for patients currently under their care. Modernizing the current regulatory requirements via retirement of these barriers is necessary to allow APRNs to provide timely, high-quality, cost-effective, and patient-centered care. The BOM continues to propose a new code to limit title use of “Doctor” and has created a subcommittee for APRN issues.

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**2007 consumer choice ranking of state’s NP regulation (100 is ideal):** 79

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**Descriptive ranking:** Grade C. The state confines patient choice.

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*\*Pearson Report 2014 update: state now deserves ranking of “C+.”*

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **6 for NPs<sup>†</sup>** (1013 in state<sup>‡</sup> results in a **1:169 ratio**)
- **4105 for MDs/DOs/Interns/Residents** (7057 in state<sup>‡</sup> results in a **1:2 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **1 for NPs<sup>†</sup>** (1013 in state<sup>‡</sup> results in a **1:1013 ratio**)
- **891 for MDs/DOs/Interns/Residents** (7057 in state<sup>‡</sup> results in a **1:8 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice personal injury actions must begin within 2 years of the date of injury or when the claimant discovered or should have discovered the injury. Expert testimony is required to opine whether the applicable standard of care was utilized. An expert must be qualified in the same field as the defendant. There is no patient compensation fund, no requirement that physicians carry professional liability insurance, and no mandate for binding arbitration. A 2003 act limits noneconomic damages to \$250,000 to \$500,000.

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**Recent state malpractice liability tort reform?** 2009–2013: None. 2008: Requires the Attorney General to notify the Governor and legislature when filing a lawsuit and when entering into settlement negotiations. 2007: Limits appeal bond amounts to \$50 million. 2006: Sets the prejudgment interest rate between 7% and 11%. 2005: Joint and liability reform bars the application of joint and several liability for defendants 30% or less at fault. The bill provides that no statement, affirmation, gesture, or conduct of a healthcare provider who expresses apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence shall be admissible as evidence of an admission of liability. The bill also provides that no healthcare provider is liable for injuries sustained as a result of the ingestion of a prescription drug or use of a medical device that was prescribed or used by a healthcare provider in accordance with instructions approved by the U.S. Food and Drug Administration regarding dosage and administration of the drug. It strengthens the requirements necessary for an employee to prove injury as a result of the employer's "deliberate intentions," which preserves an action where the employee is injured through the deliberate intention of the employer; employers in good standing with the workers' compensation fund are immune from suits by injured workers.

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## THE PEARSON REPORT

**STATE:** WISCONSIN

**NP title(s) used in this state:** APNP (Advanced Practice Nurse Prescriber), APN (Advanced Practice Nurse)

**Number of NPs in state:** 3875 APNPs

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** National certification and educational programs are accepted by the BON for APN recognition and certification by the BON to practice as an APNP; education, training, and experience determine SOP.

**NP title protection?** APNP and APN are protected titles, but “Nurse Practitioner” is not.

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes. A master’s degree in nursing or a related health field is required; however, those nationally certified as an NP, CNM, CRNA, or CNS before 1998 but without an MSN are grandfathered into practice.

**Requirement for APN member on BON?** No.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** Yes.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** APNs with prescriptive authority (i.e., APNPs) are required to have a collaborative agreement; this does not apply to APNs without prescriptive authority.

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No.

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON grants an APNP certificate to issue prescription orders to qualified APNs.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.

**Additional pharmacology hours required for prescribing?** The APN applying for a certificate to issue prescription orders must have completed at least 45 contact hours in clinical pharmacology/therapeutics within the 3 years preceding the application. An average of 8 hours of CE in pharmacology is required per year. Additionally, every APNP must annually submit to the BON proof of malpractice insurance in an amount not less than \$1 million per occurrence and \$3 million for all occurrences in a year.

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**CE requirements for NP practice?** Yes (for APNs with a certificate to issue prescription orders).

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**If so, what are the specifics?** Requirement for 8 contact hours per year through AANA, ACNM, ANCC, NCBPNP, AANP, NCC, and AACN.

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**BON mechanism for others to verify NP license?** Yes. The Department of Safety and Professional Services (DSPS) maintains a listing of all APNPs; the verifier must know the name and license number of the APNP.

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**Current listing of all active NP licenses maintained by BON?** Technically, the APNP is a certificate. APNs may practice without the APNP certificate, but they are not counted. The state is gathering data on all RN license renewals, so this may provide more data about nonprescribers in the future.

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**Current listing of authorized NP prescribers maintained by BON?** Yes. A person can purchase a mailing address from the DSPS; however, if the NP prescriber has indicated to DSPS not to release his or her name and contact information, it is prohibited from doing so.

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**If so, is this a separate list from all active NP licenses?** N/A

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**Recent legislative/regulatory changes affecting NP practice?** No.

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**Legislative/administrative plans for state?** To incorporate the conceptual pieces of the APRN consensus model into the state statute; a draft is with legislative drafters. Note that an APRN would still need the APNP certificate to prescribe.

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**Internet address for Nurse Practice Act:** <http://drl.wisconsin.gov/Default.aspx?Page=582ce3ce-0028-404c-9373-14bfd6cf17c8>

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## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

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**BOM/physician involvement in diagnosing or treating?** No. From the BON: “the core concept in determining scope of practice under the legal parameters governing the licensure and regulation of the nursing profession is the ‘education, training, and experience’ of the nurse; that is the educational preparation and demonstrated abilities of the nurse”; this applies to APNs with and without prescriptive authority.

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**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

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**Required physician record/chart review?** No.

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**Required NP/physician practice agreement?** No.

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**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, is agreement required to be kept/stored/updated?** N/A

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**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

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**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

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**If so, are protocols required to be kept/stored/updated?** N/A

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**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** A 2006 bill statutorily amended about 30 selected statutes, allowing APNPs to order or authorize medically related actions (e.g., many statutes now read “physician or APNP,” whereas previously they only specified “physician”).

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## NP SCOPE OF PRACTICE—PRESCRIBING

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**NP Rx authority granted separate from practice authority?** Yes. An APNP is an APN who has been granted a certificate to independently issue prescription orders. An APN may not independently prescribe unless he or she holds a current APNP certificate granted by the BON.

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**NP/physician prescriptive agreement required?** Yes. A collaborative agreement between an APNP and physician is required for prescribing.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** Yes.

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**If so, what words are used to characterize involvement?** APNP prescribers shall facilitate collaboration with other healthcare professionals, at least one of whom must be a physician, through the use of modern communication techniques.

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**NP authorized to Rx controlled substances?** Yes. (But only APNPs with a collaborative agreement with a physician.)

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**If so, what schedules?** Schedule II–V, with certain limitations on Schedule II prescribing.

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**NP issued Rx number by state?** No. But a separate APNP certificate is issued.

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**NP authorized to apply for DEA number?** Yes (for APNPs).

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**If so, what is DEA area field office info?:** Chicago Division Office, 230 S. Dearborn Street, Suite 1200, Chicago, IL 60604; p: 1-312-353-1236

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No (for APNPs).

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**NP name required on Rx bottle?** Yes (for APNPs).

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** WIS. ADMIN. CODE § N8.09

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**Specified limitations or restrictions on NP drug sampling?** Yes. Prepackaged drug samples may be dispensed by the APNP using prepackaged doses if the nearest pharmacy is more than 30 miles away.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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## NP REIMBURSEMENT REALITIES/LIMITATIONS

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**Legislative language permits NP reimbursement by third party or HMO?** The DSPS and BON do not have any regulations pertaining to PCPs or third-party reimbursement.

**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?** The DSPS and BON do not have any regulations pertaining to PCPs or third-party reimbursement.

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## OTHER FACTORS RELATED TO NP PRACTICE

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**Number and listing of NP schools in state:** (1) Concordia University Wisconsin—Mequon; (2) Marquette University—Milwaukee; (3) University of Wisconsin—Madison; (4) University of Wisconsin—Milwaukee; (5) University of Wisconsin—Eau Claire; (6) University of Wisconsin—Oshkosh; (7) Viterbo University—La Crosse; (8) Marian University—Fond du Lac.

**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** Concordia University; Marquette University; University of Wisconsin—Eau Claire; University of Wisconsin—Madison; University of Wisconsin—Milwaukee; University of Wisconsin—Oshkosh.

*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

**Statewide NP association(s):** The Wisconsin Nurses Association has a Special Interest Group of APNs (<http://www.wisconsinnurses.org/>).

**Organized opposition to NP legislative or regulatory changes?** Not currently.

**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 77

**Descriptive ranking:** Grade C. The state confines patient choice.

*\*Pearson Report 2014 update: state still deserves a ranking of "B-."*

**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **9 for NPs<sup>†</sup>** (3875 in state<sup>‡</sup> results in a **1:431 ratio**)
- **3478 for MDs/DOs/Interns/Residents** (23,499 in state<sup>‡</sup> results in a **1:7 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals)  
(1/1999–3/2013):

- **3 for NPs<sup>†</sup>** (3875 in state<sup>‡</sup> results in a **1:1292 ratio**)
- **835 for MDs/DOs/Interns/Residents** (23,499 in state<sup>‡</sup> results in a **1:28 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), “the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine” (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

**Relevant medical malpractice law applicable to NPs?** Malpractice actions for personal injury or death must be filed within 3 years from the date of injury, and within at least 1 year from date of discovery (up to maximum of 5 years from the date of the negligent act). A claimant’s negligence does not bar recovery as long as his negligence is not greater than that of the alleged defendant. Expert testimony is required unless the standard of care is obvious to common knowledge. Except in death cases, the total limit on noneconomic damages from all healthcare providers is \$350,000 (adjusted annually for inflation). Healthcare providers are required to pay a yearly assessment into the Wisconsin Patients Compensation Fund (the “Fund”), to prove financial responsibility, and to provide an approved plan of self-insurance. The prescribed limits are \$1 million for each occurrence and \$3 million in the annual aggregate. Healthcare providers are held liable only to the limits of their insurance. Mediation panels (the decisions of which are inadmissible in a subsequent court action) assist to voluntarily resolve disputes between healthcare providers and patients or their families.

**Recent state malpractice liability tort reform?** 2012–2013: None. 2011: Limited punitive damages to \$200,000 or two times compensatory damages, whichever is greater. 2010: Chapter Ins 17—Health Care Liability Insurance Patient Compensation Fund includes “nurse practitioner.” Establishes procedures and requirements for a mandatory risk-sharing plan to provide healthcare liability insurance coverage and liability coverage normally incidental to healthcare liability insurance on a self-supporting basis for the persons specified acting within the scope of their employment and providing healthcare services; also intended to encourage improvement in reasonable loss-prevention measures and to encourage the maximum use of the voluntary market. 2007–2009: None. 2006: Legislation restored the noneconomic caps to \$750,000 with no yearly adjustment for cost of living. 2005: The Wisconsin Supreme Court struck down the cap on noneconomic damages.

## THE PEARSON REPORT

**STATE:** **WYOMING**

**NP title(s) used in this state:** APRN (Advanced Practice Registered Nurse)

**Number of NPs in state:** 477

**NP specialties legislatively specified?** No.

**How is NP specialty scope of practice (SOP) defined by national certification, R&R, state legislation, or other?** An APRN must complete an advanced program of study in a specialty area in an accredited nursing program, take and pass a national certification examination in the same area, and be granted recognition by the BON.

**NP title protection?** Yes. Per WYO. STAT. ANN. § 33-21-134, “APRN” is a protected title and “No other person shall assume this title or use this abbreviation or any words, letters, signs, or devices to indicate that the person using same is an advanced practice registered nurse.”

**National certification required for recognition/practice?** Yes.

**BON sole state authority over NPs?** Yes.

**MSN required for practice?** Yes.

**Requirement for APN member on BON?** Yes.

**Joint BON/BOM regulation over any aspect of practice?** No.

**Physician involvement required for any aspect of practice?** No.

**If so, what words are used to describe involvement (e.g., collaboration, supervision, direction, authorization, delegation)?** N/A

**Statutory restriction against NP with doctorate being addressed as “Dr.”?** No. Although under WYO. STAT. ANN. § 33-26-102 (1977), “Practicing medicine” means any person who in any manner: “Attaches the title of M.D., D.O., physician, surgeon, osteopathic physician or osteopathic surgeon, doctor, or any other words, letters or abbreviations, or any combination thereof when used in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless the designation additionally contains the description of another branch of the healing arts for which one holds a valid license.”

**How is NP license issued (separate license from RN, NP number listed on RN license, etc.)?** The BON issues APRN recognition onto the existing license.

**Supervised practice hours required before full NP practice autonomy?** No.

**Supervised practice hours required before full NP prescribing autonomy?** No.



**Additional pharmacology hours required for prescribing?** Yes. In order to obtain initial prescriptive authority, the APRN must be a currently recognized APRN in Wyoming; provide evidence of completion of a minimum of 2 semester credit hours/3 quarter-credit hours/30 contact hours of course work approved by the BON in pharmacology and clinical management of drug therapy or pharmacotherapeutics within the 5-year period before application; and provide evidence of having completed 400 hours of advanced practice nursing in a recognized area of specialty within the 2-year period immediately before application.

**CE requirements for NP practice?** Yes. As required to maintain specialty certification.

**If so, what are the specifics?** To renew prescriptive authority the APRN must maintain current recognition as an APRN, have completed 400 hours of practice as an APRN within the past 2 years, and have documented 12 contact hours of pharmacology and/or pharmacotherapeutics within the past 2 years.

**BON mechanism for others to verify NP license?** Yes.

**Current listing of all active NP licenses maintained by BON?** Yes.

**Current listing of authorized NP prescribers maintained by BON?** Yes.

**If so, is this a separate list from all active NP licenses?** No.

**Recent legislative/regulatory changes affecting NP practice?** No.

**Legislative/administrative plans for state?** To examine new healthcare rules and Centers for Medicare and Medicaid Services (CMS) regulations to add NP recognition to reimbursement rules and hospital admitting policies where applicable.

**Internet address for Nurse Practice Act:** <https://nursing-online.state.wy.us/Default.aspx?page=28>

## NP SCOPE OF PRACTICE—DIAGNOSING AND TREATING

**BOM/physician involvement in diagnosing or treating?** No.

**If so, what words are used to characterize involvement (e.g., collaboration, supervision, direction, delegation, authorization)?** N/A

**Required physician record/chart review?** No.

**Required NP/physician practice agreement?** No.

**If so, is agreement required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, is agreement required to be kept/stored/updated?** N/A

**Required protocols (separate from any required practice and/or prescriptive agreement) for diagnosing or treating?** No.

**If so, are protocols required to be filed with state (BON, BOM, both, or other)?** N/A

**If so, are protocols required to be kept/stored/updated?** N/A

**Any legislative prohibitions against NP hospital privileges?** No.

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**Additional limitations/clarifications/expansions to NP practice?** No.

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**NP SCOPE OF PRACTICE—PRESCRIBING**

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**NP Rx authority granted separate from practice authority?** No.

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**NP/physician prescriptive agreement required?** No.

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**NP Rx from state authorized formulary required?** No.

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**If so, explain specifics of formulary.** N/A

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**BOM/physician involvement in NP prescribing?** No.

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**If so, what words are used to characterize involvement?** N/A

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**NP authorized to Rx controlled substances?** Yes.

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**If so, what schedules?** Schedules II–V

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**NP issued Rx number by state?** No.

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**NP authorized to apply for DEA number?** Yes.

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**If so, what is DEA area field office info?:** Denver Division Office, 115 Inverness Drive, East Englewood, Colorado 80112; p: 1-800-326-6900

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**DEA number required for nonscheduled as well as scheduled Rx?** No.

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**NP name on Rx pad?** Yes.

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**Physician name required on Rx pad?** No.

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**NP name required on Rx bottle?** Yes.

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**Authority to receive/dispense drug samples spelled out?** Yes.

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**If so, where (e.g., statute, rules, opinion)?** In the Nurse Practice Act.

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**Specified limitations or restrictions on NP drug sampling?** No.

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**Restrictions on out-of-state NP Rx being filled in this state?** No.

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**NP REIMBURSEMENT REALITIES/LIMITATIONS**

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**Legislative language permits NP reimbursement by third party or HMO?** Yes.

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**NPs have legal right to be listed on provider panels as Primary Care Providers (PCPs)?**  
There are no prohibitions against this.

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**OTHER FACTORS RELATED TO NP PRACTICE**

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**Number and listing of NP schools in state:** (1) University of Wyoming—Laramie.

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**American Association of Colleges of Nursing (AACN) list\* of Doctor of Nursing Practice (DNP) program(s) in the state:** University of Wyoming.

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*\*Programs (as of October 2013) that award a nursing doctorate, not necessarily including NP preparation/education.*

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**Statewide NP association(s):** Wyoming Nurses Association (<http://www.wyonurse.org/>); Wyoming Council for Advanced Practice Nurses ([www.WCAPN.org](http://www.WCAPN.org)).

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**Organized opposition to NP legislative or regulatory changes?** Not at present.

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**2007 consumer choice ranking of state's NP regulation (100 is ideal):** 97

**Descriptive ranking:** Grade A. The state is exemplary for patient choice.

**\*Pearson Report 2014 update: state still deserves a ranking of "A."**

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**Cumulative number of National Practitioner Data Bank (NPDB) filings:**

Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013):

- **7 for NPs<sup>†</sup>** (477 in state<sup>‡</sup> results in a **1:68 ratio**)
- **742 for MDs/DOs/Interns/Residents** (2960 in state<sup>‡</sup> results in a **1:4 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Cumulative number of Healthcare Integrity and Protection Data Bank (HIPDB) filings:**

Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013):

- **0 for NPs<sup>†</sup>** (477 in state<sup>‡</sup> results in a **0 ratio**)
- **179 for MDs/DOs/Interns/Residents** (2960 in state<sup>‡</sup> results in a **1:17 ratio**)

<sup>†</sup> NP total includes column count for NP, Advanced Nurse Practitioner, and DNP.

<sup>‡</sup> Provider number calculations based upon: (1) Number of NPs reported from BON (as of May 2013); (2) Number of Allopathic Physicians (MDs), MD Intern/Residents, Osteopathic Physicians (DOs), and DO Intern/Residents (for each state as of December 2012) having an active license recorded by the Federation of State Medical Boards (FSMB), "the only national database that contains the most current information about which jurisdictions have granted physicians a license, or renewal of license, to practice medicine" (p. 12).

Source: Federation of State Medical Boards (FSMB). (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99, (2), 11–24.

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**Relevant medical malpractice law applicable to NPs?** Malpractice actions must be brought within 2 years of discovery of the alleged negligence. Claimant negligence bars recovery if the claimant is responsible for more than 50% of the total fault (i.e., the doctrine of modified comparative negligence). No law may limit the amount of damages for causing injury or death.

A medical liability compensation fund provides physicians with excess insurance coverage. To qualify, physicians must obtain malpractice insurance of at least \$50,000 per claim and must pay a surcharge levied by the state. A qualified physician's liability is limited to \$50,000 per claim or to the extent of his insurance limits. Judgments in excess of \$50,000 against a qualified physician are paid by the fund up to \$1 million per year per physician. Mandatory arbitration of medical malpractice claims by a medical review panel is considered unconstitutional.

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**Recent state malpractice liability tort reform?** 2008–2013: None. 2007: Limits the amount a defendant (for small businesses of fewer than 50 employees) to secure the right to appeal to \$2 million. 2006: None. 2005: Exempts from civil liability manufacturers, sellers, etc. of food for liability based on weight gain, obesity, or a health condition. 2003: An act provides immunity from liability for volunteer healthcare professionals at nonprofit healthcare facilities.

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## 2014 Pearson Report Summary

	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
ALABAMA	<b>F</b>	No restrictions if clarify CRNP	CRNP	Written protocol—delegation, oversight, direction	Written protocol—delegation, oversight, direction; drugs within BOME formulary	9	May refer patients for PT; may Rx Schedules III–V with physician direction under BOME
ALASKA	<b>A</b>	No restrictions	ANP	<b>NONE</b>	<b>NONE</b>	1	No statute or regulatory role expansion
ARIZONA	<b>A</b>	No restrictions if clarify NP	RNP	<b>NONE</b>	<b>NONE</b>	5	No statute or regulatory role expansion
ARKANSAS	<b>C–</b>	<b>MPA Restrictions</b>	APRN, CNP, RNP	APRN— <b>NONE</b> ; RNP—protocols and MD supervision	APRN—CPA and protocols RNP may not Rx	4	New BON rules: title change; addition of another APRN to the Prescriptive Authority Committee; addition re Rx for anorexia
CALIFORNIA	<b>C</b>	No restrictions if clarify NP	APRN, NP	SP developed collaboratively and signed	SP and protocol for Schedules II–III	22	No statute or regulatory role expansion

COLORADO	<b>A–</b>	No restrictions	APN, NP	<b>NONE</b>	<b>NONE</b> (after one-time signed articulated plan)	5	No statute or regulatory role expansion
CONNECTICUT	<b>B</b>	<b>State statute restriction</b>	APRN, NP	Required collaboration	Required written collaboration	8	Global signature
DC	<b>A</b>	No restrictions	APRN, CNP, CRNP, NP	<b>NONE</b>	<b>NONE</b>	4	No statute or regulatory role expansion
DELAWARE	<b>C</b>	No restrictions	APN, NP, CRNP	Written CA	Approval by BOM	2	All prescribers/providers: tighter regulation controlled substances and prescription monitoring program; minors' treatment and exam chaperone requirements
FLORIDA	<b>F</b>	No restrictions if clarify NP	ARNP	Written protocol—supervision	Written protocol—supervision	16	ARNPs may authorize PTs
GEORGIA	<b>F</b>	No restrictions if clarify NP—but in dispute	APRN, NP	Delegation via protocol	Under delegated medical authority Schedules III–V	13	APRN now on BON; mandatory CE requirements; "Pill Mill Bill" applies to all prescribers but gives more power to BOM

	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
HAWAII	A-	No restrictions	APRN, NP	NONE	NONE	3	APRN with prescriptive authority may provide expedited partner therapy to partners of the patient under certain conditions
IDAHO	B+	No restrictions	APRN, CNP	NONE	NONE	2	NPA complies with APRN consensus plan in titling and education
ILLINOIS	D+	No restrictions if clarify NP	APN, CNP	Written CA	Delegation—CA	15	New bill—APRN's CA means categories of care or treatment (not specific tasks/duties) and may <u>not</u> restrict categories of patients within their SOP; limit third-party payers; or limit the geographic practice location



INDIANA	<b>D</b>	No restrictions	APN, NP	Required collaboration in WPA	Required collaboration in WPA	13	NPs can make referrals to PTs and certify someone as eligible for a disability license plate
IOWA	<b>B+</b>	No restrictions	ARNP, CNP, NP	ARNP— <b>NONE</b> per BON	ARNP— <b>NONE</b> per BON	6	The Iowa Supreme Court declared BON decides what procedures/activities are within NP SOP; APRNs may supervise radiologic technicians; order resp and ortho services; sign / order new mental health treatments/services
KANSAS	<b>C</b>	No restrictions	APRN	Physician-signed collaborative practice agreement	Physician-signed written protocol	5	APRNs are now issued a "license" by the BON
KENTUCKY	<b>B</b>	No restrictions if clarify NP	APRN, NP	<b>NONE</b>	Written CPA	10	"Pill Mill Bill" passed affecting all prescribers of Schedule I and II, including APRNs
LOUISIANA	<b>D</b>	No restrictions	APRN, NP	Written CPG within CPA	CPA—"direction" in CPG	8	No statute or regulatory role expansion

	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
MAINE	<b>A-</b>	State statute restrictions	APRN, CNP	NONE —after initial 2 years	NONE—after initial 2 years	3	No statute or regulatory role expansion
MARYLAND	<b>B+</b>	No restrictions if clarify NP	CRNP, NP	NONE—except BON attestation plan promising collaboration	NONE—except BON attestation plan promising collaboration	6	No statute or regulatory role expansion
MASSACHUSETTS	<b>C+</b>	No restrictions	CNP	NONE	Direction and supervision within collaboratively developed WG	11	Global signature legislation—can sign any document requiring physician signature. Rules for APRN-Rx and physician: collaborative process, can determine frequency of review and no site specification
MICHIGAN	<b>F</b>	State statute restrictions	NP	NP functions under Public Health Code definition of Nursing; to "diagnose" is delegated by medicine	Delegation and supervision; controlled substances by delegation of PAG	10	No statute or regulatory role expansion

MINNESOTA	<b>C</b>	No restrictions if clarify NP	APRN, CNP	"Collaborative Management"	Delegated via written agreement	6	No statute or regulatory role expansion
MISSISSIPPI	<b>C-</b>	No restrictions if clarify NP	APRN	Required collaboration with written protocol/ practice guidelines	Required collaboration with written protocol/ practice guidelines	5	No statute or regulatory role expansion
MISSOURI	<b>F+</b>	No restrictions	APRN, NP	Delegation or WCPA	Delegation through WCPA	13	New law waives physician proximity to 28 days per year for rural APRN; telehealth allowed in certain circumstances
MONTANA	<b>A</b>	No restrictions	APRN, CNP	<b>NONE</b>	<b>NONE</b>	1	No statute or regulatory role expansion
NEBRASKA	<b>C-</b>	No restrictions	APRN-NP	Collaboration, supervision per IPA; also written protocols if practiced less than 2000 hours	If physician wants to limit Rx Schedule II then must be written in IPA	3	NPs may order respiratory services, sign death certificates, and "acute" is added to provisions governing practice stipulations
NEVADA	<b>A</b>	No restrictions	APRN	<b>NONE</b>	<b>NONE</b> — Collaboration and signed protocols needed <b>ONLY</b> if practice hours not met <b>AND</b> Schedule II Rx included in SOP	2	New law changed: certificate to a license, APRN title, and deleted requirement for a collaborative agreement with a physician

	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
NEW HAMPSHIRE	<b>A+</b>	No restrictions	APRN	NONE	NONE	3	No statute or regulatory role expansion
NEW JERSEY	<b>B</b>	No restrictions	APN	NONE	Collaboration via joint protocol	10	APNs another provider defined for: physician orders for life-sustaining treatment forms; Medicaid; disabled person placards; school physicals; care for developmentally disabled; adoption care.
NEW MEXICO	<b>A</b>	No restrictions	CNP, NP	NONE	NONE	3	CNPs may continue to perform ultrasound procedures except "diagnostic ultrasound"; BON requires registration with PMP and Rx monitored for appropriate pain treatment

NEW YORK	<b>B</b>	No restrictions if clarify NP	NP	Collaboration with WPA and WPP	Collaboration with WPA and WPP	28	Allows NPs to issue non-patient-specific orders for pharmacists to administer meningococcal disease immunizing agents.
NORTH CAROLINA	<b>F</b>	No restrictions	NP	Supervision and collaboration within CPA	Supervision and collaboration: CPA	9	NP refresher course requirements; new Rx act limits any Rx of controlled substances for family or friends
NORTH DAKOTA	<b>A</b>	No restrictions	APRN, NP	<b>NONE</b>	<b>NONE</b>	3	Now require 1 APRN on BON
OHIO	<b>C</b>	MPA "restrictions"; NPs are using "Dr." with specialty clarification	CNP, APRN	Collaboration with written SCA	Collaboration with written SCA	16	APRN expanded Schedule II Rx authority for 14 sites; may declare death in certain situations; new APRN title and SOP now includes "acute illnesses"
OKLAHOMA	<b>C+</b>	No restrictions if clarify NP	APRN, CNP	<b>NONE</b>	Supervision via exclusionary formulary	2	NPA: BON allows "endorsement" of APRNs with Rx authority in other states who meet identified criteria

	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
OREGON	A+	No restrictions if clarify NP	NP	NONE	NONE	2	New laws: remove certain restrictions on NP authority to dispense Rx drugs; extend to 180 days the timeframe to authorize medical services and temporary disability benefits
PENNSYLVANIA	C	No restrictions if clarify NP	CRNP	Physician-signed CA	Collaboration via physician-signed written CAPA	23	CRNPs have authority to sign death certificates
RHODE ISLAND	A	No restrictions	CNP	NONE	NONE	2	New APRN law includes global signature authority for CNPs; CNPs may Rx Schedule I
SOUTH CAROLINA	F	No restrictions if clarify NP	APRN, NP	Supervision via AWP	Supervision and delegation via AWP	4	No statute or regulatory role expansion
SOUTH DAKOTA	D	No restrictions if clarify NP	CNP	Collaboration via approved CA	Collaboration via approved CA	2	No statute or regulatory role expansion

TENNESSEE	<b>C+</b>	No restrictions	APN	<b>NONE</b>	Supervision via protocol, formulary	16	No statute or regulatory role expansion
TEXAS	<b>D+</b>	No restrictions if clarify NP	NP (plus specialty), APRN	Delegation and written authorization on prescriptive authority agreements	Delegation and written authorization on prescriptive authority agreements	22	Removal of most site-based restrictions on a physician's ability to delegate prescriptive authority; specific site expansion of Rx authority to include Schedule II; Medicaid must include APRNs as PCPs
UTAH	<b>B</b>	No restrictions if clarify NP	APRN, RNP, NP	<b>NONE</b>	<b>NONE</b> (Except consultation for Schedules II–III only)	3	New law renames NPs and APRNs for workers comp billing (no more using term “physician extenders”); new law requires controlled substances prescribers to complete 4 hours of CE
VERMONT	<b>A–</b>	<b>Statutory restrictions</b>	APRN	<b>NONE</b>	<b>NONE</b>	1	No statute or regulatory role expansion



	2014 Rank for Patient Access	Doctorate NP Legally Addressed as "Dr"?	NP Title(s) Used	Physician Involvement in NP Diagnosing and Treating*	Physician Involvement in NP Prescribing	Number of NP Programs	2014 NP Role Expansion
VIRGINIA	C-	No restrictions if clarify NP	LNP, NP	Collaboration and consultation within a patient care team and WPA under CJBNM	Collaboration and consultation within a patient care team and WPA under CJBNM	9	Defines NPs as APRNs; removed reference to physician supervision and protocols; regulations loosened regarding office site, physician-to-NP ratio, and telemedicine
WASHINGTON	A+	No restrictions	ARNP	NONE	NONE	6	Removed out-of-state pharmacy restrictions for controlled substances from NPs in all other states
WEST VIRGINIA	C+	No restrictions	APRN, CNP	NONE	Collaboration: CA with WP or WG	4	APRNs were defined in law; CNP requirement for accessing CSMPD; drug Rx specifics expanded; BOM changed limiting and insulting "policy" to "recommendations" for collaborating physicians.

WISCONSIN	<b>B-</b>	No restrictions	APNP; APN	APN— <u><b>NONE</b></u> per BON	Must be APNP to prescribe: collaboration with CA	8	No statute or regulatory role expansion
WYOMING	<b>A</b>	No restrictions if clarify NP	APRN	<b>NONE</b>	<b>NONE</b>	1	No statute or regulatory role expansion

**TABLE KEY:**

\* For Pearson Report, “treating” does not include prescribing.

ANP	–	Advanced Nurse Practitioner	CPG	–	Clinical Practice Guideline
APN	–	Advanced Practice Nurse	CRNP	–	Certified Registered Nurse Practitioner
APNP	–	Advanced Practice Nurse Prescriber	IPA	–	Integrated Practice Agreement
APRN	–	Advanced Practice Registered Nurse	LNP	–	Licensed Nurse Practitioner
ARNP	–	Advanced Registered Nurse Practitioner	MPA	–	Medical Practice Act
AWP	–	Approved Written Protocols	NP	–	Nurse Practitioner
BOM	–	Board of Medicine	PAG	–	Prescriptive Authority Agreement
BOME	–	Board of Medical Examiners	PMP	–	Prescription Monitoring Program
BON	–	Board of Nursing	RNP	–	Registered Nurse Practitioner
CA	–	Collaborative Agreement	SCA	–	Standard Care Arrangement
CAPA	–	Collaborative Agreement for Prescriptive Authority	SP	–	Standardized Procedure
CJBNM	–	Committee of the Joint Boards of Nursing and Medicine	WCPA	–	Written Collaborative Practice Arrangement
CNP	–	Certified Nurse Practitioner	WG	–	Written Guideline
CPA	–	Collaborative Practice Agreement	WP	–	Written Protocol
			WPA	–	Written Practice Agreement
			WPP	–	Written Practice Protocol

**2014 Pearson Report Total Number of NPs in United States = 202,615**

ALABAMA	2267	MONTANA	609
ALASKA	765	NEBRASKA	1141
ARIZONA	4218	NEVADA	880
ARKANSAS	2897	NEW HAMPSHIRE	1675
CALIFORNIA	17,929	NEW JERSEY	6800
COLORADO	3492	NEW MEXICO	1341
CONNECTICUT	3841	NEW YORK	16,390
DC	1161	NORTH CAROLINA	4634
DELAWARE	831	NORTH DAKOTA	540
FLORIDA	12,910	OHIO	6671
GEORGIA	5729	OKLAHOMA	1389
HAWAII	807	OREGON	2761
IDAHO	841	PENNSYLVANIA	8397
ILLINOIS	5288	RHODE ISLAND	784
INDIANA	3989	SOUTH CAROLINA	4152
IOWA	1601	SOUTH DAKOTA	564
KANSAS	2577	TENNESSEE	7039
KENTUCKY	3465	TEXAS	11,025
LOUISIANA	2361	UTAH	1445
MAINE	1194	VERMONT	545
MARYLAND	3954	VIRGINIA	7244
MASSACHUSETTS	7367	WASHINGTON	4212
MICHIGAN	4700	WEST VIRGINIA	1013
MINNESOTA	3450	WISCONSIN	3875
MISSISSIPPI	2455	WYOMING	477
MISSOURI	6923	Total	202,615

## 2014 Pearson Report Summary

# Best and Worst States for NPs and Physicians (DO and MD) for National Practitioner Data Bank (NPDB) Filings\* and Healthcare Integrity and Protection Data Bank (HIPDB) Filings†

\* *National Practitioner Data Bank (NPDB) filings:* Medical malpractice reports; licensure, clinical privileges, professional society membership, and peer review reports; and Medicare/Medicaid exclusion reports (9/1/1990–3/30/2013)

† *Healthcare Integrity and Protection Data Bank (HIPDB) filings:* Adverse action reports (negative licensure actions/findings) and civil judgments or criminal convictions (individuals) (1/1999–3/2013)

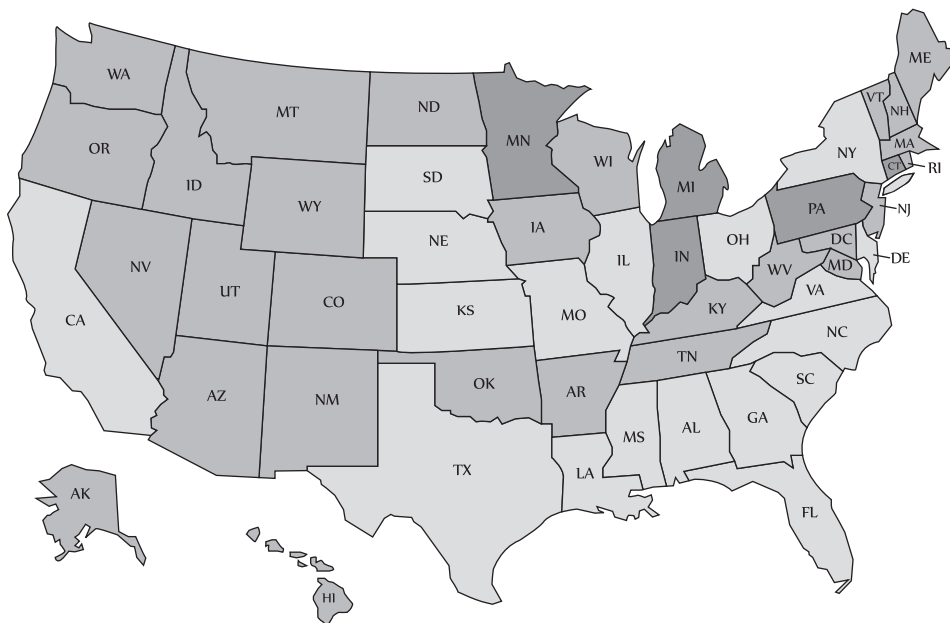
Best and Worst States	NP State NPDB Ratio: BEST State(s) and WORST State(s)	DO/MD State NPDB Ratio: BEST State(s) and WORST State(s)	NP State HIPDB Ratio: BEST State(s) and WORST State(s)	DO/MD State HIPDB Ratio: BEST State(s) and WORST State(s)
	<b>Best:</b> Vermont 1:545	<b>Best:</b> Hawaii 1:8	<b>Best: NO REPORTS</b> Delaware DC Maryland Massachusetts Missouri Montana Wyoming	<b>Best:</b> Hawaii 1:30
	<b>Worst:</b> Oklahoma 1:10	<b>Worst:</b> Florida 1:2 Kansas 1:2 Louisiana 1:2 Michigan 1:2 New Jersey 1:2 New York 1:2 Ohio 1:2 Pennsylvania 1:2 West Virginia 1:2	<b>Worst:</b> Alabama 1:11 Oklahoma 1:11	<b>Worst:</b> Ohio 1:8

	<b>NP State Ratio – NPDB Filings (1990–2013): per number of NPs</b>	<b>DO and MD State Ratio – NPDB Filings (1990–2013): per number of DO/MDs</b>	<b>NP State Ratio – HIPDB Filings (1990–2013): per number of NPs</b>	<b>DO and MD State Ratio – HIPDB Filings (1990–2013): per number of DO/MDs</b>
Alabama	1:11	1:5	1:11	1:13
Alaska	1:26	1:4	1:32	1:10
Arizona	1:59	1:3	1:422	1:9
Arkansas	1:121	1:4	1:241	1:21
California	1:152	1:3	1:1120	1:14
Colorado	1:90	1:3	1:3492	1:9
Connecticut	1:75	1:4	1:91	1:22
DC	1: 232	1:6	0	1:29
Delaware	1:139	1:5	0	1:23
Florida	1:44	1:2	1:248	1:17
Georgia	1:179	1:4	1:521	1:16
Hawaii	1:161	1:8	1:269	1:30
Idaho	1:47	1:5	1:84	1:21
Illinois	1:139	1:3	1:407	1:12
Indiana	1:210	1:4	1:665	1:34
Iowa	1:160	1:3	1:1601	1:11
Kansas	1:136	1:2	1:644	1:17
Kentucky	1:85	1:3	1:151	1:10
Louisiana	1:34	1:2	1:79	1:14
Maine	1:80	1:4	1:199	1:12
Maryland	1:113	1:4	0	1:15
Mass	1:74	1:4	0	1:18
Michigan	1:112	1:2	1:224	1:17
Minnesota	1:265	1:6	1:3450	1:25
Mississippi	1:56	1:3	1:164	1:15
Missouri	1:277	1:3	0	1:15
Montana	1:61	1:3	0	1:19
Nebraska	1:190	1:4	1:380	1:26

	<b>NP State Ratio – NPDB Filings (1990–2013): per number of NPs</b>	<b>DO and MD State Ratio – NPDB Filings (1990–2013): per number of DO/MDs</b>	<b>NP State Ratio – HIPDB Filings (1990–2013): per number of NPs</b>	<b>DO and MD State Ratio – HIPDB Filings (1990–2013): per number of DO/MDs</b>
Nevada	1:68	1:3	1:176	1:15
New Hampshire	1:120	1:4	1:838	1:17
New Jersey	1:136	1:2	1:3400	1:14
New Mexico	1:48	1:3	1:447	1:15
New York	1:100	1:2	1:278	1:12
North Carolina	1:65	1:5	1:116	1:19
North Dakota	1:108	1:4	1:540	1:13
Ohio	1:351	1:2	1:667	1:8
Oklahoma	1:10	1:3	1:11	1:12
Oregon	1:36	1:4	1:75	1:13
Pennsylvania	1:88	1:2	1:171	1:14
Rhode Island	1:60	1:3	1:196	1:13
South Carolina	1:119	1:4	1:244	1:18
South Dakota	1:43	1:5	1:71	1:23
Tennessee	1:49	1:4	1:67	1:15
Texas	1:109	1:3	1:1225	1:16
Utah	1:43	1:3	1:72	1:15
Vermont	1:545	1:4	1:182	1:14
Virginia	1:66	1:4	1:85	1:11
Washington	1:25	1:4	1:33	1:14
West Virginia	1:169	1:2	1:1013	1:8
Wisconsin	1:431	1:7	1:1292	1:28
Wyoming	1:68	1:4	0	1:17



## 2014 Pearson Report: MAP 1 OVERVIEW of *DIAGNOSING AND TREATING*(1) ASPECTS of NURSE PRACTITIONER PRACTICE



### NO REQUIREMENT FOR ANY PHYSICIAN INVOLVEMENT (28 states)

ALASKA  
ARIZONA  
ARKANSAS (2)  
COLORADO  
DISTRICT OF COLUMBIA  
HAWAII  
IDAHO  
IOWA (3)  
KENTUCKY  
MAINE (4)  
MARYLAND (5)  
MASSACHUSETTS  
MONTANA  
NEVADA  
NEW HAMPSHIRE  
NEW JERSEY  
NEW MEXICO  
NORTH DAKOTA  
OKLAHOMA  
OREGON  
RHODE ISLAND  
TENNESSEE  
UTAH  
VERMONT  
WASHINGTON  
WEST VIRGINIA  
WISCONSIN (6)  
WYOMING

### REQUIREMENT FOR PHYSICIAN INVOLVEMENT\* BUT NO REQUIREMENT FOR WRITTEN DOCUMENTATION OF RELATIONSHIP (5 states)

CONNECTICUT  
INDIANA  
MICHIGAN (1)  
MINNESOTA  
PENNSYLVANIA

(1) NP functions under Public Health  
Code definition of nursing

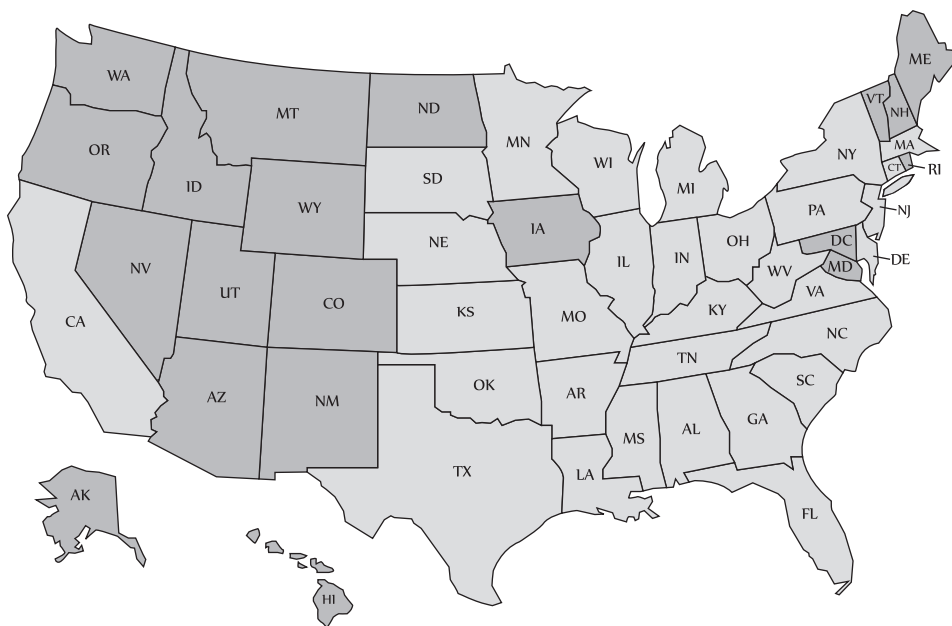
### REQUIREMENT FOR WRITTEN DOCUMENTATION OF PHYSICIAN INVOLVEMENT\* (18 states)

ALABAMA  
CALIFORNIA  
DELAWARE  
FLORIDA  
GEORGIA  
ILLINOIS  
KANSAS  
LOUISIANA  
MISSISSIPPI  
MISSOURI  
NEBRASKA  
NEW YORK  
NORTH CAROLINA  
OHIO  
SOUTH CAROLINA  
SOUTH DAKOTA  
TEXAS  
VIRGINIA

- (1) for Pearson Report, "TREATING" does NOT include prescribing
- (2) APRNs only; RNPs require physician involvement
- (3) for ARNPs per BON
- (4) after 1<sup>st</sup> 2 years of practice
- (5) after signing BON Attestation Plan promising collaboration
- (6) for APNs per BON

\* The REQUIREMENT for a physician's relationship with an NP may vary from collaboration to supervision, authorization, delegation, and/or direction.

## 2014 Pearson Report: MAP 2 OVERVIEW OF *PRESCRIBING* ASPECT OF NURSE PRACTITIONER PRACTICE



### NO REQUIREMENT FOR ANY PHYSICIAN INVOLVEMENT (20 states)

ALASKA  
ARIZONA  
COLORADO (1)  
DISTRICT OF COLUMBIA  
HAWAII  
IDAHO  
IOWA (2)  
MAINE(3)  
MARYLAND (4)  
MONTANA  
NEVADA (5)  
NEW HAMPSHIRE  
NEW MEXICO  
NORTH DAKOTA  
OREGON  
RHODE ISLAND  
UTAH (6)  
VERMONT  
WASHINGTON  
WYOMING

### REQUIREMENT FOR WRITTEN DOCUMENTATION OF PHYSICIAN INVOLVEMENT\* (31 states)

ALABAMA  
ARKANSAS  
CALIFORNIA  
CONNECTICUT  
DELAWARE  
FLORIDA  
GEORGIA  
ILLINOIS  
INDIANA  
KANSAS  
KENTUCKY  
LOUISIANA  
MASSACHUSETTS  
MICHIGAN  
MINNESOTA  
MISSISSIPPI  
MISSOURI  
NEBRASKA  
NEW JERSEY  
NEW YORK  
NORTH CAROLINA  
OHIO  
OKLAHOMA  
PENNSYLVANIA  
SOUTH CAROLINA  
SOUTH DAKOTA  
TENNESSEE  
TEXAS  
VIRGINIA  
WEST VIRGINIA  
WISCONSIN

- (1) after one-time signed Articulated Plan
- (2) for ARNPs per BON
- (3) after initial 2 years of practice
- (4) after signing BON Attestation Plan promising collaboration
- (5) required collaboration/protocols only if Rx CS II for 1<sup>st</sup> 2 yrs
- (6) required consultation for CS II-III only

\* The REQUIREMENT for a physician's relationship with an NP may vary from collaboration to supervision, authorization, delegation, and/or direction.