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ADVANCED PRACTICE REGISTERED NURSES

AUDIT OVERVIEW

The Legislative Auditor Recommends Revising the Written Collaborative Agreement Requirement for Advanced Practice Registered Nurses and Allowing Removal When Certain Conditions Are Met

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WEST VIRGINIA LEGISLATIVE AUDITOR
PERFORMANCE EVALUATION & RESEARCH DIVISION

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FINDING 1

The Legislative Auditor Recommends Revising the Written Collaborative Agreement Requirement for Advanced Practice Registered Nurses and Allowing Removal When Certain Conditions Are Met.

Summary

In accordance with West Virginia Code §30-1A-1 et seq., an application was submitted seeking an expanded scope of practice for Advanced Practice Registered Nurses. The Applicant argues that by virtue of education, training, national certification and regulation by state licensure APRNs are prepared to practice as autonomous professionals, and that restrictions to their practice exist in West Virginia Code. Currently APRNs can diagnose and treat patients but must have a written collaborative agreement with a physician in order to prescribe medication from a limited drug formulary. In addition, certified nurse midwives must establish a collaborative relationship with a physician practicing in obstetrical and gynecological patient care.

In Finding 1, the Legislative Auditor considered the request to remove the written collaborative agreement. **The Legislative Auditor's review does not find any apparent public safety issues with the prescribing and clinical practice of experienced APRNs, although the literature review does not include research created by independent sources focused on the quality of APRNs in autonomous practice.** However, there are oversight issues with the written collaborative agreement that need to be addressed legislatively. The Legislative Auditor is concerned about the impact of the collaborative agreement requirement on access to crucial primary and preventive health care for rural West Virginians. While the lack of standardization and absence of any official review process reinforces the Applicant's argument that the collaborative agreement is unnecessary, the Legislative Auditor finds that some degree of clinical supervision and collaboration is appropriate for inexperienced APRNs. In addressing the Applicant's request to eliminate the written collaborative agreement requirement as a prerequisite to the APRN obtaining limited prescriptive authority, the Legislative Auditor finds that the written collaborative agreement requirement for advanced practice registered nurses should be revised in code and rule, and may be removed when certain conditions are met.

The Legislative Auditor's review does not find any apparent public safety issues with the prescribing and clinical practice of experienced APRNs, although the literature review does not include research created by independent sources focused on the quality of APRNs in autonomous practice.

Required Analysis

The West Virginia Nurses Association (Applicant) submitted an application on May 31, 2013 in accordance with West Virginia Code §30-1A-1 et seq. seeking an expansion of the professional scope of practice

of Advanced Practice Registered Nurses (APRNs) in West Virginia requesting the following changes to West Virginia Code:

- removal of the requirement of a written collaborative agreement between a physician and APRN as a prerequisite to prescriptive authority;
- removal of the required collaborative relationship between nurse midwives and physicians;
- removal of all restrictions to prescribing medications, both controlled and legend drugs; and
- addition of the same signature authority as physicians on all health care documents.

APRNs are licensed and regulated in West Virginia by the Board of Examiners for Registered Professional Nurses (Nursing Board). Currently APRNs are allowed to diagnose and treat patients without physician involvement but must have a written collaborative agreement with an allopathic (MD) or osteopathic (DO) physician before receiving authority from the Nursing Board to prescribe medications from a restricted formulary set in West Virginia code.

For applications proposing an expansion of the scope of practice, West Virginia Code §30-1A-3 requires the Legislative Auditor's Office to evaluate the application and make a clear recommendation as to whether the scope of practice should be expanded as proposed. Six months was available to evaluate the application. Upon review, the Legislative Auditor requested an extension of an additional month from the Joint Standing Committee on Government Organization. Even with the extension, it is the opinion of the Legislative Auditor that the short time frame has impacted the quality of advice and the recommendations in Finding 1 that are required for the Legislature.

Background

An APRN in West Virginia is a licensed registered nurse who has acquired advanced clinical knowledge and skills, completed a Nursing Board approved graduate-level education program and passed a Nursing Board approved national certification examination. APRNs are trained in one of four roles: Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Certified Nurse Practitioner and Clinical Nurse Specialist. APRNs have limited prescribing authority. APRNs are considered mid-level medical practitioners as are Physician Assistants (PA). However, APRNs are trained and licensed to function autonomously, while PAs are trained and licensed to function under the supervision and control of an employing physician. APRNs usually provide primary health care services, although some specialize. Nationally, 87.2 percent of APRNs are

trained in primary care, and 75.6 percent practice in at least one primary care site. As of November 2013 there are 171,000 APRNs nationally, with 2,149 APRNs licensed in West Virginia. Of the West Virginia APRNs, 956 presently have collaborative agreements with physicians and have received limited prescriptive authority from the Nursing Board. There are currently about 21 APRNs practicing as self-employed independent primary care practitioners in West Virginia.

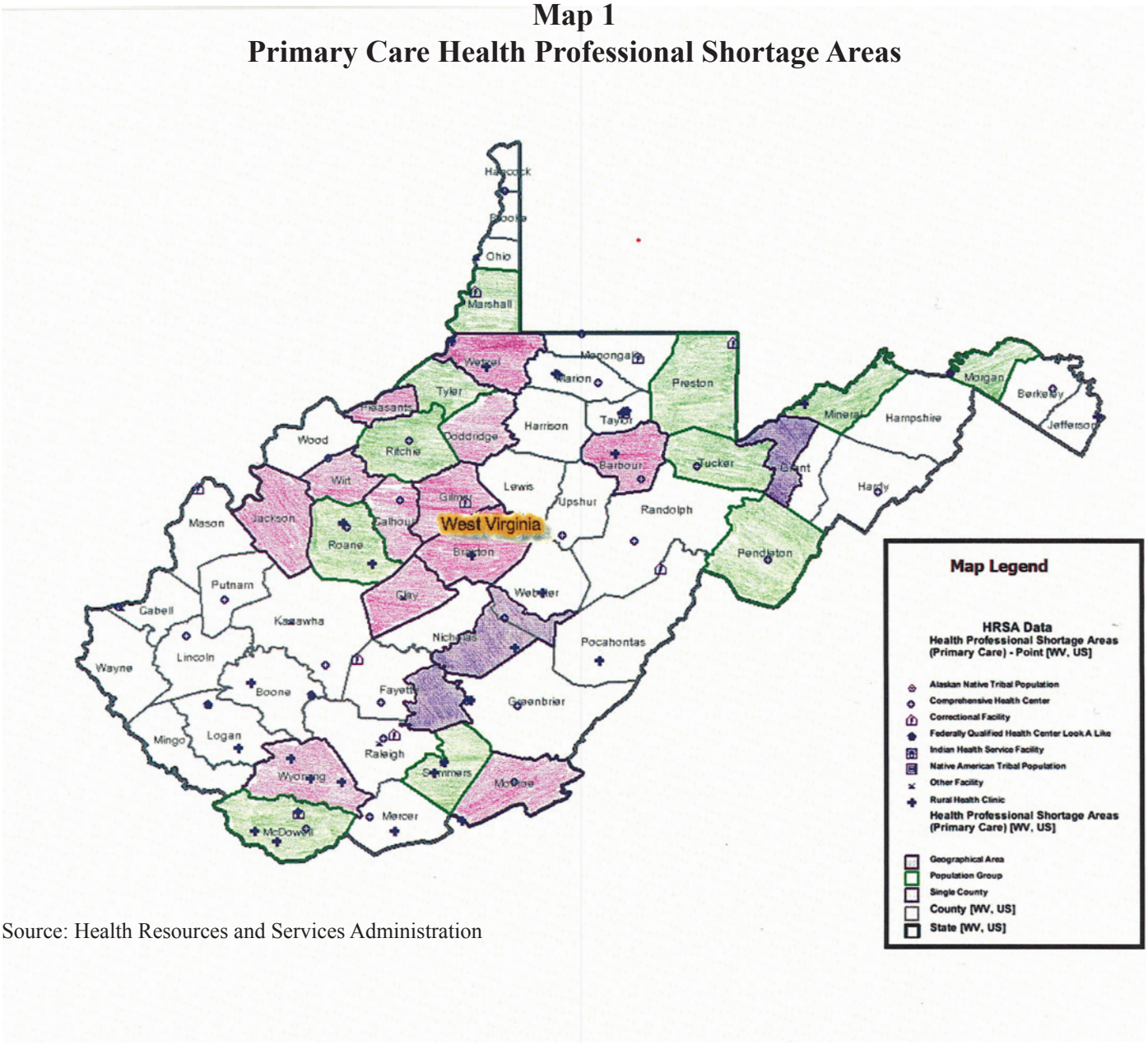
The request to expand the West Virginia APRN scope of practice comes at a time when states are anticipating a greater demand for primary health care services. The federal Health Resources and Services Administration (HRSA) projects that the demand for primary care services will increase through 2020 and demand for primary care physicians will grow more rapidly than the physician supply, resulting in a projected national shortage of approximately 20,400 primary care physicians. Consequently, states are looking for ways to increase the number of primary care providers in rural areas, and exploring whether to allow mid-level medical practitioners to furnish more services to patients.

Of the West Virginia APRNs, 956 presently have collaborative agreements with physicians and have received limited prescriptive authority from the Nursing Board.

West Virginia has estimated that 137,000 patients will be added to Medicaid coverage by 2016 due to the Medicaid expansion for the Patient Protection and Affordable Care Act (ACA). However, by December 2013 the State had received Medicaid enrollments for 82,981 consumers which is substantially higher than the original projections for 2014. West Virginia is considered the third most rural state in the nation,[1] and 50 of its 55 counties are designated, in part or full, as either Health Professional Shortage Areas (HPSA) for primary healthcare, or Medically Underserved Areas by the United States Department of Health and Human Services. There are 48 counties that have facilities, population groups or the entire county meeting the HPSA designation. See Map 1 for a view of these counties. The seven counties with no HPSAs are: Brooke, Hampshire, Harrison, Lewis, Mingo, Wayne and Wood.

[1] *This designation is based on the percentage of residents living in non-metropolitan areas with populations less than 2,500 people.*

Map 1
Primary Care Health Professional Shortage Areas



Source: Health Resources and Services Administration

West Virginia also ranked 46th out of the 50 states in overall health status in 2013, indicating a prevalence of preventable chronic conditions which require treatment and monitoring.

The Public Policy Debate on APRN Scope of Practice

The Legislative Auditor conducted an extensive literature review in its examination of the policy issues posed by the Nursing Board's application. Although numerous position papers and articles exist, the Legislative Auditor based the following summary on reputable and

established organizations. In all the literature reviewed, the vast majority of organizations support an expanded scope of practice APRNs, with the important and notable exception of the American Medical Association (AMA) and the American Osteopathic Association (AOA).

In 2010 a 586 page report titled *The Future of Nursing: Leading Change, Advancing Health* (*Future of Nursing*) was released by the Institute of Medicine (IOM).[2] This report examined the critical role that nurses, the largest segment of healthcare professionals, will play in responding to demands on the healthcare system that are expected to result from the passage of the ACA, and also from other forces such as the aging population of the United States. The *Future of Nursing* addresses the role that states and the federal government can play in reform. In addressing state reform, this report identified APRNs and noted that in many states, state laws prevent APRNs from practicing to the full extent of their education and training. The report notes that what APRNs are allowed to do after graduation varies widely across the country for reasons that are not related to their ability, education or training, but rather the political decisions of the state in which they work. Further, the states with broader nursing scopes of practice have experienced no deterioration of patient care. **The report concludes that all nurses should be playing a larger role in the health care system, both in delivering care and in decision-making about care.**

In all the literature reviewed,The vast majority of organizations support an expanded scope of practice APRNs, with the important and notable exception of the American Medical Association (AMA) and the American Osteopathic Association (AOA).

In addition, in 2008 the National Council of State Boards of Nursing's APRN Advisory Committee and the APRN Consensus Work Group issued the APRN Consensus Model in an effort to present standards that would modernize state regulations to allow for the consistent practice of APRNs from state to state. The Consensus Model also describes the standards for licensure, accreditation, certification and educational requirements across states. The current application references the Consensus Model. The Applicant asserts that it is requesting a retirement of outdated codes and regulations that limit practitioners from practicing to their full scope, and that none of the requested changes to West Virginia code allows any practice outside the current professional educational scope and standards for APRNs.

Opposition to the expansion of the APRN scope of practice is expressed in the positions of two national physicians' organizations, the American Medical Association (AMA) and the American Osteopathic Association (AOA). Both have positions that oppose the

[2] *The Institute of Medicine is one of four national private non-profit academies created by Congressional charter, to provide independent expert advice on the sciences, engineering and medicine. The other three are the National Academy of Sciences, the National Academy of Engineering, and the National Research Council.*

independent practice of non-physician clinicians such as advanced practice registered nurses. The AMA recognizes the value of APRNs within the healthcare delivery system but expresses concern that the nurse practitioner does not have an adequate clinical foundation for independent practice. The AMA opposes the enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery. The AOA acknowledges the role of non-physician clinicians in the healthcare delivery system but advocates for direct physician supervision, as does the AMA. Additionally, while considering national studies of non-physician medical providers, the Physicians Foundation, a non-profit organization that represents the interests of physicians, notes that there is a lack of evidence that physicians provide higher quality care than non-physician providers.[3]

In December 2012 the National Governors Association (NGA) issued a white paper that reviewed the research on the performance of nurse practitioners (the largest of the four types of APRNs). This review also evaluated the state rules governing nurse practitioner scope of practice. The NGA undertook the review because of the perceived need for states to increase the number of primary healthcare providers. The NGA findings substantiate the IOM report in that there is variation between states' regulations with 16 states and the District of Columbia allowing for nurse practitioners to practice completely independently of a physician, and to the full extent of their training. Another eight states (including West Virginia) allow nurse practitioners to diagnose, treat and refer patients independently but not to prescribe independently. States tend to place most of their restrictions on the nurse practitioner's ability to prescribe.

It is important to note that a recent analysis shows no variation in physician earnings between states that have expanded APRN scope of practice laws and states that have not.

In the white paper, the NGA noted that "Some observers believe that physician groups … have financial concerns about broadening state scope of practice rules for nurses but it is important to note that a recent analysis shows no variation in physician earnings between states that have expanded APRN scope of practice laws and states that have not." The NGA concluded that based on the review on health services research, nurse practitioners are well qualified to deliver certain elements of primary care.

The Federal Trade Commission has also weighed into the public policy debate in West Virginia. In a September 2012 statement issued to the West Virginia Legislature's Joint Committee on Health, the FTC concludes:

[3] *Isaacs, S., Jellinek, P. Accept No Substitute: A Report on Scope of Practice. November 2012.*

Removing the requirement that APRNs who want to prescribe medications have a collaborative agreement with a physician has the potential to benefit consumers by expanding choices for patients, containing costs and improving access. We encourage the West Virginia legislature to carefully review the safety record of APRNs in West Virginia and to consider whether the current requirement is necessary to assure patient safety in light of the almost twenty years of prescribing experience of West Virginia APRNs, as well as the findings of the Institute of Medicine. Absent countervailing safety concerns regarding APRN prescribing practices, removing the collaborative agreement for prescriptive authority appears to be a procompetitive improvement in the law that would benefit West Virginia health consumers.

States have found that the public policy decisions about changes in scope of practice for APRNs are not easy, and can take time for the assessment of all of the issues involved. In Colorado, the process of expanding the scope of APRN practice began in 1994, but was not fully implemented for autonomous practice until 2008. The state of Nevada revised its law in 2013 to allow independent prescriptive authority, following six years of legislative debate. Nevada's legislative scope of practice has been expanded in order to compensate for the lack of physicians in the state and to offer primary care services to patients in remote areas. Nevada's law goes into effect in 2014.

In 1992, the West Virginia Legislature created the requirement for a collaborative agreement between a nurse practitioner (now known as an APRN) and a physician prior to being granted the authority by the Nursing Board to prescribe certain medications.

Collaborative Agreements Are Required by WV Code and Defined by Rule

The first change in APRN scope of practice proposed by the Applicant is to eliminate the written collaborative agreement requirement as a prerequisite to the APRN obtaining limited prescriptive authority. In 1992, the West Virginia Legislature created the requirement for a collaborative agreement between a nurse practitioner (now known as an APRN) and a physician prior to being granted the authority by the Nursing Board to prescribe certain medications. This requirement is for the establishment of a collaborative agreement between an APRN and an osteopathic or allopathic physician. **It is not described as a supervisory agreement in Code**. The current requirement in West Virginia Code §30-7-15a follows:

(a) The board may, in its discretion, authorize an advanced practice registered nurse to prescribe prescription drugs in a collaborative relationship with a physician licensed to practice in West Virginia ... . An authorized advanced practice registered nurse may write or sign prescriptions or transmit prescriptions verbally or by other means of communication.

(b) ... an agreement to a collaborative relationship for prescriptive practice between a physician and an advanced practice registered nurse shall be set forth in writing. Verification of the agreement shall be filed with the board by the advanced practice registered nurse. ... Collaborative agreements shall include, but are not limited to, the following:

(1) Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advanced practice registered nurse's clinical practice;

(2) Statements describing the individual and shared responsibilities of the advanced practice registered nurse and the physician pursuant to the collaborative agreement between them;

(3) Periodic and joint evaluation of prescriptive practice; and

(4) Periodic and joint review and updating of the written guidelines or protocols.

The Nursing Board is required to forward verification of all advanced practice nurses with collaborative agreements to the Board of Medicine, the Board of Osteopathic Medicine, and the Board of Pharmacy.

Certified nurse-midwives are required in §30-15-7a to have a written collaborative agreement. The Nursing Board is required to forward verification of all advanced practice nurses with collaborative agreements to the Board of Medicine, the Board of Osteopathic Medicine, and the Board of Pharmacy and provides a master list of APRNs and collaborating physicians to these boards with updates on a monthly basis.

The Legislative Auditor determined that the Nursing Board regularly provides this information to the respective medical boards. However, this information is not used by the medical boards to audit the performance of physicians according to the terms of the collaborative agreements. The Board of Medicine noted that it does not have legislative authority to audit the agreements. However, the Board of Medicine issued collaborative agreement guidelines for physicians in 2012 recommending limits on the number of collaborative agreements per MD. The limits

are 3 collaborative agreements per MD, unless the practice setting is a hospital, indigent clinic or federally qualified health care center when the limit is 4 agreements per MD.

The Osteopathic Board stated that it has not issued any guidelines for DOs. The Osteopathic Board recently reviewed some written collaborative agreements, and stated

> *Upon review of the recently submitted Collaborative Agreements ... there is no standardization of the agreements at all. They range from a one page document to 10-12 pages. One collaborative agreement did not even list what the Nurse Practitioner could do, it simply listed 17 different protocols from published articles written by different clinical specialists. Only the articles were cited, the protocols themselves were not.*

APRNs in West Virginia are allowed to diagnose, treat and refer without a physician's written collaborative agreement.

The Board of Pharmacy noted that it uses the Nursing Board information on prescriptive authority and APRNs whose authority has been terminated to remove those APRNs from access to the Controlled Substance Automated Prescription Program database to prevent unauthorized use. It does not use the Nursing Board information in any other way.

From A Cost-Benefit Perspective, the Cost of the Written Collaborative Agreement As It Currently Exists May Exceed the Benefit

The Legislative Auditor considered whether there is a public benefit from the written collaborative agreement remaining in place. APRNs in West Virginia are allowed to diagnose, treat and refer without a physician's written collaborative agreement. A collaborative agreement is only required for APRNs who wish to prescribe medications.[4] Therefore, independent self-employed practitioners must find and pay a physician to enter into a written collaborative agreement. This can present the following problems for an independent APRN practitioner in many areas of the state.

[4] *The limited drug formulary includes controlled substances, and medications for chronic conditions such as diabetes.*

Problems With Obtaining Written Collaborative Agreements

- **Difficulty finding a physician collaborator:** Anecdotal evidence from self-employed APRNs indicates that physicians are reluctant to enter into collaborative agreements due to increased liability concerns. APRNS may invite numerous physicians to collaborate before finding a physician willing to enter into a formal collaboration. One APRN notes that she pays for additional medical malpractice insurance for her collaborating physician. In rural areas it is difficult to locate a physician willing to enter into a collaborative agreement.

- **Cost:** APRNs in a practice do not pay physicians for a written collaborative agreement. However, APRNs that are self-employed usually pay the physician an hourly rate. The APRN has no control over how long the physician will take to review charts, and how many hours will be billed. The rate paid by one self-employed Morgantown APRN is $250/hour.

- **Revocation of agreement by physician or APRN:** The physician can revoke the agreement at any time and for any reason. The APRN may be forced to terminate the agreement with the physician if there is an issue with the physician's license, or other practices. Under either circumstance, the self-employed APRN can remain in practice but is not able to prescribe medication for current patients until a new physician is located and a new collaborative agreement is in place.

Almost one-third (30.1 percent) of all of West Virginia's active physicians (primary care and other specializations) are age 60 or older according to the AAMC, ranking the state 6th in the nation for an aging physician population.

Few West Virginians currently receive health care services from APRNs in independent practices. The Legislative Auditor considered the cost of the written collaborative agreement requirement as it restricts APRNs from developing independent practices, and consequently restricts public access to primary healthcare. **Increasing access to primary healthcare is a key focus of healthcare reform.** According to the Association of American Medical Colleges (AAMC) the state has 1,372 MDs and 375 DOs who are active primary care physicians. Almost one-third (30.1 percent) of all of West Virginia's active physicians (primary care and other specializations) are age 60 or older according to the AAMC, ranking the state 6th in the nation for an aging physician population. In addition, West Virginia ranks in the bottom five states for the health of its population according to the 2013 edition of America's Health Rankings. The West Virginia Rural Health Association concludes that the state faces an increased demand for primary healthcare services

and a new wave of shortages of providers at the same time as an expansion in the numbers of newly insured and Medicaid-eligible West Virginians under the Affordable Care Act.

Variations Among Written Collaborative Agreements

The Legislative Auditor also considered whether the written collaborative agreement is currently achieving an evaluation of the APRN's prescriptive practice, and whether the written collaborative agreement is providing a layer of protection to the public. The Legislative Auditor found the following:

- **The majority of written collaborative agreements take place in work settings such as practices, clinics and hospitals**. In these close working environments, physicians already have knowledge of the APRN's prescriptive and clinical practice. In these settings, many of the written collaborative agreements spell out employer-employee duties, and responsibilities. Practice standards already exist. The collaborative agreement becomes an added document to be maintained by the medical director, or administrator. Some administrators and collaborating physicians in these settings indicate that the agreements are time-consuming and can be duplicative of effort.

There is wide variation in the details of current collaborative agreements.

- **The written collaborative agreements are not required to conform to practice evaluation standards.** No standards exist in Code or rule addressing on-site or remote supervision, the number, percentage, or frequency of chart reviews, or limiting either the numbers of APRNs with whom a physician may have an agreement, or the number of physicians with whom an APRN may have agreements. In addition, there is no provision for the variation of experience levels of APRNs, so that an APRN with 17 years of prescribing authority has the same requirement for a written collaborative agreement as a newly graduated APRN who has just received prescribing authority from the Nursing Board. Consequently there is wide variation in the details of current collaborative agreements. This variation may reflect not only the lack of required standards but also that there are variations in the APRNs' collaborations with physicians, and that in long-term collaborations the physician is confident in the APRNs' experience and prescribing practices.

- **Physicians and APRNs have multiple collaborative agreements**. In a review of a list of all 956 current collaborative agreements provided by the Nursing Board, about 55 physicians (both MDs

and DOs) are listed as having 5 or more agreements with separate APRNs despite Board of Medicine guidelines. The West Virginia Board of Osteopathic Medicine does not have policy or guidelines for written collaborative agreements. A review of the APRN master list issued by the Nursing Board found APRNs with agreements with as many as 21 separate physicians. Some APRNs have multiple collaborative agreements because they are working in group practices. Other APRNs maintain multiple agreements so that if a physician discontinues an agreement, the APRN will still retain limited prescriptive authority. Table 1 shows the number and type of physicians with written collaborative agreements. The yellow row in Table 1 highlights the beginning point where physicians exceed the number of collaborative agreements recommended by the Board of Medicine guidelines.

APRNs maintain multiple agreements so that if a physician discontinues an agreement, the APRN will still retain limited prescriptive authority.

Table 1
Numbers of Separate APRN Collaborative Agreements Held by Physicians*

Number of Separate APRN Agreements per Physician	Number of MDs	Number of DOs
13	4	0
9	3	0
8	1	1
7	6	6
6	7	1
5	23	3
4	29	4
3	48	18
2	150	30
1	418	104

PERD analysis based on information received from the West Virginia Board of Examiners of Registered Nurses.
**Physicians include Osteopathic Doctors (DOs) and Allopathic Doctors (MDs).*

It is questionable whether one physician provides a substantive review of prescriptive and clinical practice when engaged in collaborative agreements with 13 different APRNS. The Legislative Auditor found one practice where all physicians on staff have written collaborative agreements with all of the APRNs because of the practice rotation requirements.

It is questionable whether one physician provides a substantive review of prescriptive and clinical practice when engaged in collaborative agreements with 13 different APRNS.

It is equally questionable whether an APRN with 21 different physician agreements can meet varied requirements in the collaborative agreements. Attending physicians in graduate medical education programs in West Virginia are limited to 4 first year residents per 1 physician, although this limitation is to allow for supervision and teaching of the new residents.

Aside from the Nursing Board's documentation of their existence, and date, written collaborative agreements are not monitored or audited to determine if the physicians and APRNs perform according to the agreement requirements. Given the variation in practice settings, lack of evaluative standards, multiplicity and general variability, the current written collaborative agreements do not appear to be achieving a consistent benefit of protection to the public.

The Legislative Auditor concludes that there may be some protection for the public from the written collaborative agreement requirement as it applies to APRNs who are inexperienced in prescribing, although as the written collaborative agreement is currently structured, the protections are inconsistent. There also appears to be a financial cost associated with the development of independent APRN practices, particularly in rural areas. It is clear that while APRNs can provide primary healthcare, and assist in meeting the future demand, to date few APRNs have established independent practices. Given the lack of standardization within the written collaborative agreements, and the difficulty experienced by independent APRNs in rural areas in finding a collaborating physician, the cost of the written agreement appears to exceed the benefits to the public once an APRN has prescribing experience.

It is clear that while APRNs can provide primary healthcare, and assist in meeting the future demand, to date few APRNs have established independent practices.

Some States Allow APRNs to Prescribe Medications Independently

Sixteen states and the District of Columbia currently allow APRNs to practice and prescribe medications independently.[5] Appendix A contains a map showing these states. The state of Nevada will allow APRN independent prescriptive authority starting in 2014. The Legislative Auditor contacted the nursing boards in all 16 states to determine if there are any outstanding issues when APRNs practice and prescribe independently. Information and specific disciplinary issues regarding APRNs was requested. The following 10 replies were received.

[5] *According to the American Association of Nurse Practitioners, these states are: Alaska, Arizona, Colorado, Hawaii, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, and Wyoming.*

1. **Alaska:** The advanced practice nurses (ANPs) in Alaska have had autonomous practice since 1984 and controlled substance prescriptive authority since about 1988. Disciplinary issues have been no different from other nurses. ANPs can prescribe controlled substances which seldom presents a problem. The rate of drug problems requiring discipline is no different than the rate of the general population of nurses. Alaska does not maintain information on rural practice, or self-employed practitioners. Some advanced practice nurses practice hundreds or even thousands of miles from hospitals, and use telemedicine, telephone consultation and Medevac services. Alaska has a system of consultation and referral where APNs must describe for the nursing board how they would consult if necessary and identify to whom they would refer patients.

Alaska does not maintain information on rural practice, or self-employed practitioners.

2. **Colorado**: Colorado noted that it has moved toward autonomy for APRNs since 1994. Full autonomy was reached in 2008. Colorado currently has 4,816 active licensed APRNs. It does not capture data on independent or solo practice. The nursing board notes that there are no identifiable disciplinary issues related specifically to APRNs, and there are no identifiable medical malpractice issues that have arisen or appear related to APRN autonomous practice. In addition, there is no pattern of patient safety concerns that appears related to autonomous practice of APRNs.

Colorado currently has 4,816 active licensed APRNs. It does not capture data on independent or solo practice.

3. **Hawaii**: Hawaii amended its law in 2010 to allow APRNs with prescriptive authority to practice without a collegial working relationship with a licensed physician. Hawaii has not noted any increase in the number of disciplinary actions against APRNs. However, other state laws were not amended and this has created some barriers for APRNs practicing to their full scope.

4. **Iowa:** According to the nursing board, Iowa's rules for the advanced registered nurse practitioners (ARNP) were established in 1983 to allow ARNP practice. Iowa's rules do not require supervision of ARNPs. Iowa does not keep data on independent practitioners. Iowa's nursing board notes that there has been an increase in discipline concerning the prescribing of pain medications for pain management.

5. **Maine**: Maine allowed NP autonomous practice starting in 1996. Maine's nursing board does not track data on nurse practitioners (NPs) that are self-employed but notes that most

are not self-employed. There are 1,230 licensed NPs. Maine's nursing board states that it recently compared prescribing practice of Maine NPs to physicians and found no difference.

6. **New Hampshire:** Approximately two-thirds of the APRNs are in an independent practice however it is not known what percentage work in rural areas. A small percentage of APRNs have been adjudicated for drug diversion. The executive director estimated there had been 5-10 cases of APRN discipline in the past 5 years, and about half of these cases are related to drug diversion.

Maine's nursing board states that it recently compared prescribing practice of Maine NPs to physicians and found no difference.

7. **New Mexico:** New Mexico has had independent practice and prescriptive authority for advanced practice registered nurses for more than 20 years, however certified nurse midwives are regulated by the New Mexico Board of Health. APRNs are not over represented in the complaints received by the Board. Issues related to improper prescribing practices are not common. New rules for management of chronic pain with controlled substances require those APRNs with Drug Enforcement Administration (DEA) registration and the ability to prescribe opiates to increase scrutiny of patients in a variety of ways.

8. **Vermont:** Vermont first allowed APRNs to practice autonomously in 2011. Vermont stated that the nursing board knows of no disciplinary issues that relate specifically to APRNs, and knows of no medical malpractice issues. Vermont does not track information on APRNs that are self-employed.

Vermont stated that the nursing board knows of no disciplinary issues that relate specifically to APRNs, and knows of no medical malpractice issues.

9. **Washington:** Based on information provided from this board, a little over half of advanced registered nurse practitioners (ARNP) practice in rural counties. In terms of disciplinary issues, the advanced practice advisor noted that there had only been 2 or 3 cases of overprescribing controlled substances that required disciplinary action. Other prescribing issues have been dealt with by education and limitations on prescriptive authority. Washington stated that no medical malpractice issues have arisen as a result of legislation granting ARNPs autonomy in scope of practice and prescriptive authority for legend medications and controlled substances.[6]

[6] *Legend medications are state regulated drugs that are not scheduled as controlled substances.*

10. **Wyoming:** The nursing board noted that autonomous practice began in 2005. The state does not collect information on self-employment or independent practice. Disciplinary issues specific to APRNs relate to pain management prescription practices. There are not any medical malpractice issues specific to APRNs. Certified registered nurse anesthetists (CRNAs) were unsuccessful in their attempt this year to eliminate collaborative practice.

In addition to the boards of nursing, the Legislative Auditor contacted boards of medicine in the six states that are considered to have some of the nation's most expansive nurse practitioner scopes of practice.[7] The boards of medicine were asked if there are issues, or concerns that physicians express or experience in regard to advanced practice registered nurses who practice and prescribe independently. Two boards of medicine replied.

New Mexico Board of Medicine:..." Bottom line, Advanced Nurse Practitioners are well respected by most physicians and are hailed by patients."

1. **Arizona Board of Medicine:** This board stated "We do not have any direct knowledge about concerns regarding Autonomous Nurse Practitioner (s)" and referred us to the nursing board for complaint information.

2. **New Mexico Board of Medicine:** The executive director of this board replied "Once in a while we hear some grumbling about nurse independent practice, but overall NM has only benefited from Advanced Practice Nurses. As far as we know, very few Nurse Practitioners (as we call them here) are practicing independently. They are part of a team of practitioners including MDs, DOs, & PAs. NM, like most states, needs more primary care practitioners like Nurse Practitioners and Physician Assistants. … Bottom line, Advanced Nurse Practitioners are well respected by most physicians and are hailed by patients."

Additional Requirements for WV APRN Limited Prescriptive Authority

The written collaborative agreement with a physician is only one requirement that the APRN in West Virginia must meet before receiving limited prescriptive authority. The APRN must complete additional requirements specific to pharmacology training and federal requirements, which include:

[7] *These states are Alaska, Arizona, New Hampshire, New Mexico, Oregon and Washington.*

- state licensure (in good standing) as an advanced practice registered nurse having met national certification;
- completion of undergraduate instruction in pharmacology, and an advanced pharmacology graduate course with 45 pharmacology contact hours;
- completion of 15 advanced pharmacology contact hours within 2 years prior to the initial application for limited prescriptive authority; and
- compliance with federal Drug Enforcement Administration (DEA) requirements in order to prescribe Schedules III through V drugs.

Drugs in Schedule II are considered to be more dangerous than those in Schedule V. In West Virginia, APRNs are not permitted to prescribe Schedule II drugs.

West Virginia regulates all medications that are not available over the counter. Both the state and the federal government regulate controlled substances. There are five categories of controlled substances, or "schedules," which are grouped according to whether they have an accepted medical use in the United States, their potential for abuse and the likelihood of dependence when abused. Schedule I drugs have no medical use and are illegal. Drugs in Schedules II through V have medical value for use as prescription medications. However, drugs in Schedule II are considered to be more dangerous than those in Schedule V. In West Virginia, APRNs are not permitted to prescribe Schedule II drugs.

All legitimate handlers of controlled substances, including APRNs, register with the DEA and receive a DEA registration number.

The DEA serves as the primary federal agency responsible for enforcement of the federal Controlled Substances Act (CSA), ensuring that all controlled substance transactions take place within a "closed system" of distribution. All legitimate handlers of controlled substances, including APRNs, register with the DEA and receive a DEA registration number. They must maintain strict accounting for all distributions of controlled substances, or risk suspension or revocation of their registration.

Training Requirements Vary Among Medical Practitioners

The Legislative Auditor reviewed the variation in state education requirements between allopathic (MD) and osteopathic (DO) physicians, dentists, physician assistants and advanced practice registered nurses, all of whom can prescribe controlled substances and other medications. Both PAs and APRNs are considered mid-level medical practitioners but they are trained to assume different roles. PAs function under the close supervision of a physician, while APRNs are trained to function as independent practitioners, with a broader scope of practice depending on specialized training. Educational requirements for professional licensure vary, in addition to the length of educational degree programs and the specific education requirements in state code for pharmacology training.

Of the two non-physician practitioners shown in Table 2, the PA not only works in a physician-supervised setting but also must have two years of patient care experience before applying for prescriptive authority. The APRN is not required to be supervised in order to practice, and is not required to demonstrate two years of patient care experience before obtaining prescriptive authority. The single standard in the licensure requirement for all five medical practitioner categories is the successful completion of a national certification examination in their respective fields.

Table 2
West Virginia Healthcare Practitioner Requirements for Education, License, and Scope of Prescriptive Authority

Practitioner Type	Practitioner Title	90 semester hours college	BS/ BA	Master	Doctorate 4 yrs	1 yr* Residency	National Certification Exam	Prescriptive Authority
Physician Practitioner	Allopathic Physician (MD)	•			•	•	•	No Limitations
	Osteopathic Physician (DO)	•			•	•	•	No Limitations
	Dentist (DDS)	•			•		•	No Limitations (w/n scope of practice)
Non-Physician Practitioner	Advanced Practice Registered Nurse (APRN)		•	• 18 months to 2+yrs)			•	**Limitations** ^ (w/n scope of practice)
	Physician Assistant (PA)		•	• (24-28 months)			•	**Limitations+**

Source: Legislative Auditor review of educational requirements from all state colleges and universities offering training for the five categories of prescribing practitioner.
**Advanced Training following graduation from medical school.*
*° Standard 4-yr BS/BA **or** Master in Physician Assistant Studies*
^ APRN limitations: DEA controlled substance Schedules III to V; other limitations on non-controlled substance prescription drugs.
+PA limitations: 72 hr supply from DEA Schedule III and smaller of 90 dosage units or 30 day supply from Schedule IV and V; after 2 yrs patient care experience

In Table 2, the admission and graduation requirements of the state institutions offering physician training, dentist training, physician

assistant training and advanced practice registered nurse training were reviewed. The educational programs are offered by West Virginia University, Marshall University, the WV School of Osteopathic Medicine, West Liberty University, Alderson-Broaddus College, the University of Charleston and Wheeling Jesuit University.

In order to analyze one aspect of public protection, the Legislative Auditor reviewed current disciplinary information against the two main types of mid-level medical practitioners, physician assistants and advanced practice registered nurses from the National Practitioner Data Bank.[8] Table 3 shows this information.

Table 3
Adverse Actions* Against Mid-Level Medical Practitioners in Independent Practice States Compared to West Virginia

State	Advanced Practice Registered Nurses	Adverse Actions in CY2012	Physician Assistants	Adverse Actions in CY2012
Alaska	780	2	506	0
Arizona	5,495	2	2,248	15
Colorado	*3,184*	0	2,289	12
Hawaii	*912*	1	329	0
Idaho	*658*	1	662	1
Iowa	*1,329*	1	1,123	3
Maine	*1,088*	2	737	4
Montana	*553*	0	504	1
New Hampshire	1,675	1	556	1
New Mexico	1,969	0	714	4
North Dakota	*475*	1	289	0
Oregon	2,283	9	1,224	5
Rhode Island	*690*	4	399	2
Vermont	*500*	1	379	3
Washington	5,458	4	2,611	10
Wyoming	*423*	0	247	1
Total Adverse Actions		**29**		**62**
West Virginia	2,149	0	713	8

Sources: The National Practitioner Data Bank. APRN census from Nursing Board websites and the Henry J. Kaiser Family Foundation. PA census for 2013 from the American Academy of Physician Assistants.
**The Data Bank defines adverse action as (1) an action taken against a practitioner's clinical privileges or medical staff membership in a health care facility, or (2) a licensure disciplinary action.*

[8]*The National Practitioner Data Bank is an information clearing house created by Congress and housed in the U.S. Department of Health and Human Services, Health Resources and Services Administration. Information is compiled from a variety of state and federal sources.*

Physician assistants, directly supervised by physicians and generally fewer in number in each state than APRNs, have been in involved in more adverse actions, either being disciplined by their respective regulatory board, or having practice privileges or medical staff membership removed in the past year. **APRNs show far fewer adverse actions.** Colorado, Montana, New Mexico and Wyoming show no actions against APRNs in CY 2012. The experience of these 16 states does not show an increase in the risk of harm to the public from APRN autonomous practice.

Nationally APRNs Provide Safe Treatment

The Legislative Auditor reviewed national information relating to the four categories of APRNs and concludes that APRNs provide safe and effective treatment within their scope of practice.

Studies that were reviewed of patient care concluded that nurse practitioners are capable of successfully managing chronic conditions in patients suffering from hypertension, diabetes, and obesity as evidenced.

1. Certified Nurse Practitioners (CNP)

Certified nurse practitioners comprise the largest segment of APRNs nationally and in West Virginia. The CNP provides a wide range of preventive and acute health care services, ranging from taking health histories and providing physical examinations, diagnosing and treating, interpreting laboratory results, prescribing and managing medications and providing health teaching and counseling to prevent illness and maintain health.

The research review by the NGA, conducted specifically on research relating to nurse practitioners, suggests they can perform many primary care services as well as physicians, and that there is equal or higher patient satisfaction. The areas in which nurse practitioners provided at least equal quality of care to physicians were in patient satisfaction, time spent with patients, prescribing accuracy, and the provision of preventive education. Studies that were reviewed of patient care concluded that nurse practitioners are capable of successfully managing chronic conditions in patients suffering from hypertension, diabetes, and obesity as evidenced by physiological measures of patient outcomes such as decreased cholesterol, blood pressure and weight.

None of the studies in the NGA's research literature review raise concerns about the quality of care offered, and most studies showed that nurse practitioners provided care that is comparable to physicians on several process and outcome measures. The studies also suggest that nurse practitioners may provide increased access to care.

2. Certified Nurse Midwives (CNM)

Certified nurse midwives are educated in nursing and midwifery. They provide primary healthcare to women of child-bearing age, including prenatal care, labor and delivery care, care after birth, gynecological exams, newborn care, family planning, menopausal management, and counseling in health maintenance. CNMs attend more than 7 percent of all births in the United States; over 95 percent of these are in hospitals.

Various research studies conclude that CNMs provide a safe and viable alternative to maternity care in the United States, particularly for low-to-moderate-risk women. Low-risk patients in Washington State were found to have received fewer obstetrical interventions than similar patients cared for by family physicians and obstetricians, especially lower cesarean rates and resource use. In a different study, nurse midwives had statistically significant fewer infant abrasions, perineal lacerations, and complications; higher patient satisfaction with care; and lower hospital and professional fee charges. Finally, high-risk women in an inner-city hospital were compared with all U. S. deliveries for a one year period and CNMs were found to be able to provide safe care to these high-risk patients.

3. Certified Registered Nurse Anesthetist (CRNA)

A CRNA is a registered nurse who is educated to engage in nurse anesthesia. CRNAs administer more than 34 million anesthetics in the United States each year. CRNAs practice in every setting where anesthesia is available and are the primary providers of anesthesia care in rural America. They administer every type of anesthetic, and provide care for every type of surgery or procedure, from open heart to cataract to pain management. CRNAs provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists.

Few studies have been conducted on anesthesia outcomes perhaps due to a 1988 study by the Centers for Disease Control and Prevention that concluded that anesthesia-caused mortality and severe morbidity were too low to warrant a broader study. In general, anesthesia related accidents are infrequent due to improvements and technological and safety measures developed over the past 40 years. However, in recent years a 2003 study assessed surgical patients' safety with regard to CRNAs

versus anesthesiologists.[9] The study reviewed 404,194 anesthesia cases across 22 states, finding no statistically significant difference in the mortality rate for CRNAs and anesthesiologists working together versus working individually. The researchers concluded that inpatient surgical mortality is not affected by whether the anesthesia provider is a CRNA or an anesthesiologist.

4. Clinical Nurse Specialists (CNS)

The CNS is a clinician in a specialized area of nursing practice by population (pediatrics), setting (critical care), disease (cardiovascular), or type of problem (wound or pain). The CNS provides both health promotion and maintenance through assessment, diagnosis, and management of acute and chronic patient problems that includes both pharmacologic and non-pharmacologic interventions. The CNS also provides prenatal care, preventive and wellness care, behavioral health care and care for chronic conditions. Numerous studies show that clinical nurse specialists have had good results in reducing employer health care costs, reducing the costs of chronic condition care, preventing hospital acquired conditions, reducing the lengths of stay in acute and community based settings, improving mental health management, and preventing hospital readmissions.

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There are 2,149 advanced practice registered nurses in West Virginia as of November 2013. Table 4 shows the number of licensees by category listed in the most recent Nursing Board Annual Report.

Table 4
West Virginia Advanced Practice Registered Nurses

Category	Licenses
Certified Nurse Practitioners (CNP)	1,156
Certified Nurse Midwives (CNM)	67
Certified Registered Nurse Anesthetists (CRNA)	753
Clinical Nurse Specialists (CNS)	42

Source: The West Virginia Board of Examiners for Registered Professional Nurses

Adverse Actions against West Virginia APRNs Reviewed

Since the first request by the Applicant is to remove the written collaborative agreement between the APRN and a physician, the Legislative Auditor analyzed the safety of APRN practice in West Virginia by

[9] *Pine, M, Holt, KD, Lou, YB. Surgical mortality and type of anesthesia provider. AANA J. 2003 April: 71, 109-16.*

reviewing prescribing complaints against APRNs and medical malpractice court cases. While national research indicates that APRNs provide safe treatment and prescribing accuracy, decisions to make changes to state code should be informed by examination of the practice of state APRNs.

Prescribing Complaints

The Legislative Auditor requested information from the Nursing Board on prescribing complaints against advanced practice registered nurses for the time period from CY 1990 through CY 2013. The Nursing Board stated that 30 complaints had been filed between 1992 and 2013. Over this time period, 13 complaints have been dismissed. Of the remaining prescribing complaints, five complaints relate to an APRN prescribing medications that should not have been prescribed, or prescribing without a DEA number. In addition, 7 prescribing complaints resulted from an APRN prescribing either after failing to renew an existing collaborative agreement, or prescribing after a collaborative agreement had terminated. Four of these 7 APRNs were assessed a non-disciplinary fine and administrative costs, and three APRNs signed agreements placing their RN license on probation. Of the remaining complaints one was denied initial prescriptive authority related to legal probation and five are still pending.

While national research indicates that APRNs provide safe treatment and prescribing accuracy, decisions to make changes to state code should be informed by examination of the practice of state APRNs.

Medical Malpractice

The Legislative Auditor requested a legal search for medical malpractice cases against advanced practice nurses in all roles from 1993 through July 2013. The legal staff in Legislative Services found four cases from publicly available records. Legal staff explained that these are appellate cases, and that a review of any other cases, such as those cases only going to circuit court, and not being appealed, is not practical.

Two cases, in 2003 and 2005 involved two different nurse anesthetists or CRNAs. In the 2003 case, the nurse anesthetist settled with the patient prior to a trial. The 2005 case was dismissed, and later on appeal remanded for further proceedings. There was no further information available on the case. Certified nurse midwives were involved in the other two cases. In a 2001 case, a CNM, county health department, hospital and physician were alleged to have failed to diagnose and treat a breast cancer. A trial found for the patient in this case. A 2013 case that went to trial alleged the use of a prescription oral contraception contributed to the death of a patient. However, a jury found in favor of the CNM and the physician. There were no cases found that involved either clinical nurse specialists or nurse practitioners.

In 21 years, the safety record that can be documented shows that APRNs have been involved in four medical malpractice appellate court cases and received 30 complaints related to prescribing practices. Of the court cases, only one was specifically related to a prescription medication. In that case a jury found in favor of the CNM and the physician. Of the complaints, the majority related to administrative failures by the licensee. From the information provided, it was not possible to determine if any complaints related to actual errors in prescribing.

APRN Medical Malpractice Analysis Report, Rates and Paid Claims

The Legislative Auditor was not able to find any reports that tracked medical malpractice claims to autonomous practice by APRNs.

Medical malpractice paid claims, analyses by insurers and rate trends also provide some information on the safety of APRN practice. The Legislative Auditor was not able to find any reports that tracked medical malpractice claims to autonomous practice by APRNs. However, the Legislative Auditor contacted the senior vice president for the healthcare division of AON Affinity, one of the nation's largest insurers of nurse practitioners. AON provides nurse practitioner liability insurance through a CNA partnership with the Nurse Service Organization (NSO) which writes about 19 percent of the liability coverage for nurse practitioners in the United States. The senior vice president notes that NSO works to keep a national pricing structure due to the small population of NPs in some states. He stated that rates have doubled over the past 10 years from an average rate of $500 to $600 per year to an average of $1,400+ per year. He explained this by stating:

> "*…technically, it's because we are seeing increasing severity of indemnity payments as well as the increasing frequency of claims therefore demanding rate increases. However, what we at NSO feel has been driving this includes: the physician shortage, less MDs moving into family practice, thus helping to fuel the demand/growth of NPs as a profession, which has then allowed NPs to act as a primary care provider. This greater exposure has led, as well as the greater number of NPs to increased claims and thus rates. However, by comparison, NPs rates are far less than a family practice MDs rates.*"

CNA/NSO also analyzes its paid malpractice claims to provide information and risk control recommendations to nurse practitioners. The 2012 analysis provides information for paid claims from CY 2007

through December 31, 2011. The total amount in paid claims by CNA/NSO for its covered nurse practitioners in all states during this period was $44,370,490. The average paid indemnity claim increased from $186,282 to $221,852 during this time period. The most frequent allegations against nurse practitioners involved:

- failure to diagnose, and delay in making the correct diagnosis (43 percent),
- failure to provide the proper treatment and care (29.5 percent), and
- errors in medication prescribing (16.5 percent).

The most common prescribing errors were analyzed in the CNA/NSO report. The highest percentage of the most common errors (4.5 percent) was in a failure to recognize contraindication and/or know the adverse interaction among ordered medications. The improper prescribing and/or management of anticoagulants followed at 3 percent of claims. Prescribing the wrong medication, prescribing the wrong dose and the improper prescribing and management of controlled drugs each constituted 2.5 percent of the closed claims of prescribing errors. The remaining 1.5 percent of prescribing errors was not analyzed.

The most common prescribing errors were analyzed in the CNA/NSO report. The highest percentage of the most common errors (4.5 percent) was in a failure to recognize contraindication and/or know the adverse interaction among ordered medications.

Review of APRN malpractice insurance rates

The Legislative Auditor requested information on medical malpractice rates for APRNs from West Virginia and the 16 states where APRNs have autonomous practice. This request was made in order to determine whether there had been a change in rates between CY 2003 and 2013 that might reflect increasing medical malpractice claims. Eight states responded, but only three responses contained historical data to show rate changes. They were West Virginia, Alaska and Oregon. The states included rate information for all carriers of this type of insurance. The following information was gained.

- **Alaska.** Alaska provided 10-year historical rate information from four insurers: American Casualty, Continental Casualty, Medical Insurance Exchange of California (MEIC) and Norcal Mutual. The rate information showed rate increases and rate decreases, so that no trend could be established for Alaska.

- **Oregon.** Oregon's historical rate information was variable among 10 insurers, and the longest span of time was 6 years with Continental Casualty. This insurer showed a rate increase of 5 percent over 6 years. The rate information for the other companies showed rate increases and rate decreases so that no trend could be established for Oregon.

- **West Virginia.** West Virginia provided rates for 7 insurers but historical data for only one insurer, American Casualty. The historical data covered 11 years, and showed rates at $761 in 2002 increasing to $1,784 in 2013, for an NP in employed in family practice. For a self-employed NP in family practice the rate was $761 in 2002 increasing to $2,540 in 2013. These were much higher increases than those seen in Alaska and Oregon.

The Legislative Auditor concluded that due to the lack of response by the 16 states, trend information for insurance rates was not able to be established.

The Legislative Auditor concluded that due to the lack of response by the 16 states, trend information for insurance rates was not able to be established.

Comparison of West Virginia paid medical malpractice claims

The Legislative Auditor reviewed the safety of the practice of West Virginia APRNs by reviewing annual data of the number and the respective aggregate dollar amounts of paid medical malpractice practice claims by all insurers for four types of medical practitioners. These comparisons are seen in Tables 5 and 6. Both paid claims tables reflect small numbers and amounts of medical malpractice claims paid for West Virginia APRNs and PAs. APRNs, PAs, MDs and DOs medical malpractice paid claims were compared for the time period from CY 2002 through 2012 in Table 5.

Table 5
West Virginia Medical Malpractice Claims Paid CY 2002–2012

Medical Practitioners	Number of Paid Claims	Amount of Paid Claims in Millions
APRNs	16	$8.63
PAs	9	$3.43
DOs	109	$32.15
MDs	1,095	$227.34

Source: National Practitioner Data Bank Medical Malpractice Payment Reports

Table 5 extends over a 10 year period, aggregating the amounts of paid claims. The year that a claim is paid does not reflect the year that the claim was filed, and claims are generally filed at some time prior to payment. The Legislative Auditor also reviewed the paid medical malpractice claims data for CY 2012. This information is shown in Table 6.

Table 6 West Virginia Medical Malpractice Claims Paid in CY 2012		
Medical Practitioners	**Number of Paid Claims**	**Amount of Paid Claims in Millions**
APRNs	0	0
PAs	0	0
DOs	11	$2.78
MDs	61	$12.41
Source: National Practitioner Data Bank Medical Malpractice Payment Reports		

The review of the medical malpractice paid claims report for CNA/NSO shows that prescribing error comprises 16.5 percent of all paid claims nationally for this major insurer of nurse practitioners. In West Virginia, APRNs show no medical malpractice paid claims for any type of practice problem in CY 2012; over the past 10 year period, there have been 16 medical malpractice paid claims totaling $8.63 million. The Legislative Auditor acknowledges that the comparison between rates for mid-level practitioners and physicians reflects the differing liabilities between the practice of primary care and of specialties, including obstetrics and surgery.

In West Virginia, APRNs show no medical malpractice paid claims for any type of practice problem in CY 2012; over the past 10 year period, there have been 16 medical malpractice paid claims totaling $8.63 million.

Conclusion

The Legislative Auditor's review does not find any apparent public safety issues with the prescribing and clinical practice of experienced APRNs. However, there are oversight issues with the written collaborative agreement that need to be addressed legislatively. The Legislative Auditor concludes the present requirement in state code for written collaborative agreements does not provide for standardization in terms of physician review and evaluation of prescribing practice, or in terms of the number of agreements that either a physician or an APRN shall enter into. Once collaborative agreements are established, there is no audit of the written collaborative agreements to determine if physicians are conducting the review of prescribing and clinical performance according to the terms of the written agreement. Further, written collaborative agreements do not take into account the clinical or prescribing experience of advanced practice registered nurses. Finally, the written collaborative agreement is difficult to obtain for APRNs who are self-employed, especially in rural areas of the state.

The Legislative Auditor is concerned about the impact of the collaborative agreement requirement on access to crucial primary and preventive health care for rural West Virginians. While the lack of standardization and absence of any official review process reinforces the Applicant's argument that the collaborative agreement is unnecessary,

the Legislative Auditor finds that some degree of clinical supervision and collaboration is appropriate for inexperienced APRNs. In addressing the Applicant's request to eliminate the written collaborative agreement requirement as a prerequisite to the APRN obtaining limited prescriptive authority, the Legislative Auditor finds that the written collaborative agreement requirement for advanced practice registered nurses should be revised in code and rule, and may be removed when certain conditions are met.

Recommendations

1. *The Legislature should revise the statute to allow Advanced Practice Registered Nurses in U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), designated Health Professional Shortage Areas (HPSA), with five years of clinical prescribing experience, a recommendation from his or her collaborative physician and no actions against their licenses to prescribe and practice independently, without a collaborative agreement. The Legislature, as a part of such a statutory change, should authorize the Board of Medicine to license those Advanced Practice Registered Nurses who want prescriptive authority to practice independently without a collaborative agreement.*

2. *The Legislature should revise the statute to move responsibility for prescriptive authority licensure of independently practicing Advanced Practice Registered Nurses from the West Virginia Board of Examiners for Registered Professional Nurses to the West Virginia Board of Medicine.*

3. *The Legislature should amend the statute to direct the West Virginia Board of Medicine to promulgate Legislative Rules developing a standardized written collaborative agreement as well as a review process for those written collaborative agreements. The statute should allow for agreements to be entered into by both allopathic (MD) and osteopathic (DO) physicians.*

4. *The Legislature should direct the Board of Medicine to promulgate Legislative Rules creating an application process and criteria for prescriptive authority licensure of Advanced Practice Registered Nurses with five or more years of clinical experience.*

5. *If implemented, the Legislature should consider reviewing the impacts of these actions upon the public health and safety in five years.*

FINDING 2

The Requirement for a Collaborative Relationship Between Certified Nurse Midwives and Physicians Should Remain.

Summary

In Finding 2, the Legislative Auditor considered the Applicant's request to remove the requirement in state code for a collaborative relationship between a certified nurse midwife and a physician. This requirement should remain in Code as it is a reasonable expectation for the protection of the public.

Collaborative Relationship of a Nurse Midwife to a Physician

The Applicant, in addition to requesting the removal of the written collaborative agreement for prescribing authority, presented proposed legislation that **removes** §30-15-7 from Code. West Virginia Code §30-15-7 requires the APRN who is a certified nurse midwife to practice in a collaborative relationship with physicians trained and practicing in fields that directly relate to obstetrical and gynecological care. WVC §30-15-7 states:

> *The license to practice nurse-midwifery shall entitle the holder to practice such profession according to the statement of standards of the American college of nurse-midwives, and such holder shall be required to practice in a collaborative relationship with a licensed physician engaged in family practice or the specialized field of gynecology or obstetrics, or as a member of the staff of any maternity, newborn or family planning service approved by the West Virginia department of health and human resources, who, as such, shall practice nurse-midwifery in a collaborative relationship with a board-certified or board-eligible obstetrician, gynecologist or the primary-care physician normally directly responsible for obstetrical and gynecological care in said area of practice.*

The opinion of legal staff of Legislative Services is that this is a distinct section of state code and should not be construed to be the same as the requirement for a written collaborative agreement for prescriptive authority for CNMs.

The Legislative Auditor requested a legal opinion regarding this section of code, and whether it establishes a requirement for general midwife practice that is **separate from** the requirement for a written collaborative agreement for prescriptive authority for certified nurse midwives in §30-15-7a. The opinion of legal staff of Legislative Services is that this is a distinct section of state code and should not be construed to be the same as the requirement for a written collaborative agreement for prescriptive authority for CNMs.

Conclusion

The Applicant argues that all APRNs are trained to practice autonomously and that requirements for collaboration are not necessary as all four roles of APRNs are trained to identify situations where collaboration is necessary. However, while §30-15-7 does not require that a written agreement or any other proof of the collaborative relationship between the CNM and a physician be demonstrated, it states a clear expectation of the CNM. This is an expectation that is prudent, and reasonable for the protection of the public. Therefore, the Legislative Auditor finds that the requirement for certified nurse midwives to establish a relationship to collaborate with physicians trained and practicing in fields that directly relate to obstetrical and gynecological care should remain in Code.

Recommendation

6. *The Legislature should continue WVC §30-15-7 requiring the establishment of a collaborative relationship between a certified nurse midwife and a physician practicing in fields that directly relate to obstetrical and gynecological care.*

FINDING 3

The Legislative Auditor Recommends Retaining Limitations on Advanced Practice Registered Nurse Prescriptive Authority by Retaining the Current Restricted Drug Formulary.

Summary

In Finding 3, the Legislative Auditor considered the request to remove all restrictions to prescribing medications. This would involve removing drug formulary limitations imposed on the prescriptive authority of advanced practice registered nurses. The Legislative Auditor considered whether the public benefits or is harmed by the drug formulary restrictions remaining in place. The restrictions to the drug formulary were revised in rule as recently as June 12, 2013. The Legislative Auditor concludes that the limitations on prescriptive authority imposed by the restricted drug formulary provide an important layer of public protection and should be maintained.

Request to Expand Medication Prescribing

In the application the Applicant requests an expansion of medication prescribing to allow APRNs to prescribe and monitor medications based on best practice evidence. The Applicant argues that the current law is convoluted and cumbersome and does not allow for appropriate and timely prescribing of medication for primary care patients. The Applicant notes that the current law restricts the kind and amount of medications that the APRN may prescribe. The Applicant gives examples of current rheumatoid arthritis therapies, pain medications and certain endocrine treatments that are common primary care prescriptive interventions. The Legislative Auditor evaluated this request to determine whether the public benefits from the current restrictions in the drug.

The restrictions to the drug formulary were revised in rule as recently as June 12, 2013.

Exclusionary APRN Prescription Formulary Detailed in WV Code and Rule

WVC §30-7-15a (c) lays out restrictions to APRN prescribing authority. APRNs are not allowed to prescribe from Schedules I and II of the Controlled Substances Act (which include opiates and other pain medications) and are limited to a 72 hour supply (no refills) from Schedule III. APRNs are not allowed to prescribe antineoplastics, radiopharmaceuticals, general anesthetics, and MAO inhibitors.[10] MAO inhibitors are used in the treatment of depression and neurological disorders such as Parkinson's disease.

[10] *Except when in a collaborative agreement with a psychiatrist.*

APRNs can prescribe an annual supply of any medication (with the exception of controlled substances) prescribed for the treatment of a chronic condition, other than chronic pain management. A chronic condition is defined as a condition which lasts three months, generally cannot be prevented by vaccines, can be controlled but not cured by medication and does not generally disappear. These conditions, with the exception of chronic pain, include but are not limited to arthritis, asthma, cardiovascular disease, cancer, diabetes, epilepsy and seizures, and obesity.

WVC §30-7-15a (c) requires the Nursing Board to promulgate legislative rules governing the eligibility and extent to which an APRN may prescribe drugs. "*Such rules shall provide… a state formulary classifying those categories of drugs which shall not be prescribed by advanced practice registered nurse(s) ….*" Over the years, the restrictions in the drug formulary for APRNs have been revised. The most current revision was in 2013. This revision followed public meetings held by the Nursing Board. The rule revision received input from the West Virginia Medical Association, the West Virginia Board of Medicine and the West Virginia Board of Pharmacy. APRNs are currently required to have a written collaborative agreement with a physician in order to prescribe. Drugs excluded from APRN prescriptive authority are listed in legislative rule §19-8-5 which can be seen in Appendix B.

The rule revision received input from the West Virginia Medical Association, the West Virginia Board of Medicine and the West Virginia Board of Pharmacy.

Concerns Related to Expanding the Formulary

The Legislative Auditor solicited comments from professional groups and organizations that could be considered stakeholders in the impact of the APRN application to expand the scope of practice. The following entities were contacted: the West Virginia Board of Medicine, the West Virginia Board of Osteopathic Medicine, the West Virginia Board of Pharmacy, the West Virginia Board of Dentistry, the West Virginia Board of Optometry, the West Virginia State Medical Association, the West Virginia Academy of Family Physicians, and the Department of Health and Human Resources Bureau for Public Health. Comments are contained in Appendix C. Physicians and dentists raised differing concerns related to expanding the drug formulary. Summaries of both groups' concerns follow.

- **Prescription medication concerns:** Many physicians' groups questioned the training and education of APRNs to prescribe controlled substances. Most noted that the removal of limitations on Schedule II and III controlled substances could exacerbate the drug diversion problem in West Virginia. The state currently holds the distinction of having the most drug overdose deaths, the

majority of which are from prescription drugs, of any state in the nation.

- **Dental Practice Act concerns:** The West Virginia Board of Dentistry noted that the Dental Practice Act was revised in the 2013 legislative session, and significant modifications were made to the section covering the administration of anesthesia in dental settings. The APRN designation of certified registered nurse anesthetist (CRNA) is impacted in that many dentists employ CRNAs to administer anesthesia in their offices. The Dental Board noted that expansion of prescriptive authority for CRNAs may have unintended consequences. If CRNAs are given an expanded scope to prescribe anesthesia, this could afford an opportunity for dentists to avoid the requirements of the new legislation. The Dental Board suggested that it would be prudent to wait at least a year to evaluate the effects of the modifications to the Dental Practice Act before expanding the prescribing scope of APRNs.

The Dental Board noted that expansion of prescriptive authority for CRNAs may have unintended consequences.

In response to the pharmacology education concerns raised by physician stakeholders, the Legislative Auditor examined the pharmacology coursework requirements and continuing education requirements in state code for practitioner licensure, and prescriptive authority and renewals. They are found in Table 7.

Table 7
West Virginia Healthcare Practitioners
Pharmacology Specific Education Requirements

Practitioner Type	Practitioner Title	Pharmacology Coursework in completing degree(s)	Continuing Education
Physician Practitioners	Allopathic Physician (MD)	Doctoral: (WVU) 7 semester hours (Marshall) 12 semester hours	• Drug Diversion Therapy: 3 hours in previous two year period
	Osteopathic Physician (DO)	Doctoral: (SOM) 9 semester hours	• Drug Diversion Therapy: 3 hours in previous two year period
	Dentist (DDS)	Doctoral: 5 semester hours	• Drug Diversion Therapy: 3 hours in previous two year period
Non-Physician Practitioners	Advanced Practice Registered Nurse (APRN)	Undergraduate: 1 course Graduate: 3 semester hours*	• Initial License: Advanced Pharmacology: 1 semester hour in previous two year period • Renewal License: Pharmacology Minimum 8 contact hours (about half of a semester hour) • Drug Diversion Therapy: 3 hours in previous two year period
	Physician Assistant (PA)	4 semester hours	• Rational Drug Therapy:10 clock hours in previous two year period • Drug Diversion Therapy: 3 hours in previous two year period

Source: West Virginia University School of Medicine Education Requirements, Marshall University School of Medicine, West Virginia School of Osteopathic Medicine, Legislative Rules, National Commission on Certification of Physician Assistants.
**Board of Examiners for Registered Professional Nurses define 15 contact hours as 1 semester hour.*

West Virginia laws and rules governing the practice of physicians and dentists are non-specific as to the number of pharmacology-specific educational hours to be completed as part of their degree work.[11] However, the laws and rules governing the practice of APRNs and PAs stipulate the number of pharmacology-specific educational hours these mid-level, non-physician practitioners must complete as part of their degree work.

[11] *The varying number of pharmacology semester hours offered in different state medical programs do not reflect additional pharmacology information integrated into the physician's clinical training.*

In response to the drug diversion concerns raised, the Legislative Auditor reviewed actions taken by the DEA against West Virginia DEA registration numbers from medical practitioners between CY 2002 and CY 2012. In this period, DEA took actions to suspend or revoke the registration numbers of 10 MDs, and 4 DOs, but no DEA actions were taken against West Virginia APRN or PA registrations. The 16 autonomous practice states report that while there are few complaints against APRNs, they do experience some problems related to pain medication prescribing (involving controlled substances). A total 13 DEA actions have been taken against APRN registration numbers in these states over a 10 year period.

Restrictions in the APRN Drug Formulary Provide Protection for the Public

Additionally, there is an MAO-specific provision in legislative rule for the restricted drug formulary. The requirement is for a collaborative agreement with a psychiatrist in order to prescribe MAO inhibitors. The Legislative Auditor concludes that the requirement of a collaborative agreement with a psychiatrist should remain, despite the recommendation in Finding 1 to relax the collaboration requirement when certain conditions are met. For all other prescribing, such as the annual supply of any drug prescribed for a chronic condition that is not pain management, the limited drug formulary provides a layer of public protection in that it is specific and detailed in regard to medications that are either limited, or not allowed to be prescribed by APRNs. While APRN prescribing practice in West Virginia appears to be safe, given that the state is currently struggling with the multiple problems of drug abuse and prescription drug overdose deaths, this does not appear to be an appropriate time to relax the restrictions of the current drug formulary.

For all other prescribing, such as the annual supply of any drug prescribed for a chronic condition that is not pain management, the limited drug formulary provides a layer of public protection in that it is specific and detailed in regard to medications that are either limited, or not allowed to be prescribed by APRNs.

Conclusion

The restricted prescriptive formulary for APRNs provides a layer of protection to the public if the written collaborative agreement is removed. APRNs are trained to recognize and to treat common health problems, monitor specific chronic conditions, provide preventive care and educate patients. Self-employed APRNs are able to function with the current prescriptive restrictions. When a condition requires medications beyond the APRN's prescriptive authority, the APRN can refer patients to a physician. It is the opinion of the Legislative Auditor that the human and economic costs of prescription drug abuse and addiction in West Virginia are too high. Expanding the number of practitioners able to prescribe Schedule II narcotics is adverse to the public health and interest.

Therefore, the Legislative Auditor concludes that limitations through a restricted drug formulary should remain.

Recommendations

7. *The Legislature should not expand the limited prescriptive authority for Advanced Practice Registered Nurses by removing restrictions in the APRN drug formulary at the present time.*

8. *The Legislature should continue to require collaborative relationships between a psychiatrist and an APRN for the prescription of MAO inhibitors.*

FINDING 4

The Request for the Addition of the Same Signatory Authority as Physicians on All Health Care Documents Is Too Broad and Non-Specific to Be Evaluated by the Legislative Auditor.

Summary

The Legislative Auditor was not able to provide an evaluation on the Applicant's request to provide Advanced Practice Registered Nurses with global signature authority. The proposed legislation would allow APRNs the same signature authority as physicians wherever physicians are required to sign documents. The Applicant did not provide a list of the signature authority documents that APRNs want to be able to sign. Therefore, the Legislative Auditor was not able to provide an analysis of whether to grant global signature authority to Advanced Practice Registered Nurses.

The Applicant makes the request that whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it is important that it also be deemed to include a signature, certification, stamp verification, affidavit or endorsement by a nurse practitioner.

Request for Global Signature Authority

In the application, the Applicant requests an expansion of practice to include the ability to sign documents related to patient care. The Applicant notes that West Virginia law does not consistently support the APRNs ability to sign health related documents, such as death certificates, Do Not Resuscitate Orders, or certain Handicap Supportive Services. The Applicant makes the request that whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it is important that it also be deemed to include a signature, certification, stamp verification, affidavit or endorsement by a nurse practitioner. The Applicant does not provide a specific list of documents for the analysis.

Proposed Change to Existing West Virginia Code

The Applicant proposes the following language be inserted in a new section, §30-7-15d, of state Code.

> *Allowance of APRNs for global signatures on patient care documentations. (a) Whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed equal to include a signature, certification, stamp, verification, affidavit or endorsement by an advanced practice registered nurse.*

Specific Information Not Provided

The Legislative Auditor was asked to provide an analysis of whether the APRNs should be granted global signatory authority for healthcare documents. The Applicant lists three examples, death certificates, Do Not Resuscitate orders and various handicapped accessible documentations. Some states allow APRNs to sign death certificates. In West Virginia, the Office of Vital Statistics in the Bureau for Public Health notes that it would not oppose a change allowing APRNs to have the ability to sign death certificates.

Lacking a detailed list of the specific documents, it is not possible to provide an analysis.

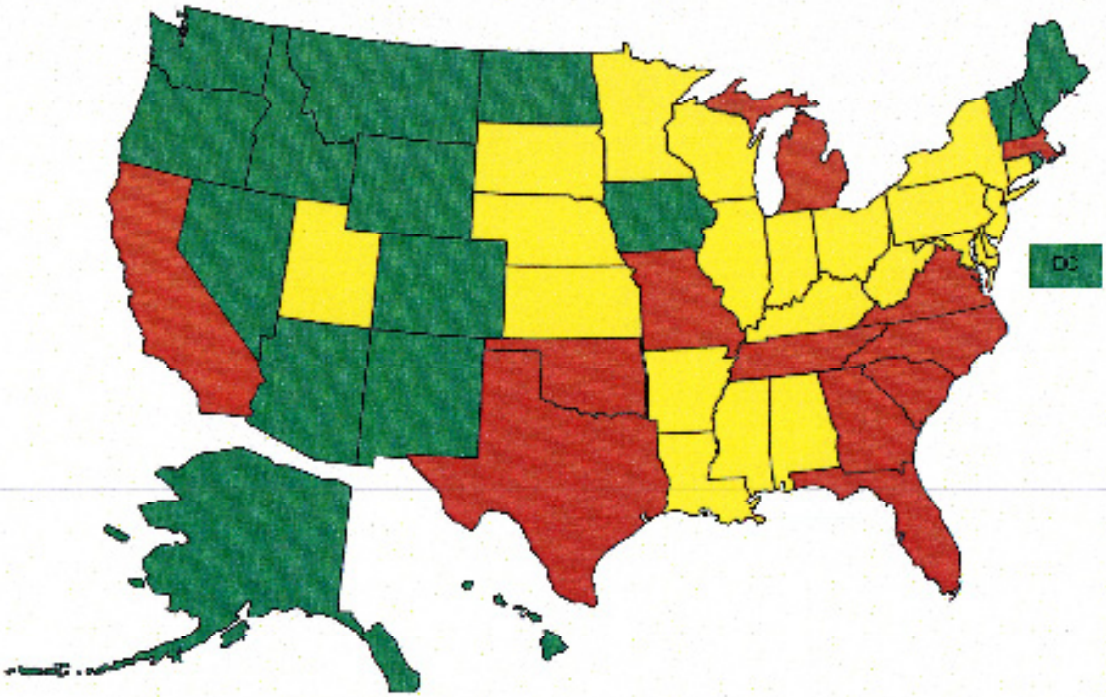
Aside from the three examples given, there was no list attached to the application. Based on the scope of practice authorities for APRNs listed by Barton Associates[12], which shows that West Virginia APRNs can sign some handicapped documents, this request is not only non-specific but also confusing. The Legislative Auditor does not know whether there are three documents, or a much larger number of documents that would be affected by global signatory authority. Lacking a detailed list of the specific documents, it is not possible to provide an analysis. It may be that this request has merit, but the information provided was too limited.

[12] *Barton Associates, an agency supplying temporary physicians, CRNAs and CNPs created an interactive graphic based on The Pearson Report 2012, (an annual report on state laws) to provide information on the varied authorities under different states' APRN scope of practice laws.*

Appendix A
States That Allow APRNs to Practice and Prescribe Independently

AANP American Association of NURSE PRACTITIONERS

2013 Nurse Practitioner State Practice Environment



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure law reduce the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation or team-management by an outside health discipline in order for the NP to provide patient care.

Source: State Nurse State Practice Acts
And Administration Rules, 2012
©American Association of Nurse Practitioners, 2013

Update 8.4.2013

Appendix B
Legislative Rule 19CSR8 - Limited Prescriptive Authority for Nurses in Advanced Practice

19CSR8

TITLE 19
LEGISLATIVE RULE
REGISTERED PROFESSIONAL NURSES

2013 MAY 13 PM 2:09

SERIES 8
LIMITED PRESCRIPTIVE AUTHORITY FOR NURSES IN ADVANCED PRACTICE

§19-8-1. General.

1.1. Scope. — This rule establishes the requirements whereby the board authorizes qualified nurses in advanced practice to prescribe prescription drugs in accordance with the provisions of W. Va. Code §§30-7-15a, 15b, 15c, and 30-15-1 through 7c. An authorized advanced practice registered nurse practitioner may write or sign prescriptions or transmit prescriptions verbally or by other means of communication.

1.2. Authority. -- W. Va. Code §§30-7-15a, and 30-15-7a.

1.3. Filing Date. – May 13, 2013

1.4. Effective Date. – June 12, 2013

§19-8-2. Definitions.

2.1. Advanced Practice Registered Nurse (APRN) means a registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board approved national certification examination.

2.2. "Antineoplastics" means chemotherapeutic agents in the active treatment of current cancer.

2.3. "Certified Nurse-Midwife" means a nurse who has been licensed by the board to practice nurse-midwifery as provided for in W. Va. Code §30-15-1c.

2.4. "Chronic Condition" means a condition which lasts three months or more, generally cannot be prevented by vaccines, can be controlled but not cured by medication, and does not generally disappear. These conditions include anemia, anxiety, arthritis, asthma, bladder outlet obstruction, cardiovascular and pulmonary disease, cancer, diabetes, epilepsy and seizures, thyroid disease, and obesity, and do not include any condition which requires antineoplastics, all subject to the scope of practice of the advanced practice registered nurse with limited prescriptive authority privilege W.Va. Code §30-7-15(a)(b)(c) and this rule.

2.5. "Pharmacology Contact Hour" means a unit of measurement that describes at least 50 minutes of an approved, organized didactic learning experience related to advanced pharmacological therapy."

§19-8-3. Application and Eligibility for Limited Prescriptive Authority.

3.1. The board shall grant prescriptive authority to an advanced practice registered nurse applicant who meets all eligibility requirements specified in W. Va. Code §30-7-15b and the following:

3.1.a. Prior to application to the board for approval for limited prescriptive authority, the applicant shall:

3.1.a.1. Successfully complete an accredited course of instruction in pharmacology during undergraduate study;

3.1.a.2. Successfully complete an advanced pharmacotherapy graduate level course approved by the board of not less than 45 pharmacology contact hours;

3.1.a.3. Provide documentation of the use of pharmacotherapy in clinical practice in the education program;

3.1.a.4. Provide evidence of 15 pharmacology contact hours in advanced pharmacotherapy completed within 2 years prior to application for prescriptive authority;

3.1.a.5. Submit official transcripts or certificates documenting completion of pharmacology and pharmacotherapy course work.

3.1.a.6. The board may request course outlines and/or descriptions of courses if necessary to evaluate the pharmacology course content and objectives.

3.1.b. The advanced practice registered nurse shall submit a notarized application for prescriptive authority on forms provided by the Board with the following:

3.1.b.1. A fee set forth in the board's Fees rule, 19CSR12.

3.1.b.2. Written verification of an agreement to a collaborative relationship with a licensed physician holding an unencumbered West Virginia license for prescriptive practice on forms provided by the board. The applicant shall certify on this form that the collaborative agreement includes the following:

3.1.b.2.A. Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advanced practice registered nurse's clinical practice;

3.1.b.2.B. Statements describing the individual and shared responsibilities of theadvanced practice registered nurse and the physician pursuant to the collaborative agreement between them;

3.1.b.2.C. A provision for the periodic and joint evaluation of the prescriptive practice; and,

3.1.b.2.D. A provision for the periodic and joint review and updating of the written guidelines or protocols.

3.1.b.2.E. Additional documentation at the request of the board.

3.2. If the board obtains information that an applicant for prescriptive authority was previously addicted to or dependent upon alcohol or the use of controlled substances, the board may grant prescriptive authority with any limitations it considers proper. The limitations may include, but are not limited to, restricting the types of schedule drugs a nurse may prescribe.

3.3. The board shall forward a copy of the verification specified in Subdivision 3.1.b.2. of this rule to the Board of Medicine or to the Board of Osteopathy, whichever is indicated.

3.4. Upon satisfactory evidence that the advanced practice registered nurse applicant has met all above requirements for prescriptive authority, the Board shall assign an identification number to that nurse.

3.5. The board shall notify the Board of Medicine, the Board of Osteopathy, and the Board of Pharmacy of those advanced practice registered nurses who have been granted prescriptive authority, and shall also provide the prescriber's identification number and effective date of prescriptive authority.

3.6. The advanced practice registered nurse shall file with the board any restrictions on prescriptive authority that are not imposed by W. Va. Code §60A-3-301 *et seq.*, or this rule, but which are within the written collaborative agreement and the name of the collaborating physician for each advanced practice registered nurse on the approved list.

3.7. The advanced practice registered nurse with prescriptive authority who wishes to prescribe Schedules III through V drugs shall comply with federal Drug Enforcement Agency requirements prior to prescribing controlled substances.

3.8. The advanced practice registered nurse shall immediately file any and all of his or her Drug Enforcement Agency registrations and numbers with the board.

3.9. The board shall maintain a current record of all advanced practice registered nurses with Drug Enforcement Agency registrations and numbers.

3.10. Any information filed with the board under the provisions of this rule shall be available, upon request, to any pharmacist, regulatory agency or board or shall be made available pursuant to other state or federal law.

3.11. The APRN shall maintain with the board a current mailing and, if available, a current e-mail address.

§19-8-4. Renewal of Prescriptive Privileges.

4.1. An applicant for renewal of prescriptive authority shall meet all eligibility requirements as specified in W. Va. Code §30-7-15b for advanced practice registered nurse or W. Va. Code §30-15-7b for certified nurse-midwives.

4.2. The applicant shall maintain an active, uninterrupted national certification as an advanced practice registered nurse.

4.2.a. The licensee is responsible for submitting to the board all documentation evidencing national certification as an advanced practice registered nurse and subsequent, uninterrupted renewal of national certification thereof.

4.2.b. The board shall consider the national certification as an advanced practice registered nurse of a licensee to be lapsed where such licensee fails to renew his or her national certification prior to its expiration dates, or fails to provide to the board, at the office of the board, all proper documentation and evidence of an uninterrupted renewal of such national certification prior to its expiration date.

4.3. The applicant shall complete during the 2 years prior to renewal a minimum of 8 contact hours of pharmacology education that has been approved by the board.

4.4. The board shall renew prescriptive authority for advanced practice registered nurses biennially by June 30, of odd-numbered years.

4.5. The advanced practice registered nurse shall submit an application for renewal of prescriptive authority on forms provided by the board. The application must be notarized, and the fee set forth in the board's rule, Fees For Services Rendered by the board, 19CSR12 must accompany the application.

§19-8-5. Drugs Excluded from Prescriptive Authority.

5.1. The advanced practice registered nurse shall not prescribe from the following categories of drugs:

5.1.a. Schedules I and II of the Uniform Controlled Substances Act;

5.1.b. Antineoplastics;

5.1.c. Radio-pharmaceuticals; or

5.1.d. General anesthetics.

5.1.e. MAO Inhibitors, except when in a collaborative agreement with a psychiatrist.

5.2. Drugs listed under Schedule III and benzodiazepines are limited to a 72 hour supply without refill.

5.3. The advanced practice registered nurse may prescribe drugs from Schedules IV through 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:

5.3.a. Prescriptions for phenothiazines shall be limited to up to a 30 day supply and shall be non- refillable;

5.3.b. Prescriptions for non-controlled substances of antipsychotics, and sedatives prescribed by the advanced practice registered nurse 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.

5.4. Pursuant to a collaborative agreement as set forth in the law governing prescriptive authority the advanced practice registered nurse may prescribe an annual supply of any drug, with the exception of controlled substances, which is prescribed for the treatment of a chronic condition, other than chronic pain management.

5.5. The maximum dosage of any drug, including antidepressants, prescribed by the advanced practice registered nurse shall be consistent with the advanced practice registered nurse's area of practice.

5.6. Each prescription and subsequent refills given by the advanced practice registered nurse shall be entered on the patient's chart.

5.7. Advanced practice registered nurse shall not prescribe other prescription drugs or refill for a period exceeding 6 months; provided, that this limitation shall not include contraceptives or those treating a chronic condition as defined in WV Code §30-7-15a and section 19-8-5.4 of this rule.

5.8. An advanced practice registered nurse may administer local anesthetics.

5.9. The advanced practice registered nurse who has been approved for limited prescriptive authority by the board may sign for, accept, and provide to patients samples of drugs received from a drug company representative.

5.10. The prescription authorized by an advanced practice registered nurse shall comply with all applicable state and federal laws and regulations; must be signed by the prescriber with the legal designation or the designated certification title of the prescriber and must include the prescriber's identification number assigned by the board or the prescriber's national provider identifier assigned by the National Provider System pursuant to 45 CFR §162.408.

5.10.a. All prescriptions shall include the following information:

5.10.a.1. The name, title, address and phone number of the prescribing advanced practice registered nurse;

5.10.a.2. The name and date of birth of the patient;

5.10.a.3. The date of the prescription;

5.10.a.4. The full name of the drug, the dosage, the route of administration and directions, for its use;

5.10.a.5. The number of refills;

5.10.a.6. The Drug Enforcement Agency number of the prescriber, when required by federal laws; and

5.10.a.7. The prescriptive authority identification number issued by the board.

5. 10.b. An advanced practice registered nurse shall at the time of the initial prescription record in the patient record the plan for continued evaluation of the effectiveness of the controlled substances prescribed.

5.10.c. An advanced practice registered nurse shall prescribe refills of controlled substances according to current laws and standards.

5.10.d. Drugs considered to be proved human teratogens shall not be prescribed during a known pregnancy by the advanced practice registered nurse. This prohibition includes all Category D and X drugs from the Federal Drug Administration Categories of teratogen risks (21 CFR 201.57). Category C drugs should be given only if the patient benefit justifies the potential risks to the fetus and only after consultation with the collaborating physician.

5.11. The board may approve a formulary classifying pharmacologic categories of all drugs which may be prescribed by an advanced practice registered nurse with prescriptive authority.

19CSR8

§19-8-6. Termination of Limited Prescriptive Privileges.

6.1. The board may deny or revoke privileges for prescriptive authority if the applicant or licensee has not met conditions set forth in the law or this rule, or if the applicant has violated any part of W. Va. Code §30-7-1 et seq. or §30-15-1 et seq.

6.2. The board shall notify the Board of Pharmacy, the Board of Osteopathy, and the Board of Medicine within 24 hours after the termination of, or a change in, an advanced practice registered nurse's prescriptive authority.

6.3. If the board finds that the public health, safety and welfare requires emergency action and incorporates a finding to that effect into its order, the board shall order summary suspension of the prescriptive authority privilege pending proceedings for other action. The board shall promptly institute and determine further disciplinary action.

6.4. The board shall immediately terminate prescriptive authority of advanced practice registered nurse if disciplinary action has been taken against his or her license to practice registered professional nursing in accordance with W. Va. Code §30-7-11.

6.5. Prescriptive authority for the advanced practice registered nurse terminates immediately if either the license to practice registered professional nursing or the Advanced Practice Registered Nurse license in the State of West Virginia lapses.

6.6. Prescriptive authority is immediately and automatically terminated if national certification as an advanced practice registered nurse lapses or if the advanced practice registered nurse fails to provide the board evidence of current certification or re-certification of national certification before the expiration of the last certification on record with the board.

6.7. If authorization for prescriptive authority is not renewed by the expiration date which appears on the document issued by the board reflecting approval of prescriptive authority, the authority terminates immediately on the expiration date.

6.8. An advanced practice registered nurse shall not prescribe controlled substances for his or her personal use or for the use of members of his or her immediate family.

6.9. An advanced practice registered nurse shall not provide controlled substances or prescription drugs for other than therapeutic purposes.

6.10. An advanced practice registered nurse with prescriptive authority may not delegate the prescribing of drugs to any other person.

6.11. Prescriptive authorization shall be terminated if the advanced practice registered nurse has not filed a current verification of a collaborative agreement with the board. Upon dissolvement of a collaborative agreement, if there is no other current collaborative agreement the advanced practice registered nurse shall cease prescribing immediately, prescribing privileges will be terminated, and the advanced practice registered nurse shall have 30 days to provide the board verification of a current collaborative agreement to reinstate the prescribing privilege, after 30 days a reinstatement application must be completed and submitted for reinstatement of the prescribing privilege.

§19-8-7. Reinstatement of Lapsed or Terminated Limited Prescriptive Privileges

7.1. Any advanced practice registered nurse who allows her or his prescriptive authority to lapse or be terminated by failing to maintain:

7.1.a. An uninterrupted, active license to practice registered professional nursing in the State of West Virginia; or

7.1.b. An uninterrupted, active national certification or re-certification as an advanced practice registered nurse and failing to provide proof of such to the board; or

7.1.c. An uninterrupted, active grant of prescriptive privileges specifically authorized by the board, where such prescriptive authority is subsequently terminated by the board, may have his or her prescriptive authority reinstated by the board on satisfactory explanation for the failure of the licensee to retain an uninterrupted, active license to practice registered professional nursing in the State of West Virginia, an uninterrupted, active national certification as an advanced practice registered nurse, or an uninterrupted, active grant of prescriptive privileges specifically authorized by the board, and upon submission of an application for prescriptive authority, including an application fee.

Appendix C
West Virginia Stakeholder Comments

State of West Virginia
Board of Medicine

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October 25, 2013

Via Hand Delivery
Michael Midkiff, Audit Manager
West Virginia Legislature
Office of the Legislative Auditor
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610

Re: Response of the West Virginia Board of Medicine to the Sunrise Application Filed on Behalf of Advanced Practice Registered Nurses (APRNs)

Dear Mr. Midkiff:

In response to your September 30, 2013, correspondence inviting comments upon the Sunrise application for the expansion of the scope of practice of Advanced Practice Registered Nurses (APRNs), please accept the following response on behalf of the West Virginia Board of Medicine. On October 15, 2013, at a special meeting of the Legislative Committee, the Board, after a careful review of the Sunrise application submitted by the American Association of Nurse Practitioners, unanimously opposed the expanded scope of practice proposed for APRNs, and encourages the Performance Evaluation and Research Division of the West Virginia Office of the Legislative Auditor to conclude that the proposed change in the scope of practice is neither necessary nor appropriate at this time. A detailed explanation of the Board's position is provided herein below.

The West Virginia Legislature has tasked the West Virginia Board of Medicine with responsibility for protecting the public interest by ensuring "a professional environment that encourages the delivery of quality medical services within this state." W. Va. Code §30-3-2. In accord with this public policy goal, the Board licenses and regulates medical doctors, podiatrists and allopathic physician assistants. The Board also protects the public interest by acting as the disciplinary body for its licensees. Currently, six thousand nine hundred and two physicians and podiatrists hold licenses issued by the WVBOM to practice medicine and surgery in West

Virginia. Seven hundred and fifty-five physician assistants are licensed by this Board to provide health care services in West Virginia as part of physician-led health care teams. Additionally, as of September 20, 2013, seven hundred and seventy-one APRNs[1] have current collaborative agreements (which include limited prescriptive authority) with one or more licensees of this Board.[2]

The delivery of quality health care services to the citizens of West Virginia requires the robust participation of not only physicians, but of all health care practitioners. Practitioners of all levels should be permitted to contribute at a level which is commensurate with the practitioner's level of education and training as part of a physician-led team approach to the delivery of health care services. The importance of a team approach, which maximizes the role of all team members, is central to the patient-centered medical home (PCMH) model of health care, a growing model for the delivery of health care services across the country and in West Virginia.[3] West Virginia has embraced the patient-centered medical home model, and has acknowledged that, at the heart of this multidisciplinary approach is "an ongoing relationship with a personal physician...." who leads "a team of health care providers who take responsibility for the care of the patient or for arranging care with other qualified professionals." W. Va. Code §16-29H-9. As this model begins to be implemented, fewer physicians are entering or remaining in independent practice as the costs and complexity associated with independent practice is increasingly prohibitive and is not conducive to the unfolding team based system of health care.

Like Physician Assistants and other non-physician providers, Advanced Practice Registered Nurses play an important role in West Virginia's health care system. However, as noted in previous years when APRNs attempted to expand their scope of practice, APRNs are not physicians, and they cannot substitute for physicians.

The education and training of physicians is substantially more involved and complex than the training and education of APRNs. For example, the education and training required to become a family physician includes approximately 21,700 hours of training, clinical experience and education over roughly an eleven year period. By contrast it takes 5,350 hours of training, clinical experience and education over five and a half to seven years to complete training as a nurse practitioner.[4]

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[1] There are four general categories of APRNs: Certified Registered Nurse Practitioners (NPs); Certified Nurse Midwives (CNMs); Certified Registered Nurse Anesthetists (CRNAs); and Clinical Nurse Specialists (CNSs). The aggregate information provided to the Board by the West Virginia Board of Examiners for Registered Professional Nurses does not delineate the APRNs with collaborative agreements by category or type of practice much like the Sunrise application fails to delineate the proposed expansion in scope of practice on a category by category basis.
[2] This number does not include APRNs who have entered into collaborative agreements with osteopathic physicians.
[3] See generally *Primary Care for the 21st Century Ensuring a Quality, Physician-led Team for Every Patient*, American Academy of Family Physicians (2012). A copy of this article is attached hereto as Attachment A.
[4] *Primary Care for the 21st Century Ensuring a Quality, Physician-led Team for Every Patient*, American Academy of Family Physicians, (2012), provided as Attachment A, at pp. 9-11.

Regardless of the nature of their practice or category of practice, APRNs, like Physician Assistants, play a vital role in the delivery of health care in this state and are integral to a team approach.[5] That role, however, is not the role of a physician. While the APRNs application makes reference to an expanded scope of practice that "overlaps" with other professions, the expansion of the scope of practice sought on behalf of APRNs is tantamount to permitting APRNs to practice as physicians without the necessary training, education and experience required for licensure as a physician in this state.

The scope of practice currently in place in West Virginia for APRNs is appropriate. It is consistent with the requisite level of education and training, and acknowledges the important role APRNs play as mid-level health care practitioners in West Virginia.

Collaborative Agreements and Related Limitations on Prescriptive Authority are Integral to the Appropriate Scope of Practice for APRNs.

The Board understands the value of collaborative relationships between physicians and APRNs, and has worked diligently to develop clear and appropriate guidelines to foster the development of such collaborative relationships between APRNs and physicians in this state.[6] To wit, in March 2012, the Board developed a Position Statement to provide guidance to physicians seeking to enter into collaborative agreements with APRNs.[7]

When a physician enters into a collaborative agreement with an APRN, or any other supervisory agreement with a health care practitioner, the physician has an obligation to meet the standard of care in conjunction with such agreement. To assist physicians in understanding the standard of care and diligence required, the Board's Position Statement has incorporated the minimum requirements for collaborative agreements as stipulated in the legislative rule of the West Virginia Board of Examiners for Registered Professional Nurses. These guidelines are not onerous. Nor do they diminish the ability of APRNs to operate autonomously within the parameters of the collaborative agreement.

[5] Physician Assistants are mid-level practitioners who receive rigorous education and training from accredited programs and national certification. Physician assistants are trained and educated in a manner which is pedagogically similar to the training of physicians to develop similar practice-based reasoning. By design, physician assistants and physicians work together as a physician-led team. Physician supervision is inherent in the physician assistant concept. As part of a physician-led team, physician assistants use autonomous decision-making to perform delegated tasks. For detailed information about Physician Assistant practice, see the website of the American Academy of Physician Assistants located at http://www.aapa.org/the_pa_profession/what_is_a_pa.aspx (accessed on October 23, 2013).

[6] Collaborative agreements are required for an APRN to obtain limited prescriptive writing privileges.

[7] A copy of this Position Statement is provided with this letter as Attachment B. Contrary to the assertion of the APRN Sunrise application, the Board's Position Statement provides clear and helpful guidelines to assist in forming collaborative agreements. Such guidelines are only "burdensome" to practitioners who are not invested in utilizing the collaborative agreement for a true and thoughtful collaboration between physicians and APRNs.

The guidelines call for all collaborative agreements to include: (1) mutually agreed upon written guidelines or protocols for prescriptive authority; (2) statements describing the individual and shared responsibilities of the APRN and physician pursuant to the collaborative agreement; (3) periodic and joint evaluation of prescriptive practice; and (4) periodic review and updating of the prescriptive guidelines and protocols established in the collaborative agreement. See Attachment B. These minimum requirements are *identical* to the requirements set forth by the legislative rule of the West Virginia Board of Examiners for Registered Professional Nurses which establishes the requirements for limited prescriptive authority by APRNs. *Compare* Attachment B *with* W. Va. Code R. §19-8-3.1.2.b (2013).[8] The remaining guidelines are provided to assist physicians in crafting and implementing agreements which are in keeping with the appropriate scope of practice.

APRNs are currently authorized to prescribe within the appropriate scope of practice for a mid-level practitioner in this state. In terms of categories of drugs which may be prescribed, the limited prescriptive authority available to APRNs is consistent with the prescriptive authority available to other mid-level practitioners, such as physician assistants. Physician assistants, who are required to complete a rigorous educational course, achieve national certification[9] and complete a CME course in best practice prescribing, are also eligible to receive limited prescriptive writing authority. In order to obtain prescriptive writing privileges, a physician assistant must file an application with a compliant formulary approved by his or her supervising physician. This is not a formality; the Board has imposed discipline upon physician assistants and their supervisors, when prescribing occurs by physician assistants who have not properly obtained prescriptive privileges from the Board.

Like APRNs, physician assistants are prohibited from writing prescriptions for schedule II controlled substances, and may only write a 72 hour supply for schedule III controlled substances. As part of a physician-led team approach, these limitations are appropriate, and permit mid-level practitioners to provide immediate assistance to patients who either have an acute need for a schedule III for a short duration or who need evaluated by a physician for the possible prescribing of a more highly controlled medication or a schedule III for a longer duration. Moreover, the current limitations clearly permit mid-level practitioners the ability to prescribe an annual supply of medications to treat many chronic conditions other than pain. Such authority is consistent with the patient-centered medical home model, and best utilizes the education and training of mid-level practitioners, including APRNs.

[8] The West Virginia Legislature authorized W. Va. Code R. §19-8-1 (2013) last session.

[9] Unlike physicians and physician assistants, APRN schools do not have a national accreditation body that monitors advanced nursing profession schools or establishes national standards for clinical training. *See Education Gaps between Family Physicians and Licensed Nurse Practitioners,* Annals of Family Medicine May/June 2012. A copy of this article is provided as Attachment C.

The majority of states, roughly two-thirds including Maryland, Kentucky, Ohio, Pennsylvania and Virginia, require some collaborative arrangement or agreement between APRNs and physicians for prescriptive authority.[10] The current scope of practice in West Virginia is consistent with the national majority, the surrounding states, and is appropriate for APRN practice in this state.

Expanding the Class of Practitioners With Authority to Prescribe Narcotics and Other Controlled Substances Without Restriction Is Contrary to the Public Interest and May Jeopardize the Health, Safety and Welfare of the Public in Light of the Current Prescription Drug Abuse Epidemic

It is undisputed that West Virginia is experiencing a prescription drug abuse epidemic. Prescription drug abuse has harmful societal and economic costs. A report issued earlier this month by the Trust for America's Health entitled *Prescription Drug Abuse: Strategies to Stop the Epidemic 2013*, identified West Virginia as having the highest number of drug overdose deaths of any state in the country, at 28.9 per every 100,000 people.[11] In contrast, this report also acknowledged that West Virginia has implemented eight out of the ten key indicators of legislative action to combat prescription drug abuse and related overdose deaths. Despite meeting eight out of ten indicators, West Virginia still experienced the highest number of overdose deaths.

The West Virginia Board of Medicine has not sought an expansion of the prescriptive authority for the mid-level practitioners it licenses and regulates. This is, in part, because of the vast difference in education and training between physicians and non-physician practitioners. Please keep in mind that a physician, after four years of medical school, does not have prescriptive authority until they are in a supervised post graduate residency program. Even then, the physician is prescribing in the course of his or her residency program. To obtain a DEA number to prescribe outside of residency practice, a physician must be licensed to practice medicine in at least one state.

The Board has grave concerns that an unfettered expansion of prescribing privileges will exacerbate the proliferation of prescription drug abuse in this state. It is clear that even with the training, education and experience physicians bring to the diagnosis and treatment of medical conditions, which include the treatment of pain, a real problem exists with the abuse and misuse of prescription medications. At this time, it would be irresponsible to expand the prescribing ability to non-physician practitioners with less training, education and experience and no physician oversight.

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[10] Some states treat the scope of practice differently for different categories of APRNs. For example, as noted in the Sunrise application, CRNAs are not eligible for prescriptive authority in Maryland, Ohio and Pennsylvania. The current Sunrise application makes no such distinction in its requests.

[11] *Prescription Drug Abuse: Strategies to Stop the Epidemic* (October 2013) at p. 6. A copy is provided as Attachment D.

A licensing board is responsible for the licensing, regulation and discipline of its licensees. A current basis for the discipline of physicians and physician assistant is inappropriate prescribing of controlled substances. In the current climate of prescription drug abuse, prosecuting these claims effectively is extremely important to preserve the public health. Unlike many other disciplinary causes of action, such as diversion of narcotics from an automated prescription system or prescribing without authority, the investigation and prosecution of improper prescribing cases can be very challenging. The investigation requires the development of patient records, prescribing histories and related information to determine if the prescribing practice falls within or without the standard of care. Almost uniformly, an expert medical opinion must be obtained evaluating the evidence developed by the investigation. If the scope of practice for APRNs is expanded, the responsible licensing board will have to handle such investigations and disciplinary prosecutions. Some concern exists regarding the preparedness and ability to do so effectively.[12]

APRNs are not Physicians; Global Signature Authority Cannot Be Equated to That of a Physician.

There are many ramifications in the medical and legal sphere regarding signature authority, and again training and education cannot be ignored or minimized. Signature authority on documentation such as deaths certificates has legal as well as medical ramifications which are stipulated in various areas of the West Virginia Code. To implement a blanket directive permitting mid-level professionals the authority to sign any document a physician is authorized to sign not only an oversimplification of the issue, but also fails to take into consideration that there may be specific reasons why certain documents may only be signed by physicians. Such a request is clearly self-serving and not in the best interests of the public.

[12] On at least one occasion in recent years, the West Virginia Board of Medicine referred a matter to the West Virginia Board of Examiners of Registered Professional Nurses for potential disciplinary action involving APRNs who had collaborative agreements with a physician, Augusto T. Abad, M.D., who pled guilty in the United States District Court for the Southern District of West Virginia to conspiracy to misuse his DEA number to distribute a controlled substance and aiding and abetting health care fraud. The Board revoked the physician's license to practice medicine and surgery in West Virginia on September 25, 2010. The Board further disciplined a physician assistant licensed by this Board for misconduct related to the use of Dr. Abad's DEA number. In the court documents in that case, unidentified APRNs employed at the Justice Medical Clinic were implicated in prescribing outside the scope of their authority with the use of the physician's DEA number. A copy of the Board's referral and attachments are on file with the West Virginia Board of Medicine and are available upon request. It is the information of the Board that no disciplinary action occurred to any of the APRNs involved. The website for the West Virginia Board of Examiners for Registered Professional Nurses includes a link to its Disciplinary Reports. These reports are aggregate summaries, and do not appear to include any information which would permit the viewer to discern whether discipline was imposed upon an RN or an APRN. See http://www.wvrnboard.com/default2.asp?active_page_id=83 (accessed on October 23, 2013).

An Expanded Scope of Practice for APRNs is Not the Answer to the Primary Care Dilemma in West Virginia

Much has been made of this primary care dilemma for decades in West Virginia and nationally. The first clear delineation of this issue can be found in a 1975 study brought forth by the West Virginia Joint Committee on Government and Finance.[13] The study defines the health care issue regarding the underserved rural areas of our state. Despite the advent of mid-level professions such as Physician Assistants and APRNs since that time, under populated rural areas of the state remain underserved. More recent studies by the American Medical Association[14] and the Agency for Healthcare Research and Quality[15] have shown distribution of such mid-level professions mirror that of physicians with concentrations noted in urban areas of our state and nationally. Also note that mid-level professions have begun to specialize in their practice in line with current physician specialties. To permit the independent practice of APRNs allows not only primary care APRNs independent practice, but other select specialties of APRNs as well.

After decades of striving for solutions to resolve the issue of underserved areas, it is obvious that no one segment of the health care profession holds the answer. Rather physician-led teams provide a stronger argument for well-rounded quality health care.

Recently, California has been facing legislative changes to the scope of practice for APRNs. During that process, the California Medical Association aptly noted that "[a] patient's care should begin with a primary care physician, who can most ably advise a patient on what care he or she needs. Simply expanding the scope of practice of practitioners, without expanding training or education, can mean lowering the standard of care for patients. It is imperative that the drive for "access" docs not translate into a second tier of health care, one that offers convenience and lower cost in exchange for poorer quality and reduced patient safety. All Californians deserve a health care system that protects their safety and standard of care."[16] Likewise, West Virginians deserve a health care system that protects their safety and standard of care and supports a patient centered, physician-led multidisciplinary approach to the delivery of quality health care.

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[13] West Virginia Legislature Joint Committee on Government and Finance, Subcommittee on Family Physicians, *Final Report, Assessment of West Virginia's Physician Needs and Determination of How to Meet Them,* (August 1975). A copy of this Final Report is provided as Attachment E.

[14] Chart: West Virginia Primary Care Physician to Advanced Practice Registered Nurse Distribution Comparison (based upon data from American Medical Association, American Osteopathic Association and the West Virginia Board of Examiners for Registered Professional Nurses) (2008). A copy of this chart is provided as Attachment F.

[15] *Primary Care Workforce Facts and Stats No. 3,* Agency for Healthcare Research and Quality (AHRQ Pub. No. 12-P001-4-EF) (January 2012) A copy is attached hereto as Attachment G.

[16] *CMA's Top Issues*, California Medical Association located at http://www.cmanet.org/issues-and-advocacy/cmas-top-issues (accessed on October 23, 2013). California Senate Bill 491, which sought to expand the scope of independent practice by NPs failed to advance in the California Legislature this September. *See* http://leginfo.legislature.ca.gov/faces/billVersionsCompareClient.xhtml (accessed on October 22, 2013).

This is not the first bid by APRNs to expand their scope of practice to that of a physician without matching the training and education of a physician. It has been an ongoing effort over the years. The Board of Medicine however, is pleased to see some effort to improve and clarify the statutory language relating to APRNs and has urged for such updating of language in past years. The Board would also suggest improvements in the collaborative agreement which deserves the same level of scrutiny and clarification that the statute has been given.

The Board of Medicine is also pleased to see the national educational standards for physician assistants and APRNs have risen in response to advances in medicine and health care. This however does not bring them to the level of education or training as that of a physician and should never be construed as such. Aside from the obvious difference in the amount of time in training, physicians are trained extensively in the practice of medicine: the field of applied science related to the art of healing by diagnosis, treatment, and prevention of disease encompassing a variety of health care practices to maintain and restore health by the prevention and treatment of illness in human beings which applies health science, biomedical research, and medical technology to diagnose and treat injury and disease, typically through medication or surgery. In contrast, APRNs are nurses, trained for the most part by other nurses, for the advanced practice of nursing, not medicine.

It is the position of the Board of Medicine that the dissolution of the collaborative agreement, the deletions of prescriptive authority restrictions and the broadening of signatory authority not be permitted. Further, the Board of Medicine is of the opinion that if the practice of medicine, and not nursing, is the goal of APRNs, they should fall under the regulation of the Board of Medicine as do the other primary health care professions of physicians, physician assistants and podiatrists.

On behalf of the West Virginia Board of Medicine, thank you for the opportunity to respond to this Sunrise application.

On Behalf of the Committee,

Robert C. Knittle
Executive Director

Attachments

STATE OF WEST VIRGINIA
BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street, Suite 402
Charleston, WV 25301

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November 8, 2013

Via Hand Delivery
Michael Midkiff, Audit Manager
Office of the Legislative Auditor
Performance Evaluation and Research Division
1900 Kanawha Boulevard, East
Building 1, Room W-134
Charleston, WV 25305-0610

RE: Response of the West Virginia Board of Osteopathic Medicine to the Application of Advance Practice Registered Nurses Change in Scope of Practice

Dear Mr. Midkiff:

Let me begin by thanking your office for allowing the West Virginia Board of Osteopathic Medicine additional time in responding to the Sunrise Application filed by the Advance Practice Registered Nurses. Our Board met on Friday, November 1, 2013, and reviewed the application as submitted.

The West Virginia Board of Osteopathic Medicine is in opposition to expanding the scope of practice of Advance Practice Registered Nurses and provide the following concerns:

1) As outlined in the Legislative Rule for Registered Professional Nurses, §19-8-3.3, the West Virginia Board of Registered Professional Nurses agree to provide a copy of the written collaborative agreement between a registered professional nurse and the osteopathic physician. To date, our Board has never received copies of any collaborative agreements and have no documentation of which osteopathic physicians are currently in such an agreement with an Advance Practice Registered Nurse;

2) At a time when the Governor and the State Legislature have passed legislation, (Senate Bill 437) to address the issue of prescription drug abuse in our state, to expand the number of practitioners with authority to prescribe controlled substances without supervision or oversight seems to be contrary to the licensing boards interest in protecting the public. Physicians who have received four years of medical school education are not given prescriptive authority until later in training.

3) When using the same West Virginia map in the PERD Application submitted by the Advance Practice Registered Nurses, (Appendix B) the percentage of Osteopathic Physicians serving these "underserved" areas equals 82%. The APRN application states that 18% of all APRN's practice in rural areas.

The West Virginia Board of Osteopathic Medicine understands that medicine is changing and that the team approach is the new and needed way of practicing medicine. We believe the word, "team" means just that. We need to work together as partners in providing access to healthcare. Efforts made in the improvement of educational standards for all mid-level practitioners are applauded, but they still do not equal the training of a physician. Just because a citizen lives in a rural part of West Virginia should not preclude them from receiving the best care. Technology is making great strides in that arena but, again, we must be sure the rights of the patient are protected and secure.

Thank you, again, for the opportunity to respond to this application.

Sincerely,

Ernest Miller, Jr., D.O.
President

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October 17, 2013

Mr. Michael Midkiff
Audit Manager
West Virginia Legislature
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, WV 25305-0610

Re: Sunrise Application for the expansion of scope of practice of Advanced Practice Registered Nurses (APRNs)

Dear Mr. Midkiff:

As the WV Board of Dentistry's licensees presently have responsibilities regarding APRN supervision, the Board wishes to make the following comments:

The Board of Dentistry regulates anesthesia in dental facilities under authority of WV Code §30-4A. This primary function of this statute and proposed/emergency rule 5CSR12 is protection of the public. Dentists who administer anesthesia to the public are required to have extensive training and experience in delivering anesthesia safely, their facilities are required to have proper equipment and emergency medications available, and the training of qualified monitors is specified as well. There are three levels of anesthesia permits issued by the Board, but it also regulates the use of nitrous oxide and anxiolytic drugs without a permit.

Those dentists who employ certified registered nurse anesthetists (CRNAs) to perform anesthesia in their offices must by law have a permit equivalent to the level of anesthesia being performed and must supervise the CRNA. For example, if a dentist possesses a conscious sedation permit (Class 3), the CRNA may only sedate the patient to that level,

even though the CRNA will probably have been trained in general anesthesia. The Board's concern is that with removal of supervision and subsequent elimination of permit status, dentists with a Class 2 permit, which requires only 6 hours of continuing education to acquire, could have general anesthesia services provided in their office.

It should be noted that in the past legislative session, the Dental Practice Act was completely rewritten with the most significant modifications in the area of administration of anesthesia in dental settings. The amendments to that area of the code were noted by the West Virginia Dental Association to put our statute in the top one-third of states in terms of regulation aimed at safeguarding the public through best and safe practices mandated when anesthesia is administered. In fact, other health care providers who administer anesthesia are using our law as a template or basis for modification to strengthen their statutes. The passage of the revised Dental Practice Act was a collective agreement between the Board of Dentistry, the West Virginia Dental Association, and the West Virginia Dental Hygiene Association.

The new proposal may be premature in that many of the recently enacted reforms have yet to have much of an opportunity to fit into practice and be evaluated as they should. The Board of Dentistry is progressive and embraces its role as protector of the public. It does not now nor has it in the past acted as a protector of the practitioner. The Board's primary objective is to protect the public and that is its guiding star. Having said that, it is our position that while the nurse practitioner proposal may have merit, it should be closely examined and with particular reference to the dental arena, waiting a year to evaluate the effects of the sweeping modifications of the Dental Practice Act would be a more prudent course of action.

Very truly yours,

Richard D. Smith, DDS

RICHARD D. SMITH, DDS
Executive Secretary

RDS/smc

WEST VIRGINIA BOARD OF OPTOMETRY
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October 22, 2013

Mr. Michael Midkiff, Audit Manager
West Virginia Legislature
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard E
Charleston, WV 25305-0610

Dear Mr. Midkiff:

The West Virginia Board of Optometry appreciates the opportunity to comment on the sunrise application filed regarding advanced practice nurses to eliminate the collaborative physician agreement, removing restrictions on their prescriptive authority and allowing advanced practice nurses to sign documents such as death certificates subject to regulation by the West Virginia Board of Examiners for Registered Professional Nurses and the Legislature. The Board agrees with two points asserted by the application. There is a shortage of primary health care in rural areas of West Virginia, and healthcare is evolving in this country. Each profession should be allowed to practice to the full extent of its education and training.

As health and medical knowledge advances there are professions who have expanded the training of their licensees. The Board supports the idea that trained and tested persons should practice to the full extent of their training in order to improve health care for West Virginia's citizens. As the application states, "Because health care is an evolving, dynamic system, changes in regulated scope of practice are inherent in health care delivery."

Each governing board that has been created by the Legislature is filled with individuals who have the specialized expertise to evaluate training in their particular field and to establish requirements for licenses, certificates and permits for review and action by the Legislature. Each Board has a unique perspective on the practice of each profession as it honors its oath to protect the public.

Thank you for the opportunity to comment on this application.

Sincerely,

James Campbell, O.D.
Board President

MISSION STATEMENT

To ensure that all applicants for licensure and all Doctors of Optometry currently licensed, practice their profession in a manner that benefits and protects the public, and to ensure that the highest quality optometric eye and vision care is provided in a professional, competent, and ethical manner.

West Virginia State Medical Association
PO Box 4106 • Charleston, WV 25364

West Virginia Academy of Family Physicians
2632 Main Street • Hurricane, WV 25526

West Virginia Chapter of the American College of Physicians
190 N Independence Mall West • Philadelphia, PA 19106-1572

October 24, 2013

Performance Evaluation & Research Division
State Capitol Complex
Building 1, Room 314W
Charleston, West Virginia 25305

Response to the APRN Sunrise PERD Application

The West Virginia State Medical Association (WVSMA), the West Virginia Academy of Family Physicians (WVAFP), and the WV Chapter of the American College of Physicians (ACP) strongly oppose the APRN request for increased scope of practice because doing so could compromise the health and safety of West Virginians. Current WV Code, which requires collaborative agreements between licensed physicians and APRNs, is a necessary protection for the public since APRN education programs are not standardized and provide far less clinical training compared to medical school programs. Further, the APRNs' request to prescribe all controlled substances without any reasonable limitations could have the disastrous effect of aggravating West Virginia's prescription drug abuse problem, already the worst in the nation. In addition, the request to allow APRNs to have "global signature" authority raises red flags since the scope of this policy change would be far-reaching.

Although a small minority of states have removed the statutory protections of collaborative agreement requirements, there is no data to show that this has led to increased access to care in those states. Thirty-four other states, including all of our surrounding states, require collaborative agreements. Collaborative agreements provide important safeguards for public health and safety, especially in regard to rules that call for reasonable limits on APRNs' prescriptive authority for potentially dangerous controlled substances. The WV law on APRN scope of practice has been recently updated and already allows APRNs to prescribe many medications and to practice independently in any locations they choose. Removing the collaborative agreement requirement would not affect APRNs' ability to practice in rural areas, it would only remove a practical method of oversight that enhances patient safety. The APRNs have cited a number of research studies that purport to show that APRNs offer the same quality of care as physicians, but these studies are riddled with methodological problems and other shortcomings, and many show that APRNs have skills that are different than

those of physicians (although complementary). Further, APRNs can be reimbursed at levels up to 100% of doctors' fees for the same services, and studies show that APRNs tend to order more tests and use more services than do physicians, so they do not achieve cost savings. The WVSMA and the WVAFP believe that a team approach, incorporating the strengths of the professions of medicine and nursing, leads to the best quality of medical care, and research supports this theory.

The APRNs' request for "global signature" authority also causes the medical community grave concern. The APRNs are requesting carte blanche permission to sign any documents currently required by law to be signed by physicians. This is a patient safety issue. The Legislature has made careful decisions in many sections of the WV Code to require physicians' judgment for such important documents as medical orders, forensic medical determinations, competency declarations, disability evaluations, end-of-life documents, death certificates, and more. No documentation of medical need was provided in the APRN "Sunrise Application." Any statutory change to allow "global signature" authority for APRNs should not be approved until a special legislative interim study can be conducted to assess any medical need and potential effects on public safety.

The following report outlines ten reasons for opposing APRN scope of practice expansion, with substantiation for the ten reasons on the following pages.

Reginald J. McClung, MD

President, West Virginia State Medical Association

John A. Parker, Jr., MD

President, West Virginia Academy of Family Physicians

Karen E. Clark, MD, FACP

Governor, West Virginia Chapter of the American College of Physicians

Reasons to Oppose APRN Scope of Practice Expansion

1. West Virginia has the highest rate of death by overdose of prescription drugs, and granting APRNs prescriptive authority for Schedule II controlled substances could exacerbate this problem.
2. While WV APRNs are requesting the unfettered right to autonomously prescribe all classes of controlled substances, all of our surrounding states (KY, MD, OH, PA, VA) require collaborative agreements with physicians, as well as imposing other limitations on APRNs' prescriptive authority.
3. Physicians' training is substantially different than that of APRNs. It is far more rigorous, lengthy, and standardized. In contrast, APRN programs vary widely and can be completed in as little as 18 months through online courses. APRN training is not equivalent to medical school, but it does provide complementary skills, which are best utilized through collaborative arrangements between APRNs and physicians.
4. Nurses have authored a glut of research studies on quality of care of APRNs, but most of the studies suffer from a variety of shortcomings and limitations. Many studies indicate that APRNs have different strengths than physicians, suggesting that the best model for care is a collaborative team approach.
5. Increasing APRNs' scope of practice is unlikely to increase access to primary care in rural areas. APRNs are much more likely to practice in urban settings in West Virginia, even though collaborative agreements do not limit them from rural areas. Further, increased scope of practice has *not* led to increased access to care in other states.
6. Not only are APRNs unlikely to provide cost savings, they can increase costs of care. They can bill Medicaid for their services at 100% of the physician rates and Medicare at 85% (100% if "incident to" physician services). Further, research studies show that nurse practitioners are less productive, and tend to order more exams and utilize more resources compared to physicians, leading to increased costs of care when working independently.
7. Research shows that patients have a clear preference for physician-led health-care services, and the WV Legislature has already addressed this issue.
8. Current WV Code specifies recently updated, reasonable rules for collaborative agreements between physicians and APRNs that provide important protections for health care consumers in the state.
9. Proposed changes to the law are broad and potentially could have far-reaching unintended consequences.
10. Research shows that the best and most cost-effective medical care occurs when physicians and nurses work together to provide a team approach, balancing the strengths of each profession. Virginia has recently enacted a new law, drafted by nurse and physician groups working in conjunction, which stipulates requirements for patient care teams. Virginia's new law calls for collaboration, just as current West Virginia law already requires.

1. *West Virginia has the highest rate of death by overdose of prescription drugs, and granting APRNs prescriptive authority for Schedule II controlled substances could exacerbate this problem.*

West Virginia has a serious prescription drug abuse problem. Expanding APRNs' prescriptive authority and removing the statutory requirement for collaborative agreements, which provides an important level of oversight, could make the problem much worse.

A report just released by the Trust for America's Health states that West Virginia has the highest drug overdose mortality rate in the country, with 28.9 deaths per 100,000 people, a 605% increase since 1999. One of the authors' key recommendations is, "Ensure responsible prescribing practices, including increasing education of healthcare providers and prescribers."[1] Physicians have far more extensive education than do APRNs, and expanding prescriptive authority for dangerous substances to a less educated group is a step in the wrong direction.

According to the CDC, some of the people most vulnerable to prescription drug overdose are those who obtain multiple prescriptions from multiple providers ("doctor shopping"). Other high-risk groups include low-income people and those living in rural areas. Increasing the number of less-trained providers increases the potential risk of prescription drug abuse, particularly in a state such as West Virginia.[2] Further, an FDA advisory panel in January recommended reclassifying hydrocodone as a Schedule II drug, with the understanding that, in most states, the reclassification would effectively limit prescriptive authority for the drug to physicians, in an effort to help control the drug diversion problem.[3]

A recent WV Supreme Court of Appeals case demonstrates the potential problem with relying on the WV Board of Examiners for Registered Professional Nurses (RN Board) for oversight, and thus the need to maintain the current system of collaborative agreements. In *State ex rel. Fillinger v. Rhodes* (2013), the Court chastised the RN Board for failing to conduct disciplinary hearings for a nurse accused twice of unlawfully obtaining prescription narcotics for personal use and distribution. The nurse had been fired for that reason from CAMC in 2008 and Logan Regional Medical Center in 2009. Both medical centers filed complaints with the RN Board, but it never conducted a hearing on either complaint. Since the RN Board denied the nurse due process, the Court had to dismiss the case, and the nurse's license was not suspended. Justice Benjamin called the RN Board's failure to act "excessively vexatious conduct," and Justice Loughry called it "unconscionable."[4]

The exorbitant rate of death by overdose in West Virginia should lead to more protective laws to limit the overuse of prescription medications in an effort to curtail the problem. The APRNs' proposal to increase their prescriptive authority to include Schedule II drugs would make our laws less protective. The proposed law would allow less educated providers to prescribe potentially dangerous controlled drugs, increasing the opportunity for abuse. Further, removing the collaborative agreement rule would leave oversight of nurses' prescribing practices to the RN Board, which has been shown to be unreliable and ineffective for this purpose.

2. *While WV APRNs are requesting the unfettered right to autonomously prescribe all classes of controlled substances, all of our surrounding states (KY, MD, OH, PA, VA) require collaborative agreements with physicians and impose other limitations on APRNs' prescriptive authority.*

Kentucky:
KRS 314.042 requires that an APRN must enter into a collaborative agreement with a physician, defining the scope of prescriptive authority for nonscheduled legend drugs, and a separate collaborative agreement with a physician for controlled substances, before prescribing such substances, and also obtain DEA registration.

KRS 314.011 provides additional limitations on APRNs' prescriptive authority, including that they can only prescribe Schedule II substances in a 72-hour supply, without refill; Schedule III for 30 days without refill, and Schedule IV and V substances to the original prescription plus refills not to exceed a 6-month supply.

Maryland:
Ch. 77 8-302 (b) states that a certified nurse practitioner (CNP) may not practice in the state without an attestation that a collaborative agreement is in place with a licensed physician, and an agreement to consult with that physician and other health care providers as needed.

Ch. 77 8-508 (a)(1) lists requirements and limits for CNPs' prescriptive authority.

Ohio:
OAC 4723-8-04 requires that, prior to engaging in practice, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner must enter into a "standard care arrangement" with a collaborating physician.

ORC 3719.06 (A) (2) states that a CNS, CNM, or CNP who is authorized to prescribe drugs, may only prescribe Schedule II controlled substances for patients with terminal conditions, for a 24-hour supply, and if the collaborating physician initially prescribed the substance.

Pennsylvania:
§ 21.283 provides that a certified registered nurse practitioner (CRNP), acting in a collaborative agreement with a physician, may prescribe and dispense drugs, after obtaining prescriptive authority approval by successfully completing 45 hours of coursework in advanced pharmacology, as well as meeting other specific conditions.

§ 21.284b. provides requirements for CRNPs who prescribe controlled substances.

Virginia:
Chapter 213 (HB 346), passed in March 2012, which was drafted by a coalition of physicians and nurses in the state, requires that nurse practitioners may only practice as part of a "patient care team," and the law stipulates various requirements for collaborative practice agreements.

3. *Physicians' training is substantially different than that of APRNs. It is far more rigorous, lengthy, and standardized. In contrast, APRN programs vary widely and can be completed in as little as 18 months through online courses. APRN training is not equivalent to medical school, but it does provide complementary skills, which are best utilized through collaborative arrangements between APRNs and physicians.*

Quality of care in medicine depends in large part on the practitioner's education and training. In West Virginia, the education requirement for an APRN is a graduate degree in nursing plus license and certification from the state RN Board.[5] The graduate degree must be from an accredited school and include a "supervised clinical component,"[6] although the rule does not provide specific minimum requirements for this component. A bachelor's degree is not even necessary to enroll in a master's of nursing program: most programs also accept an associate's degree or nursing diploma. The master's degree can be obtained from an online program. Currently over 70 online programs exist nationwide, in addition to countless traditional programs, and they can be completed in as little as 18 months of full-time study.[7] There is no standardization among programs, although the APRN consensus model calls for 500 hours of clinical practice.[8]

Physicians, in contrast, have to complete a four-year college degree, four years of medical school (no on-line programs available), and a three- to five-year residency, as well as optional fellowships for additional years. Further, medical schools and residency programs are highly competitive. In addition, licensure requires passing multiple medical board exams. So, while APRNs have as little as 1.5 years post-graduate work, physicians have at least seven, five of which comprise clinical training. Even with the minimum three-year residency, primary care physicians spend about 34,000 hours on education, and specialists spend nearly 50,000 hours.[9] The American Academy of Family Physicians estimates that family physicians spend 20,700 to 21,700 hours on education compared to 2,800-5,350 for NPs.[10] That means family practice physicians accrue four to eight times as many hours of education as do NPs, and other specialists may accrue up to 18 times as many!

Family practice physicians undertake at least 15,000 hours of clinical education and training during their four years of medical school and three to seven years of residency training.[11] In comparison, APRN programs vary, but, if they are in line with the APRN consensus model, they require 500 of clinical experience.[12] That means that family practice physicians have 30 times as much clinical training as do APRNs.

The fact is, physicians have substantially greater medical education and far more hours of clinical training compared to nurse practitioners, and more education and training equates to more knowledgeable diagnoses and treatment. Nurses' training is not equivalent to that of physicians, but it is complementary, and ideally the two professions should work together collaboratively.

4. *Nurses have authored a glut of research studies on quality of care of APRNs, but most of the studies suffer from a variety of shortcomings and limitations. Many studies indicate that APRNs have different strengths than physicians, suggesting that the best model for care is a collaborative team approach.*

Research studies on the quality of care provided by APRNs suffer from various limitations. For example, one large study focused on patients with pre-existing, common diagnoses with well-established treatment protocols.[13] Another study that appeared large because of the patient population actually involved only a single, possibly anomalous nurse practitioner (NP) with 15 years of critical care nursing experience compared with physicians in training rotating through the unit for a week or two at a time.[14] The data in one study that was touted as demonstrating cost savings associated with APRN care indicated that NPs missed a known diagnosis in 40% of patients![15]

In their PERD Application, APRNs list a plethora of research studies purporting to show that APRNs provide care that is equivalent to that of physicians. Many of the studies have methodological limitations, however, and, as the authors of a meta-analysis sponsored by the American Nurses Association stated, "There was a lack of methodological rigour and logical formulation in many of the included studies."[16]

In some studies cited by the APRNs, the findings cannot be extrapolated because of the specificity of the setting or other parameters. For example, one of the studies compared senior house officers (SHOs) and NPs in an emergency room in Glasgow, Scotland;[17] another study was from Bristol, England.[18] In the United Kingdom, SHOs are doctors in training, and the qualifications for NPs are more rigorous compared to the U.S. training programs: A levels are required for applicants, and the post-graduate training has a 3-year duration, as well as additional clinical training, so those studies are not relevant to care in the United States. Further, some of the studies cited evaluated care in nursing homes;[19] and three of the studies dated all the way back to the 1970s,[20] predating today's advanced medical technology, and long before any online NP training programs existed, and therefore not germane. Another important limitation of the studies is that they generally compare patient populations with simple, chronic conditions; in the case of nurse midwives, the studies typically include low-risk patients with uncomplicated pregnancies.

Some of the studies actually show that APRNs have a different skill set which would be complementary to physicians in a collaborative team approach. For example, several studies reported that NPs tend to have better communication and interviewing skills compared to physicians.[21] One of the most compelling studies listed by the APRNs was a study of 1,207 general medicine patients randomized to receive either traditional care or care by a multidisciplinary team of physicians and NPs. The researchers found that the multidisciplinary teams were more cost effective, achieving a net cost savings of $978 per patient.[22]

The research studies on quality of care by NPs help to demonstrate that physicians and APRNs have different skill sets which can best be utilized by encouraging collaboration on multidisciplinary teams.

5. *Increasing APRNs' scope of practice is unlikely to increase access to primary care in rural areas. APRNs are much more likely to practice in urban settings in West Virginia, even though collaborative agreements do not limit them from rural areas. Further, increased scope of practice has not led to increased access in other states.*

One of the main arguments that NPs offer for increasing their scope of practice is that doing so will improve access to care, particularly for people in rural areas. Unfortunately, evidence does not support this theory. Most NPs practice in urban areas; only about half practice primary care; and states that have laws granting them greater autonomy are not significantly different than those without such laws.

Nationally, there are 152,000 APRNs, 106,000 of which are NPs, and they are much more likely to practice in urban areas. Their density in urban areas is 3.6 NPs per 10,000 population compared to only 2.8 per 10,000 in rural areas. In West Virginia, the comparative density is even worse, with 3.7 NPs per 10,000 in urban areas compared to only 2.6 in rural,[23] even though West Virginia's proportion of population living in rural areas is significantly higher than that of the nation, with 44% of West Virginians living in rural areas compared to only 17.7% nationwide.[24] While all counties in West Virginia have at least one actively practicing primary care physician, at least seven counties have no practicing APRNs.[25]

Further, nearly half of NPs do not practice in primary care settings. Although the American Academy of Nurse Practitioners reports that 89% of NPs are trained in primary care and 75% practice in primary care settings,[26] data from the National Provider Identifier File, a database tracking all clinicians who file insurance claims, shows that only 52% of NPs actually practice in primary care settings.[27]

Changing state laws to provide more autonomy for NPs has not helped the problem: the handful of states that allow NPs to practice independently have not experienced increased access to care in underserved areas. No significant difference exists in the relative practice densities of NPs in states with more statutory autonomy for NPs.[28]

The fact is, nothing is preventing WV APRNs from practicing in rural areas now because they are allowed to practice independently in any location they choose. Collaborative agreement requirements in West Virginia do not stipulate any limitations on practice locations. There is no reason why APRNs cannot practice in underserved rural areas under the current law, and there is no reason to believe that changing current law would motivate them to change their practice locations. Changing the law is highly unlikely to make any difference in access to care.

6. *Not only are APRNs unlikely to provide cost savings, they can increase costs of care. They can bill Medicaid for their services at 100% of the physician rates and Medicare at 85% (100% if "incident to" physician services). Further, research studies show that nurse practitioners are less productive, and tend to order more exams and utilize more resources compared to physicians, leading to increased costs of care when working independently.*

APRNs claim that increasing their autonomy will provide health care cost savings, but facts and research data do not support this claim. The fact is, they can bill at the same rate as physicians, and research studies have shown that they utilize more resources, compared to physicians, leading to increased costs.

APRNs can bill at 100% of the physician rates for services. In West Virginia, the Department of Health and Human Resources allows primary care physicians and APRNs to bill for reimbursement at the same rate.[29] Medicare provides reimbursement to APRNs at 100% of the physician rate if the service is "incident to" physician services and otherwise at 85% of the physician rate.[30] This slight savings may be short-lived, however, since the American Nurses Association is currently lobbying for pay parity.[31]

Research studies have shown that APRNs can be associated with higher costs of care because of their lower productivity, relative to physicians, and their tendencies to order more tests and utilize more resources. A study cited by the APRNs in their application reported that APRNs are only 60% as productive physicians.[32] In a literature review from the Cochrane Collaboration, researchers screened over 4,000 articles and reviewed 25 articles comparing doctors and nurses providing similar primary health care services. The researchers reported that the studies showed that, when the nurses provided first contact care to patients, they tended to use more resources and have lower productivity compared to doctors. They reported that salary differentials varied between nurses and doctors, but even when nurses salaries were lower than doctors' no cost savings was achieved because of the decreased productivity and increased use of tests and other services.[33]

In another study on resource utilization, researchers collected data on number of radiologic and laboratory tests for patients assigned to either a NPs or an attending or resident physician at a Veterans Administration medical center. They found resource utilization was higher in 14 of 17 measures for NPs compared to residents (doctors in training) and 10 of 17 measures for NPs compared to attendings (fully trained physicians). None of the utilization measures was lower for the NPs compared to either physician group. The researchers concluded that NPs utilize more resources than do physicians in a primary care setting.[34]

Although APRNs claim that increasing their autonomy will result in lower health care costs, the reports they cite are generally speculative. Research demonstrating that actual cost savings can be achieved typically involve settings in which APRNs and physicians are working together in health care teams, as discussed below (#10).

7. *Research shows that patients have a clear preference for physician-led health-care services, and the WV Legislature has already addressed this issue.*

The WV Legislature in 2009 enacted legislation to address the issue of physician-led health care services through patient-centered medical homes in §16-29H-9. In pertinent part, the statute provides: "(b) The patient-centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology."

Research studies affirm that the majority of patients prefer that their clinicians are physicians. A recent study showed that the vast majority of people older than 65 years prefer seeing a physician for health care services rather than a nurse practitioner (77% vs. 6%). This groups makes up about a third of the patients in primary health care visits. For those aged 35-64 years, the ratio is about 55% to 20%.[35]

Another study found that, even though the majority of retail healthcare consumers under 65 consider affordability their primary concern, they would not visit a nurse practitioner rather than a physician in order to save costs. Retail consumers are defined as those under 65 who have individual insurance, insurance through a small group employer or are uninsured. Of this group, 72% consider affordability their most important healthcare concern, over quality of care and accessibility, yet 59% would not go to a nurse practitioner for routine visits to save costs.[36]

Other research shows that patients have a strong preference for physician-led health care:

- 86% of patients believe they benefit from a physician-led primary care team;
- 80% prefer a physician to have primary responsibility for their health care;
- 78% do not think nurse practitioners should be able to run their own practices without physician involvement;
- 79% do not think NPs should practice independently of physicians without direct supervision;
- 92% believe that only physicians should be allowed to diagnose heart conditions;
- 83% believe only physicians should prescribe complex medications;
- 78% think only physicians should diagnose and treat chronic diseases;
- 75% say they would prefer to be seen by a physician instead of a mid-level provider even if it took longer for them to get an appointment;
- 98% say physicians and nurses need to work in a coordinated matter to ensure patients get the care they need.[37]

Patients have voiced a strong preference for physician-led health care teams, and the Legislature has found that such teams provide the best way to meet patients' needs.

8. *Current WV Code specifies recently updated, reasonable rules for collaborative agreements between physicians and APRNs that provide important protections for health care consumers in the state.*

West Virginia's current statutes for APRNs have been recently updated and are less restrictive in regard to APRN prescriptive authority than those in most other states, including all of our contiguous states.

Over the past four years, the WV Legislature has expanded APRNs' prescriptive authority, and in this past session, introduced a statutory definition of the term APRN. In 2009 the WV RN Board collaborated with the WVSMA and the WV Board of Medicine to develop new rules significantly rewriting and expanding the existing prescriptive authority rules for nurse midwives and nurse practitioners (SB 664, codified as §30-7-15a and §30-7-15b), and in 2012 a definition of APRN was added to the statute, replacing previous language referring to advanced nurse practitioners (SB 572, adding §30-7-1a). In 2012 other changes were also made to the APRN rule: §30-7-15b and §30-7-15c were amended to add a grandfather clause, and allow the WV RN Board to set an application fee and providing rule-making authority.

The current rules, §30-7-15 and §30-15-7, permit APRNs and nurse midwives to prescribe medications, including those listed under Schedule IV and V, without limitation, pursuant to a collaborative agreement with a physician. They are also permitted to prescribe Schedule III medications in a 72-hour supply without refill.

West Virginia statutes provide fewer restrictions on APRN practice compared to laws in most other states. West Virginia is one of only 22 states that allow APRNs to diagnose and treat patients without physician involvement. While West Virginia does require that APRNs have collaborative agreements to prescribe medications, it is one of 38 states that have such a requirement.[38]

Collaborative agreements provide an important level of patient protection because they require a physician to provide a periodic review and evaluation of the APRN's prescriptive practices to ensure patient safety and to help protect the public from unsafe prescribing practices. Also, having a collaborating physician means that the APRN has a readily available contact who can share information and expertise.

The WV Board of Medicine has promulgated a set of guidelines for collaborative agreements that helps ensure patient safety. The guidelines provide common-sense rules, such as providing that the collaborating physician should be in the same specialty as the APRN, and the agreement should not include medications that the physician does not prescribe in his or her own practice, or those with which the physician is not familiar and knowledgeable.[39]

West Virginia's statutes regarding APRNs provide reasonable protections for health care consumers in the state, and they are already more permissive for APRNs than those in a significant majority of other states.

9. *Proposed changes to the law are broad and potentially could have far-reaching unintended consequences.*

The APRNs' proposed changes to existing WV statutes include removing the limitations on NPs' and nurse midwives' prescriptive authority for Schedule II and III controlled substances, removing the requirement for collaborative agreements with physicians, and permitting APRNs the authority to sign, or otherwise affirm, any documents that WV law or regulations currently require to be authorized by a physician. These changes could have unintended negative consequences.

Removing current limitations on APRNs' and nurse midwives' prescriptive authority for Schedule II and III controlled substances could exacerbate the drug diversion problem in West Virginia. Removing the current reasonable limitations would allow mid-level providers, who have considerably less training than physicians, to prescribe substances recognized for their potential for abuse. Further, this would increase opportunities for patients who are vulnerable to abusing controlled substances to shop for multiple providers.

Another significant risk of allowing APRNs and nurse midwives to prescribe controlled substances without collaborative agreements is that this would remove an important level of oversight. Collaborative agreements require that physicians periodically evaluate prescriptive practices with the APRN or nurse midwife, which helps prevent misuse and protects public safety. Not only would periodic reviews be eliminated, but egregious abuse might go unpunished, as demonstrated in the recent WV Supreme Court of Appeals case, *State ex rel. Fillinger v. Rhodes* (2013). The case revealed that the WV RN Board failed to take action against a nurse who was fired from two different hospitals following accusations that she had unlawfully obtained narcotics for personal use and distribution.[40]

Removing the collaborative agreement requirement also eliminates the partnership with a physician, which can be very beneficial if the APRN has questions or concerns regarding patient care. This can be particularly important regarding de novo diagnoses, as one study showed that NPs working independently missed a known diagnosis in 40% of patients.[41]

The proposed addition to the law allowing global signatures could result in significant issues. The extent of the consequences of this change cannot be estimated since the number of documents to which it refers is unclear. Some of the documents include disability determinations, forced psychiatric admissions, competency declarations, etc., which could lead to increased costs (as from accelerating the number of disability claims) and other issues. This proposed change merits careful consideration to investigate all of the potential ramifications.

Finally, changing laws to define APRNs as equivalent to physicians could have the unintended consequence of aggravating the current shortages of primary care physicians and registered nurses. It could discourage medical students from entering primary care residency programs since such residencies would be considered equivalent to training that is significantly shorter and less rigorous, and it could discourage nurses from traditional nursing positions.

10. Research shows that the best and most cost-effective medical care occurs when physicians and nurses work together to provide a team approach, balancing the strengths of each profession. Virginia has recently enacted a new law, drafted by nurse and physician groups working in conjunction, which stipulates requirements for patient care teams. The new law calls for collaboration, just as current West Virginia law already requires.

Studies show that a multi-disciplinary team approach provides cost effective and high-quality health care because such an approach takes advantage of the relative strengths of each profession. For example, data from Kaiser Permanente Georgia shows that health care teams with high levels of collaboration and teamwork performed 40-90% better when caring for patients with chronic diseases such hypertension, diabetes, and asthma.[42] A large study of inpatients at the UCLA Medical Center shows that multidisciplinary teams of physicians and NPs achieved significant cost savings.[43] Researchers at a Veterans Administration hospital found that patients treated by multidisciplinary teams had significantly lower average lengths of stay with no difference in mortality or readmissions.[44] These studies and many others demonstrate that multidisciplinary teams provide the most effective model for health care delivery.

The Virginia State Legislature, recognizing the benefits of the team approach, in 2012 unanimously passed landmark legislation requiring APRNs to practice as part of physician-led patient care teams.[45] The legislation was the culmination of 18 months of combined effort by the Medical Society of Virginia and the Virginia Council of Nurse Practitioners, and their cooperation and focus on patient safety and quality of care ensured easy passage of the bill.[46] As well as requiring that APRNs practice only as part of teams, the new law also requires that APRNs are jointly licensed by the Virginia Boards of Nursing and Medicine.[47] The Virginia legislation provides a model for other states to enhance patient-centered care, a key recommendation of the Institute of Medicine (IOM) report, *The Future of Nursing*.

The IOM report, which is often touted by nurses but, like some earlier IOM reports, is the subject of criticism by many physicians, does include some recommendations and comments that are unassailable. One of the key messages of the report is that health care should focus on the unique needs of patients, not on the convenience of health care professionals.[48] The report also notes that APRNs are trained to focus on promoting health as opposed to curing illness; valuing public health, as opposed to emphasizing technology and interventions.[49] Further, the IOM acknowledges that APRN education is not standardized, with "multiple educational pathways leading to licensure… which state legislators are sometimes confused about (or susceptible to mischaracterizations of)."[50] For example, a 2-year nursing degree is sufficient in many cases for entrance in a master's program for APRN certification, and, while there is an APRN Consensus Model for education and accreditation, the model only provides recommendations, not mandates. Considering those issues, the best way to provide patient-centered care is to recognize the differences between APRN and physician training, and promote collaborative, multidisciplinary teams that balance the relative strengths of each profession.

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Mr. Michael Midkiff, Audit Manager
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Charleston, WV 25305-0610

Dear Mr. Midkiff:

The West Virginia Association of Physician Assistants (WVAPA) has reviewed the "Sunrise Application" to the Performance Evaluation and Research Division of the West Virginia Legislature and would like to comment on this issue.

Healthcare is an ever changing and evolving industry. All sectors of healthcare will experience the need to increase patient access. With the evolution in healthcare today, we believe that both Physician Assistants (PA) and APRNs will play a major role in patient care and access. Both PAs and NPs have been shown to provide quality care while lowering healthcare costs.

However, we believe that a physician-led team is the best approach to the future of healthcare. Being properly supervised by, delegated to, or collaborating with a physician does not mean that a provider cannot work autonomously. This is privileges that come with experience and trust in the provider's relationship with the physician-led team and does not require independent practice to accomplish.

The National Association of Community Health Centers states-Facilitating Health Care Teams- State scope of practice standards set the boundaries by which key primary care providers, namely NPs and PAs, can deliver care. State policymakers must consider how these standards encourage or discourage primary care professionals to locate in and form teams in underserved areas. Some states, including Colorado and Pennsylvania, have dealt with primary care shortages in underserved areas by expanding scope of practice for NPs, PAs, CNMs, nurses, and dental hygienists. If health centers are to form medical or health care homes and maximize quality and efficiency, policies that facilitate team functions for patients will be needed.[1]

Rural and underserved areas will continue to be served by practitioners with ties to the communities and other health care programs that give incentives. Both PAs and NPs have a history of working in rural areas throughout the life of their profession without independent practice. The American Association of Physician Assistants (AAPA) West Virginia PA practice snap shot shows that 48% of patients seen by PAs

1. National Association of Community Health Centers. (2008) Access Transformed http://www.nachc.org/client/documents/ACCESS%20Transformed%20full%20report.PDF

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are in the rural setting. There are a total of 713 PAs in clinical practice in WV per the AAPA in 2012[2]. This also is without independent practice. Additionally, independent practice also does not guarantee that practices will be set up in rural and underserved areas.

While both PAs and NPs receive substantial education during their training, it still does not match that of physicians. Non-physician practitioners clinical rotation typically is their last of nearly three years training, whereas physicians spend the last two years of medical school in clinical rotations followed by at least three years in residency taking care of patients. Physician' training, being a medical model with subsequent residency provides them the opportunity to apply the knowledge and skills they have attained under physician supervision. PAs are also instructed under a medical model approach; however, our length of training and patient contact is not the same length and would not warrant independent practice. APRNs are taught from a nursing model and length of training does not match what a physicians' training entails.

Safe, high-quality, and efficient care can be delivered over the state of West Virginia as well as the country. This has been accomplished by both PAs and NPs for several decades without requiring independent practice. The WVAPA is committed to continuing to build physician-PA relationships by working with both the West Virginia Board of Medicine and the West Virginia Board of Osteopathy, as well as other state medical associations to help increase patient access to care. Quality measures to provide evidence based medicine, yet control the spiraling increase in health care cost has already been implemented by both government and third-party payers. Some insurance payers will only reimburse NPs if they are collaborating with a physician, regardless of the state law. This shows the push for unity to take care of and manage each patient by either physicians and/or non-physician providers as a health care team.

In closing, while the WVAPA values the health care services and patient access provided by APRNs in this state, we firmly believe that a physician-led, team approach will provide safe, high-quality, and efficient patient management in the current and future healthcare environment for all non-physician providers to follow.

Regards,

West Virginia Association of Physician Assistants

[2]American Academy of Physician Assistants (2013) Retrieved October 26 , 2013
http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/West-Virginia2013.pdf

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