Approved 3-22-89
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 a.m./p.m. on March 20, 1989 in room 423-S of the Capitol.

All members were present except:

Representative Ben Foster, absent

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Terri Roberts, Executive Director, Kansas State Nurses' Association
Jolene Zivunski, Legislative Chairperson for ARNP Task Force/Nurse Practitioner at OB/GYN Dept. at HCA Wesley Medical Center/University of Ks. School of Medicine, Wichita.
Patsy Quint, Nurse Clinician in an Industrial Setting/Chairman of KSNA Advanced Practice Conference Group, Sedgwick/Sumner
Wanda Maltby, R.N., C., ARNP, Wichita State University Student Health Services. (Written testimony only)
Chip Wheelen, Kansas Medical Society
Tom Hitchcock, Executive Secretary, Ks. State Board of Pharmacy
Mary Harness, ARNP, Hays, Kansas
Richard Gannon, Executive Director, Ks. Board Healing Arts
Jackie Oakes, Ks. Academy of Physicians' Assistants

Chairman called meeting to order, making announcements, there is a heavy agenda to cover this week, there will be an 8:00 a.m. meeting tomorrow in Room 254-E, and he asked that conferees this date be as brief and concise as possible in order that all who are scheduled will have an opportunity to give their views.

HEARINGS BEGAN ON SB 23.

Terri Roberts, Executive Director, Ks. State Nurses' Association, (Attachment No.1), explained the packet of information provided. She noted SB 23 in its present form as amended by Senate Public Health/Welfare Committee presents a clear message regarding ARNP's prescribing under standing orders and protocol. New language added to ARNP statute does address two issues, i.e., ARNP's may transmit prescription orders based on jointly adopted protocol; may not practice in areas that exceed the scope of their responsible physician/ and language is in place that defines what is meant by responsible physician. She noted an article in her packet stating in 99% of the time, the prescribing privileges are appropriate. She asked for support of SB 23. She answered questions, i.e., yes, whe is aware SB 23 was introduced because the State Board of Nursing did not have the right to write Rules and Regulations, not because anyone wishes to single out the ARNP's in regard to prescriptions; she noted she reads the bill to say protocol would be written for a specific diagnosis, not for each different patient; discussion on protocol; yes, the Insurance Industry thinks this has affected the liability issue for ARNP's, however, there are more claims filed in hospitals in OB units and recovery rooms, than there are against ARNP's in settings other than those mentioned.

Jolene Zivunski, Practicing ARNP, Wichita, (Attachment No.2), highlighted services their Medical Center offers to primarily poverty level, indigent consumers in the Sedgwick County areas, as well as many rural patients, some who travel 4 hours to the clinic. She noted a letter in her handout from Dr. Dan Roberts urging support of SB 23. She explained in detail what transmitting per protocol means in their facility. She detailed

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 a.m./p.m. on March 20, 1989.

HEARINGS CONTINUED ON SB 23:Ms. Zivunski continued:

the progression of experience with the physician over a number of years, and after he worked along with her doing diagnosis, and prescribing treatments, a protocol was established. She noted more serious cases are seen by the physician and not the ARNP.

Jeanette Pucci, Kansas State Board of Nursing, (Attachment No.3), spoke on behalf of Dr. Lois Scibetta who is out of town and cannot present the testimony herself. Ms. Pucci noted their Board states it was never their intent to seek presciptive powers for ARNP's, only to clarify the written protocols and/or standing orders. For the purpose of clarification they did ask, is the group of "Scientific Investigator" is not defined, and they wonder is this group regulated or licensed in any way? She answered questions, i.e., there are four categories of ARNP, Nurse Clinician, Nurse mid-wife, Registered Nurse Anesthetist, Clinical Nurse Specialist. It was also noted the Nurse Anesthetist also works with Dentists and Podiatrists.
Patsy Quint, Chairman, KSNA Advanced Practice Conference Group, gave hand-out, (Attachment No.4). She noted SB 23 will clarify the language regarding transmission of prescription orders, pursuant to written protocol jointly developed by the ARNP and the Physician for the medical plan of care. We are not seeking independent prescriptive privileges she said, only to be able to follow precise protocol, which is somewhat like the old standing order of the physician. She asked for passage of SB 23.

She noted (Attachment No. 5), letter from Wanda Maltby, Wichita State University, and various forms indicating protocols used.

Ms. Quint answered numerous questions, i.e., she felt with the numbers of protocols there are, it would be cost prohibitive for the Pharmacists to have all this on record, especially those businesses that are not computerized; discussion ensued on diagnosis, and she stated if there is any question, the Doctor then sees the patient; discussion on protocol and the old standing orders differences, it was determined the protocol is more clearly defined.

Chip Wheelen, Kansas Medical Society, (Attachment No. 6), noting his printed testimony makes a mis-statement, i.e., (allowing physicians to delegate the prescribing). He noted this is not what we are talking about here. What we do wish to address is, enabling the physician to establish a written protocol that the ARNP would follow in the process of transmitting a prescription order. When language was drafted in SB 23, which they helped formulate, it was discussed if the Healing Arts Act should be amended as well. He suggested (respectfully) the committee might want to amend one of the 3 or 4 bills that pertain to the Healing Arts Act in a manner that would clarify that physicians may adopt protocol that the ARNP then may transmit to patients. He noted Mr. Buening of Board of Healing Arts may have an amendment to submit to committee on this subject. He answered questions, i.e., yes, it is the physician, (the captain of the ship) who is assuming responsibility as that prescription order is transmitted, as this constitutes the practice of medicine; if I were a physician, he said, I would not allow a prescription to be transmitted without first having seen the patient personally, and have done at least a cursory examination and personal diagnosis, otherwise, I have exposed myself to a gareat deal of liability; yes, this bill would amend the Nurse Practice Act, that is why I have suggested the Healing Arts Act be amended as well.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on March 20, 1989

HEARINGS CONTINUED ON SB 23:--

Tom Hitchcock, Executive Secretary, Ks. State Board of Pharmacy, (Attachment No. 7), noted their Board agrees with clarification of definition of the term "Practitioner" as it appears in the pharmacy and controlled substances act, and that ARNP's may not prescribe drugs, but may only transmit prescription orders pursuant to written protocol as authorized by a reasonable physician. His Board favors passage of SB 23. He answered questions, i.e., yes, pharmacists feel the protocols on file would be invaluable to them, would eliminate time lapse in getting back to the physician to check on authenticity of the prescription; discussion in regard to formula, rather than the written protocol from doctors being filed.

Mary Harness, Nurse Practitioner from Hays, Kansas. She noted she had written a letter to all committee members, and there was a mis-statement she wished to correct, i.e., they have served not 60,000 clients, but 16,000 clients. They have 3 physicians, and 3 Nurse Practioners, and have had to hire more Nurse Practioners after some physicians in their area have moved away. She noted many people drive many miles to receive care in their clinic. A Nurse Practioner in their facility may see 20 patients each per day, the physicians are also seeing as many or more, the Nurse Practioners deal with common acute infections, i.e., ear infections, upper respiratory infections. She detailed their procedure of dealing with these clients, follow-up procedures, and the use of protocol because the physician is not always available as he may be working with other patients, at hospital making rounds, or in surgery. We have precise guidelines to follow, we can make diagnosis for common illness, but if it is critical, the doctors see the patients.

HEARINGS CLOSED ON SB 23.

HEARINGS BEGAN ON SB 183.

Richard Gannon, Executive Director, Board of Healing Arts, (Attachment NO. 8), detailed the bill, noting it represents a compromise between their Board and the Physicians' Assistants, and is agreeable to all concerned. He noted there are problems they have tried to address, i.e., a case where a PA has established his own Corporation, maintains a medical clinic and has hired a responsible physician in order to comply with Statutes, however. Other cases a PA has been left alone to run the office while the physician is out of town. We seek to correct these situations, and SB 183 should resolve these concerns. He answered questions, i.e., yes, we have experienced difficulties in being notified of what PA works with what physician; SB 183 will shift the responsibility from the PA to the Doctor who should be the ultimate responsible party; no, we are not always notified when a PA ceases to be under the supervision of a responsible physician even though it is a Statutory requirement; in line 109, we would like the burden be placed on the physician, not the PA.

Jackie Oakes, Academy of Physicians' Assistants, (Attachment No. 9) noted there are currently 130 physicians' assistants registered in Kansas. There are 110 active. She drew attention to a breakdown of areas by county in which these PA practice. She stated their support of SB 183, noting their are pleased that new language has satisfied their concerns after a very beneficial meeting with the Board of Healing Arts. She noted they heartily endorse the advisory council, saying it will be most helpful in keeping lines of communication open between the Board of Healing Arts and Physicians, and Physicians' Assistants. She answered questions.

There was discussion in regard to the parallels between a ARNP and a PA.

HEARING CLOSED ON SB 183.

Chair announced a meeting 8:00 a.m. Tuesday. Meeting adjourned.

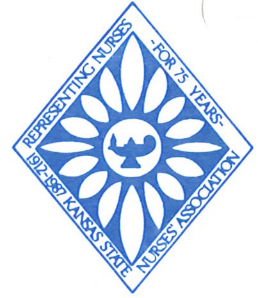
GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Monday 3-20-1989

Name	Organization	Address
Janette Pucci	Board of Nursing	Topeka
Cheryl Neuhaus	Washburn University School of Nursing	Tecumseh
Pat Johnson	Board of Nursing	Topeka
Joan Felts	Board of Nursing	Wichita
Delora Donovan	Bd. of Nursing (ARNP Comm.	Wichita
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Jo Spangler	KDHE	Topeka
Tom Hitchcock	Bd. of Pharmacy	"
Joleen Zivnuska	ARNP - HCA Wesley	Wichita
Debbie Wendt	ARNP - HCA Wesley	Wichita
[illegible]	KSNA Advanced Practice Conference Group	Wichita
Willie E. Richards Jr.	CITIZENS ADV. COMM. JAYHAWK AA ON AGING	TOPEKA
Grace Jolly	K-NEA	Meriden
Allison Harbaugh	KNEA	Meriden
Belva Ott	Planned Parenthood of KS.	Wichita
Jacque Oakes	PA	Topeka
Mary [illegible]	ARNP - Hays Family Practice	Hays
[illegible]	ARNP / KSBN	Wichita
Richard G. Hanner	Bd of Healing Arts	
Larry Buening		
Bob Williams	Ks Pharmacists Assoc.	Topeka
Chip Wheelen	Ks Medical Society	Topeka
Terri Roberts	KSNA	Topeka

KSNA
the voice of Nursing in Kansas



FOR FURTHER INFORMATION CONTACT:

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
820 QUINCY, SUITE 520
TOPEKA, KANSAS 66612
(913) 233-8638

S.B. 23

Representative Littlejohn and members of the House Public Health and Welfare Committee, my name is Terri Roberts, J.D., R.N. I am a registered nurse representing the Kansas State Nurses' Association.

I have prepared a folder of information that may be helpful to you in your deliberation on Senate Bill 23. The first item I would like to bring to your attention is a chronology of events surrounding this issue. It began three years ago, and includes an Attorney General's opinion, requested by the Board of Pharmacy to clarify whether or not ARNP's could prescribe under standing orders and protocol. The Attorney General's opinion 86-125, issued August 27, 1986, was that Advanced Registered Nurse Practitioners may not issue prescription orders pursuant to a physicians' standing orders or protocol, because they have not been granted such authority by the statutes and regulations under which they are licensed. I have included a copy of that Attorney General's opinion in your folder. The Pharmacy Board adopted a different posture related to filling of orders prescribed by ARNP's. Their position paper is included in your packet. That position paper recognized that ARNP's-Nurse Practitioners may prescribe under standing orders and protocol, and that pharmacists can legally fill such orders under K.S.A. 65-1626X and K.S.A. 65-1130(c)(1).

The Joint Committee on Administrative Rules and Regulations submitted this bill for legislative consideration in an attempt to clarify the issue of whether or not ARNP's-Nurse Practitioners, may prescribe medications under standing orders and protocols jointly adopted with a collaborating physician. ARNP-Nurse Practitioners are Registered Nurses who have had formal training to prepare them as Nurse Practitioners. They function in what we refer to as the expanded role or advanced nursing practice.

S.B. 23 in its present form, as amended by the Senate Public Health & Welfare Committee, presents a clear message regarding ARNP's prescribing under standing orders and protocol. New language was added to the ARNP statute K.S.A. 65-1130 line 76-87 addresses two issues:

1. ARNP's may transmit prescription orders based on jointly adopted standing orders and protocol. Specific statutory authority.

2. ARNP's may not practice in areas that exceed the scope of their responsibile physician and language is in place to define what is meant by responsible physician. This language was submitted by the Kansas Medical Society to clarify roles and to assist in disciplinary matters, should they arise.

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There are a number of ARNP's here to tell you about their practice setting, clients they serve and why there is a need to adopt this specific statutory language which enables them to write prescriptions based on standing orders and protocol.

We ask for your support for S.B. 23 that accurately reflects the current practice by ARNP's writing prescriptions based on standing orders and protocol jointly adopted with their collaborating physician. We are committed to collaborative and interdependent relationships with physicians recognizing that both have specific practice acts governing their discipline and are individually accountable to the public they serve.

I have included, for your reference, a January, 1989 article from the Nurse Practitioner Journal analyzing Prescriptive privileges in the 50 states and D.C. Twenty-eight states, including Missouri and Nebraska, have specific provisions for this.

A research article is also included about prescribing behaviors of Primary Care Nurse Practitioners. It provides documentation of appropriate and safe prescribing patterns by them.

I would be happy to provide additional articles about this if competency is an issue.

Thank you for the opportunity to speak.

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3-20-92

ATTORNEY GENERALS OPINION ON ARNP'S WRITING PRESCRIPTIONS BASED ON STANDING ORDERS AND PROTOCOLS CONTINUES TO HAUNT KANSAS ARNP'S

By: Terri Roberts, J.D., R.N.

This is a chronology of events that have centered around the refusal of one pharmacist in one small rural community in north-central Kansas to fill prescriptions based on written protocols, called or written by an ARNP working in a collaborative relationship with three physicians. The Kansas Pharmacy Association, the Kansas Board of Pharmacy, the Kansas Medical Society, the Kansas State Board of Nursing, and the Kansas State Nurses' Association have been involved in the discussions and decisions related to this area. The Physicians Assistants have a new law that was passed in 1987 with regulations recently enacted that set tighter constraints on their practice as it relates to supervision and collaboration by their respective physician counterpart.

Spring, 1986

The Board of Pharmacy requested an Attorney General's Opinion as to whether physician assistants or ARNP's may issue, pursuant to standing orders or protocol of a physician, prescriptions for non-controlled substance medication.

The Pharmacy Association lobbied to change the definition of "Practitioner" in the definition section of the Pharmacy Act to the following language in SB 799 effective July 1, 1986:

> In order to prescribe medication, then, a person must be a practitioner. Prior to July 1, 1986, a "practitioner" was defined as follows:
>
> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law to administer, prescribe and use prescription-only drugs in the course of professional practice or research."
>
> K.S.A. 65-1626 (t) (Ensley 1985).
>
> The 1986 session of the legislature amended this provision in Senate Bill No. 779:
>
> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law *expressly licensed or registered* to administer, prescribe and use prescription-only drugs in the course of professional practice or research."
>
> K.S.A. 65-1626 (t) (L. 1986, ch. 236, 1).

The Board of Pharmacy's Attorney, Lynn Ebel, wrote a position statement for the Board of Pharmacy that supported ARNP's and PA's writing prescriptions based on standing orders and protocols. The Board of Pharmacy adopted the position statement. The opinion concluded:

"While the definition of practicing does not expressly include ARNP's and PA's, there is certainly room for inclusion in its general provision. An ARNP, in conjunction with a physician, are lawfully authorized to administer and use prescription only drugs. I would assert, that under standing orders, the authority to prescribe likewise exists for ARNP's and PA's."

August 27, 1986

The Attorney General's Office released the Attorney Generals Opinion No. 86-125 written by Rita Noll, Assistant Attorney General, which stated the following:

Synopsis: It is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the art of prescribing medicine, we conclude that orders under the direction and supervision of a physician. Cited herein: K.S.A. 65-1113(d), (g); 65-1626(t), (x), as amended by L. 1986, ch. 236, sl; 65-2869 (b); 65-2896e; 65-2897a (a), (c); K.A.R. 1985 Supp. 60-11-104; 60-11-105; 60-11-106.

September 21, 1986

Board of Pharmacy meeting, after discussing the Attorney General's Opinion, based upon concerns for the public health and welfare, voted to support the Board of Pharmacy's Attorneys opinion that pharmacists may fill prescriptions originated by ARNP's and PA's under pre-established protocols until such time as the legislature further clarifies this issue.

November 13, 1986

Representatives from KSNA, including Advanced Practice Chairperson, Pam Byl, met with the Kansas Medical Society Legislative Committee to identify the issues related to ARNP's writing prescriptions based on standing orders and protocols.

Spring, 1987

The House Public Health and Welfare Committee, Chairperson and legislative staff, in discussions with the Kansas Board of Pharmacy, Kansas State Board of Nursing, Kansas Medical Society, Kansas Pharmacy Association, and Kansas State Nurses' Association representatives, indicates that ARNP's who write prescriptions based on standing orders and protocols are 'transmitting" under the definition in the Pharmacy Act. This was not a legislative decree, simply informal discussion by members as indicated. The Board of Pharmacy continued to defend their position.

August 6, 1987

The Board of Pharmacy requested from the Board of Nursing a written statement regarding the KSBN position of ARNP's prescribing or transmitting a prescription pursuant to protocol. Specifically requesting that KSBN respond to both requests dealing with prescribing and transmitting.

October 20, 1987

ARNP Committee of the Board of Nursing, Elaine Harvey and Mary Harness, present at the meeting discussed and made a formal recommendation to the Board of Nursing to endorse the Attorney General's Opinion No. 86-125.

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October 21, 1987

The KSBN Board Meeting, Board Member — Elaine Harvey, made a motion to endorse the Attorney Generals Opinion No. 86-125 and to have the KSBN Attorney, Mark Stafford, write a letter to the Board of Pharmacy responding to their letter.

December 23, 1987

The Board of Nursing staff, Janette Pucci, wrote a letter to the Board of Pharmacy indicating the following:

> "The Board of Nursing reviewed your request at their regularly scheduled meeting on October 21, 1987, concerning the prescriptive powers of advanced registered nurse practitioners (ARNP). The Board indicated that the prescriptive powers of the ARNP's should comply with the Attorney General's Opinion No. 86-125."

January 15, 1988

The Board of Pharmacy mailed agenda for their Board Meeting, January 24 - 25th, including on it the response from the KSBN as an agenda item.

January 20, 1988

KSNA Executive Director, Terri Roberts, requested Helen Chop, President of the Board of Nursing, to revisit the KSBN decision related to the endorsement of the Attorney General's Opinion No. 86-125, noting that the letter was going to be considered by the Board of Pharmacy the following weekend. KSNA staff supplied the Board of Nursing members with a copy of the AG's Opinion and was given the opportunity to present rationale for KSBN reversing their endorsement. Libby Dayani was also given an opportunity to speak about ARNP's writing prescriptions based on standing orders and protocol. The Board of Nursing, after receiving these comments went into Executive Session with their attorney, Mark Stafford, and when they returned they made the following motion:

> That the ARNP Committee was to convene and "Review the regulations regarding ARNP's and elaborate on the limitation on this role, with particular attention to the prescriptive power, protocol, transmission of orders, and guidelines."

January 25, 1988

Janette Pucci appeared before the Kansas Board of Pharmacy to inform them of the Kansas State Board of Nursings action on January 21st to refer this issue to the ARNP Committee for action.

January 27, 1988

The ARNP Committee of the Board of Nursing met and discussed the decision by the Board of Nursing to endorse the Attorney General's Opinion 86-125 related to ARNP Prescriptive Privileges. The Committee recommended:

1. That the Kansas State Board of Nursing reverse the endorsement of the Attorney General's Opinion 86-125, and
2. That the Board ask the Attorney General's Office to reevaluate the Attorney General's Opinion 86-125.

There were 12 ARNP's in attendance at this meeting and at least four of them requested that as President of the Board, Helen Chop, consider an emergency KSBN Meeting to review the ARNP Committee recommendations. Helen Chop indicated that she would take this under advisement.

March 9, 1988

9:00 a.m. — The ARNP Committee of the Board met to discuss this issue. Joan Felts chaired the ARNP Committee in Helen Chops absence. Approximately 20 ARNP's and interested parties were present and allowed to voice their concerns related to the Boards current position.

March 9, 1988

11:00 a.m. — The Board of Nursing allowed for discussion by interested parties on the agenda item "ARNP's Prescriptive Privileges." The ARNP's, Representatives of KSNA and KANA all asked the Board to consider the implications of their endorsement and reverse their position in support of the Attorney General's Opinion. The Board went into Executive Session with Attorney, Mark Stafford, and upon reconvening Board member Joann Peavler made the following motion:

I move, that in light of the ARNP Committee recommendation and the comments presented today by interested parties that the Board charges the ARNP Committee the task of defining in Regulatory form, the explanation of protocols or guidelines (expands 60-11-104f) to be presented to the May Board.

March 23, 1988

A conference call was held by the ARNP Committee of the Board to discuss the Boards charge to the committee and strategies for addressing the issues. Joan Felts, Carla Lee, and Mary Harness were the ARNP Committee members on the conference call. Staff was directed to obtain language from several other states Nurse Practice Acts on this issue.

Summer 1988

The KSBN ARNP Task Force [illegible]epared regulations expanding the de[illegible] of protocols in the existing regulation K.A.R. 60-11-104.

August 23, 1988

Hearing was held on Temporary Regulations K.A.R. 60-11-104a which clearly defines the role of prescribing under standing orders and protocols by ARNP-Nurse Practitioners. Over twenty ARNP's and several organizations testified in support of the language. KSBN adopted the regulations as temporary, with some recommendations for additional language in the permanent regulations.

September 12, 1988

Rules and Regulations Board approved the Temporary Regulations K.A.R. 60-11-104a for immediate implementation.

November 15, 1988

KSBN held a hearing on permanant regulations K.A.R. 60-11-104a, which would permit nurse practitioners to write prescriptions based on standing orders or protocol. There were several proposed changes to the temporary regulations in place for this authority. Some of the changes were clean-up, such as the addition of nurse and practitioner, the most substantive change was the addition of a new section 5 with a requirement that the protocol or guideline be maintained in 8 1/2 X 11 loose leaf notebook and have a cover page containing: the name, license number, certificate number, and telephone number of the nurse practitioner and the responsible physician, the name, address, and telephone number of a designated physician who agrees to direct and supervise the nurse practitioner in the absence or unavailability of the responsible physician, and documentation regarding the frequency of review for the protocols and the patients charts.

Before the hearing began, Mark Stafford, KSBN legal counsel gave the following explanation regarding his November 14th appearance before the Joint Committee on Administrative Rules and Regulations. Representative Marvin Littlejohn, who chairs the House Public Health and Welfare Committee and is also on the Joint Committee on Administrative Rules and Regulations, questioned (as did other legislators) the legislative authority of the Board of Nursing to promulgate these regulations.

Statements by Mark Stafford, KSBN Legal Counsel; prior to the testimony being taken on Proposed Permanent Regulations for A.R.N.P. Nurse Practitioner Prescriptive Privileges - K.A.R. 60-11-104a:

"The Educational Specialist, Janette Pucci, and myself, had a busy time over at the legislature. The Joint Committee on Rules and Regulations reviewed these regulations. There was some concern by the legislators that the Board may not have the authority to make these regulations. I think one thing is clear and that is that there is question about whether or not we do. I think there is a good argument and they agree, that there is a good argument, that the Board does have this authority. The committee would prefer that this matter be taken up by the legislature and not by the Board. I'm making no judgement and no recommendation on their request, I'm just merely a messenger because they didn't have time to get the message to the Boad by this morning. That message is that they would request that the Board not adopt the regulation at this time, so that the matter can be taken up by the legislature. They did not ask that we withdraw the temporary regulation, their feeling is that they would like to have a study of this and proceed that way. So it's just a message at this point, like I said, to make no recommendation on that."

All of the testimony presented was by ARNP's and other nurses advocating the adoption of the permanent regulations, however, most all of the conferees were unaware of the prior days reaction of the Joint Committee. The Board of Pharmacy did offer testimony asking that the regulations include the following information on the actual prescriptions: Name of the attending physician, and whether the order was under standing orders and protocol or otherwise. The Board did not take any action on these regulations, and deferred discussion of the alternatives until the December 7, 1988 Board meeting.

December 7, 1988

At the KSBN Board Meeting, a motion was made to seek an extension of the temporary regulations 60-11-104a through the Rules and Regs. Board meeting on December 16, and to implement the permanent regulations - K.A.R. 60-11-104a.

December 16, 1988

Before the Rules and Regs. Committee, KSBN staff requested an extension of the temporary regulations for 120 days. This was granted. This extends the temporary regulations K.A.R. 60-11-104a until May 10th.

Also on December 16, the Joint Committee on Administrative Rules and Regs. met and, approved a bill draft for the 1989 Kansas Legislature that would change the Nures Practice Act to prohibit A.R.N.P. - Nurse Practitioners from prescribing drugs, and a language change to the Pharmacy Act which would change the definition of "Practitioner".

S.B. 23

The substantive changes in the bill draft are as follows:

Amends Nurse Practice Act K.S.A. 65-1130 (c)(3) to add:
line 72
An advanced registered nurse practitioner may not prescribe drugs but may transmit prescription orders in accordance with the pharmacy act of the state of Kansas.

Amends the Pharmacy Act K.S.A. 65-1626 (t) to delete language added in 1986 to the definition section of "Practitioner".
line 197
(t) Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator,or optometrist licensed under the optometry law as a therapeutic licensee or diagnostic therapeutic licensee or other person expressly licensed or registered to administer, prescribe and use prescription only drugs in

Aug 2 9 1986

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
ANTITRUST: 296-5299

August 27, 1986

ATTORNEY GENERAL OPINION NO. 86- 125

Lynn Ebel Davis
Board of Pharmacy Attorney
Kansas State Board of Pharmacy
503 Kansas Avenue
P.O. Box 1007
Topeka, Kansas 66601

Re: Public Health -- Healing Arts -- Physicians' Assistants; Issuance of Prescriptions

Public Health -- Examination, Licensure and Regulation of Nursing -- Advanced Registered Nurse Practitioners; Issuance of Prescriptions

Public Health -- Examination and Registration of Pharmacists -- Persons Authorized to Issue Prescription Orders

Synopsis: It is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the act of prescribing medicine, we conclude that physicians' assistants may issue prescription orders under the direction and supervision of a physician. Cited herein: K.S.A. 65-1113(d), (g); 65-1626(t), (x), as amended by L. 1986, ch. 236, §1; 65-2869(b); 65-2896e; 65-2897a(a), (c); K.A.R. 1985 Supp. 60-11-104; 60-11-105; 60-11-106.

* * *

PH&W
attm #1
P94
3-20-9

Dear Ms. Davis:

As attorney for the Board of Pharmacy, you request our opinion as to whether physicians' assistants or advanced registered nurse practitioners may issue, pursuant to standing orders or protocol of a physician, prescriptions for non-controlled substance medication. The controversy surrounding this issue was heightened by passage of 1986 Senate Bill No. 779. While this issue raises many related questions, this opinion concerns only the question as presented above.

The Board of Pharmacy is concerned whether a pharmacist may lawfully fill a prescription issued by a physicians' assistant (PA) or an advanced registered nurse practitioner (ARNP) pursuant to standing orders or protocol. Under the statutes concerning the examination and registration of pharmacists, a "prescription order" means:

> "(a) An order to be filled by a pharmacist for prescription medication issued and signed by a <u>practitioner</u> in the authorized course of his or her professional practice or (2) an order transmitted to a pharmacist through word of mouth, note, telephone or other means of communication directed by such <u>practitioner</u>." K.S.A. 65-1626(x), as amended by L. 1986, ch. 236, §1. (Emphasis added.)

In order to prescribe medication, then, a person must be a practitioner. Prior to July 1, 1986, a "practitioner" was defined as follows:

> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law to administer, prescribe and use prescription-only drugs in the course of professional practice or research." K.S.A. 65-1626(t) (Ensley 1985).

The 1986 session of the legislature amended this provision in Senate Bill No. 779:

> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific

> investigator or other person ~~licensed, registered or otherwise authorized by law~~ expressly licensed or registered to administer, prescribe and use prescription-only drugs in the course of professional practice or research." K.S.A. 65-1626(t) (L. 1986, ch. 236, §1).

The question is whether PAs and ARNPs fit under this definition.

I. Advanced Registered Nurse Practitioner

An ARNP is defined in K.S.A. 65-1113(g) as "a professional nurse who holds a certificate of qualification from the board [of nursing] to function as a professional nurse in an expanded role . . . ." The categories of ARNPs and the role and authority of each are set forth in K.A.R. chapter 60, article 11. An ARNP nurse-midwife and an ARNP nurse anesthetist are both authorized to "participate in the joint review and revision of adopted protocols or guidelines." K.A.R. 1985 Supp. 60-11-105(e); 60-11-106(i). An ARNP nurse clinician has authority to:

> "manage the medical plan of care prescribed for the client, based on protocols or guidelines adopted jointly by the nurse practitioner and the attending physician;
>
> . . . .
>
> "participate, when appropriate, in the joint review and revision of adopted protocols or guidelines when the advanced registered nurse practitioner is involved in the medical plan of care." K.A.R. 1985 Supp. 60-11-104(f), (l).

It is maintained that an ARNP is authorized by law to prescribe medicine since certain ARNPs have authority by regulation to manage the medical plan of care developed for the patient based on protocols adopted jointly by the ARNP and the attending physician. The question is whether, in accordance with K.S.A. 65-1626(t), as amended by L. 1986, ch. 236, §1, an ARNP is expressly licensed or registered to issue prescription orders.

An ARNP functions as a nurse in an expanded role. The definition of the practice of nursing does not include

PH&W
attm #1
pg 5
3-20-9

prescribing medicines. K.S.A. 65-1113(d). As provided by regulation, certain ARNPs in their expanded role may participate in developing a health care plan and manage that plan. This grant of authority does not, however, authorize an ARNP to issue a prescription order. As we are not aware of any statute or regulation which states that an ARNP may issue prescription orders or that they may issue such an order pursuant to standing orders or protocol, we must conclude that ARNPs are not authorized by law to do so.

II. Physicians' Assistants

A PA is defined under the Healing Arts Act as "a skilled person . . . who is qualified by academic training to provide patient services under the direction and supervision of a physician who is responsible for the performance of that assistant." K.S.A. 65-2897a(c). A PA registered with the Board of Healing Arts is authorized to perform the acts outlined in K.S.A. 65-2896e:

> "A person whose name has been entered on the register of physicians' assistants may perform, only under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the physician's assistant. Before a physician's assistant shall perform under the direction and supervision of a physician, such physician's assistant shall be identified to the patient and others involved in providing the patient services as a physician's assistant to the responsible physician. A physician's assistant may not perform any act or procedure performed in the practice of optometry except as provided in K.S.A. 65-1508 and 65-2887 and amendments thereto." (Emphasis added.)

"Direction and supervision" is defined as follows:

> "'Direction and supervision' means the guidance, direction and coordination of activities of a physician's assistant by his or her responsible physician, whether written or verbal, whether immediate or by prior arrangement, and shall not be construed to mean that the immediate or

> physical presence of the responsible physician is required during the performance of the physician's assistant." K.S.A. 65-2897a(a).

The issue whether physicians' assistants may issue prescription orders was raised during the 1978 session of the legislature. As a result of an interim study concerning physician extenders, the special committee on public health and welfare recommended introduction of 1978 House Bill No. 2719. Section seven of the bill as introduced to the House of Representatives read as follows:

> "Prescriptions may be written by physicians' assistants as provided in this section when authorized by the responsible physician except for those controlled substances that are listed on schedule II under federal and Kansas uniform controlled substances acts. The prescription shall include the name, address and telephone number of the responsible physician. The prescription shall also bear the name and the address of the patient and the date on which the prescription was written. The physicians' assistant shall sign his or her name to such prescription followed by the letters 'P.A.' and his or her federal drug enforcement administration registration number."

The special committee's report on the proposed bill reads in pertinent part as follows:

> "The Committee has concluded that the scope of practice of a physicians' assistant in Kansas should be determined by the employing physician rather than by the Board of Healing Arts or by statutes. Experience in those states which have adopted a statutory 'laundry list' of responsibilities which can be assumed by the physicians' assistant indicates that this approach needlessly limits the use of the physicians' assistant.
>
> "In reaching the conclusion that the responsible physician should determine the

PH&W
attm #1
pg 6
3-20-9

> scope of practice of the physicians' assistant, the Committee recognizes that the physician who employs a physicians' assistant remains legally and medically responsible for the actions of that assistant. Ultimately, only the employing physician can judge effectively how the physicians' assistant performs and the limits of his capabilities. The physician should be free to exercise judgment in such matter, fully realizing that if his judgment is faulty he retains the liability for the practice acts of the physicians' assistant.
>
> . . . .
>
> In line with its conclusion that the scope of practice of the physicians' assistant should be determined by the responsible physician, the Committee has concluded that statutory authorization should be given for physicians' assistants to prescribe legend drugs and controlled substances, except those substances in Schedules I and II of the state and federal controlled substances act. The Committee recognizes that there will be opposition to allowing the physicians' assistant to prescribe drugs. However, the members conclude that such authority should be available if the responsible physician chooses to authorize his assistant to exercise it. Again, the Committee notes that the decision to authorize a physicians' assistant to prescribe, and any limitations on such authority, is that of the responsible physician who also is legally and medically liable for the practice actions of the physicians' assistant." Report on Kansas Legislative Interim Studies to the 1978 Legislature, Vol. II, pp. 1100-1102. (Emphasis added.)

Section seven of 1978 House Bill No. 2719 was deleted from the bill by the Senate Committee on Public Health and Welfare on March 7, 1978. Minutes of that meeting read as follows:

> "Senator Talkington made a motion seconded by Senator Morris to delete New Section 7 . . . . Based on Committee reaction to testimony about the ways in which physician's assistants now write prescriptions it was noted that this seems to be OK as long as the procedure being used is technically legal and the legislators do not have to endorse it . . . . It was again noted that New Section 7 does not authorize a physician's assistant independently to write prescriptions. It is permissible only if the responsible physician authorizes it and only to the extent of his authorization. Motion carried with six voting in favor." (Emphasis added.)

It cannot be said that the senate committee intended to prohibit PA's from issuing prescriptions under the direction and supervision of their responsible physician. The above testimony indicates the committee recognized the authority of a physician's assistant, did not want to endorse this practice in the bill, but wanted to allow each physician the decision whether to allow his or her assistant to write prescriptions.

The question is whether, under K.S.A. 65-1626, as amended by L. 1986, ch. 236, §1, a PA is expressly licensed or registered to prescribe medication. The term "expressly" is defined as "in direct or unmistakable terms; explicitly; definitely; directly." Blacks Law Dictionary 522 (rev. 5th ed.). 1986 Senate Bill No. 779, which changed the definition of "practitioner," was referred to the committee of the whole in both the Senate and House of Representatives the same day it was introduced into each respective house. The language "expressly licensed or registered" was added to the bill by the House on Final Action. Therefore, there are no committee minutes to explain the purpose and scope of the amendment.

The 1986 legislature did not amend or enact a law which states that a PA may not prescribe. In outlining a PA's authority, K.S.A. 65-2896e states that a "physician's assistant may not perform any act or procedure performed in the practice of optometry . . . ." This statute was not amended by the 1986 legislature. The doctrine of expressio unius est exclusio alterius provides that if the "statute specifies one exception to a general rule or assumes to specify the effects of a certain provision, other exceptions or effects are excluded." Blacks Law Dictionary 521 (rev. 5th ed.).

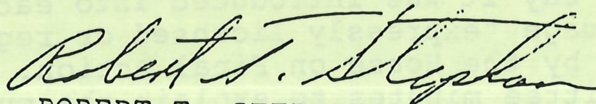
PH&W
attm #1
pg 7
3-20-9

Given this rule of statutory construction, it follows that PAs are not prohibited from prescribing medication because the legislature would have so stated if it had so intended.

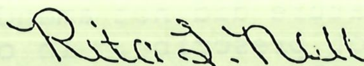
The evidence does not show that it was the intent of the legislature to exclude PAs from issuing prescription orders by changing the definition of "practitioner." The statutes, therefore, must be examined to determine whether a PA is "expressly licensed or registered" to prescribe medicine. A prescription order must be issued and signed by a "practitioner," which is defined to include persons licensed to practice medicine and surgery. K.S.A. 65-1626(t) and (x). A provision among the healing arts statutes states that "[p]ersons who prescribe, recommend or furnish medicine or drugs" are deemed to be engaged in the practice of medicine and surgery. K.S.A. 65-2869(b). A PA is authorized to perform "under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery." K.S.A. 65-2896e. Therefore, it is our opinion that physicians' assistants may issue prescription orders under the direction and supervision of a physician.

In summary, it is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized by statute to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the act of prescribing medicine, we conclude that physicians' assistants may issue prescription orders under the direction and supervision of a physician.

Very truly yours,



ROBERT T. STEPHAN
ATTORNEY GENERAL OF KANSAS



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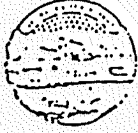

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LYNN E. EBEL
BOARD ATTORNEY

BOARD OF PHARMACY OF THE STATE OF KANSAS

LEGAL POSITION PAPER

To: Board Members of the Kansas State Board of Pharmacy
Executive Secretary

From: Lynn E. Ebel, Board Attorney

ISSUE: Whether or not a physician may lawfully issue standing orders/protocol, which are to be followed by physician's assistants, or advanced registered nurse practitioners, which standing orders include the issuance of prescriptions for prescription only medication for the physician's patients.

A question has been raised as to whether or not a physician may establish, by protocol or standing orders, a course of treatment which includes the prescribing of prescription only drugs. In particular, the question relates as to whether or not a nurse practitioner (ARNP) or physician's assistant (PA) may follow a physician's standing orders, including those orders which direct, in certain instances, the issuance of a prescription.

At the outset, it is imperative that this opinion be interpreted and construed with the following points in mind:

(1) This opinion deals with standing orders/protocol which include prescribing as part of those orders; it is not concerned with the act of dispensing as that area has been previously been addressed by Attorney General Opinion Nos. 80-208 and 81-182. (Attached for your reference).

(2) This opinion is limited to standing orders/protocol which include prescribing of non-controlled substance prescription medication.

(3) The focus of this opinion is on the legal responsibility and liability of a pharmacist presented with a prescription which he or she knows has been prepared by a health professional (not a physician) pursuant to standing orders/protocol. There is not contained herein, either directly or implied, a commentary on standards of competent medical practice.

PH&W
Attm #1
Pg 8.
3-20-9

With these points in mind, I believe it would be helpful to review the licensing requirements of both physician's assistants and advanced registered nurse practitioners.

Physician's Assistants, K.S.A. 65-2896 et seq.

A physician assistant (PA) is a person registered under K.S.A. 65-2896a and who is qualified, by reason of academic training, to provide patient services under the direction and supervision of a responsible physician. (K.S.A. 65-2897a(c)). A PA may perform, under the direction and supervision of a physician,[1] acts which constitute the practice of medicine and surgery[2] to the extent, and in a manner, authorized by a responsible physician.

The statutory scheme dealing with PA's defines direction and guidance of the physician to mean the guidance, direction and coordination of PA activities, written or verbal, whether by immediate or prior arrangement. The supervising physician accepts continuous and ultimate responsibility for the actions of the PA while performing under his or her direction. (K.S.A. 65-2897a). The specific acts of prescribing and/or dispensing by a PA have not been specifically addressed in the statutes. (However, refer to footnote 2.)

Advanced Registered Nurse Practitioners (ARNP), K.S.A. 65-1130

An advanced registered nurse practitioner (hereinafter ARNP) is licensed under separate statutory authority from that applicable to registered or practical nurses. (K.S.A. 65-1130; K.S.A. 65-1115; and K.S.A. 65-1116.) An ARNP must complete specified post-basic training in education and nursing in order to qualify for ARNP status. K.S.A. 65-1131. The Board of Nursing has adopted a regulation which defines and limits the roll of the ARNP; which categorized specialties of the ARNP is recognized by the nursing profession pursuant to K.S.A. 65-1130(c)(1); and which lists the various functions of the ARNP, as nurse clinician and nurse practitioner. Those functions include:

(a) Basic nursing functions;
(b) Evaluation of both physical and psychological health status by examination, patient history, etc;
(c) Assessment of findings;
(d) Planning, implementing an evaluation of care;
(e) Consultation
(f) Management of the medical plan of care proposed for the client based on protocol guidelines adopted jointly by the ARNP and the attending physician;
(g) Initiation of records and tapes;
(h) Development of individualized teaching plans;
(i) Counseling about health and illness;

----
[1] Does not require immediate or physical presence.
[2] The Attorney General of the State of Kansas has opined that the act of dispensing is an act which constitutes the practice of pharmacy, and not the practice of medicine and surgery. (A.G. Opinions No. 80-208 and 81-182).

(j) Recognition, development and implementation of professional and community educational programs;
(k) Periodic and joint evaluation of services rendered;
(l) A joint review and revision of the adopted protocols and guidelines when the ARNP is involved in the medical plan of care. (K.A.R. 60-11-104)

While the physician maintains continuous and ultimate responsibility for the actions of the PA under his or her supervision, the ARNP, by Nursing Board regulation, is directly accountable and responsible to the consumer. (K.A.R. 68-11-101(a)(2)). This regulation does not serve to absolve the physician; nor is it determinative in the civil courts of whether or not the nurse practitioner is civilly liable for injury to or damages of the consumer. It does indicate that the ARNP is to have some extended discretionary control over and responsibility to the persons under his or her care.

Standing Order/Protocol

The Attorney General's Office of the State of Kansas opined, in 1982, that the Board of Pharmacy of the State of Kansas has no authority under the statutes to provide that the issuance of standing orders by a practitioner is outside the scope of professional practice of a physician. (A.G. Opinion 82-241.) Jurisdiction of such matters lies, instead, with the Board of Healing Arts, which Board may investigate complaints against practitioners who allegedly issue standing orders in contravention of standards of competent medical practice. Impiedly, the Attorney General further opined that the Board of Pharmacy may not exercise control or jurisdiction over the contents of such standing orders/protocol. (A.G. Opinion No. 81-241.)

Nevertheless, a pharmacist, under the law (and pursuant to regulations of the Board), has certain responsibilities, not the least of which is taking care to insure the prescriptions filled by the pharmacist are lawful. Hence, the issue presented herein, is really whether or not a pharmacist may lawfully fill a prescription issued by an ARNP or PA pursuant to standing orders/protocol. It is my legal opinion that a pharmacist may lawfully fill such a prescription.

I. Both ARNP's and PA's are authorized to perform functions traditionally reserved for physicians.

As stated herein, a PA may perform, under the direction and supervision of a physician, acts which constitute the practice of medicine. (K.S.A. 65-2897 et seq.) Prescribing is an act which constitutes the practice of medicine.[1] Supervision does not require immediate or physical presence of the practitioner, but requires, instead, guidance, direction and coordination of the PA's activities, whether written or verbal. Those activities can constitute the practice of medicine. The key is that the PA cannot exceed the scope of responsibility delegated to him or her by the physician and the physician remains ultimately and continuously liable to and responsible for the patient.

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[1] "Dispensing", on the other hand, constitutes the practice of pharmacy and may not be delegated. (A.G. Opinion No. 80-208)

PH&W Attm #1 Pg 9. 3-20-9

The ARNP, likewise, is given authority by the statutes, to manage the medical plan of care develop (prescribed) for the patient based on protocols or guidelines adopted jointly by the ARNP and the attending physician. (K.S.A. 65-1130; K.A.R. 68-11-104.) It is probably because of the fact that standing orders/protocols are adopted jointly, that the ARNP also assumes responsibility for the patient.

II. Definitions of Prescriptions Order and Practitioner are Broad Enough to Allow Prescribing by ARNP's and PA's Pursuant to Protocol.

K.S.A. 65-1626(x) defines "prescription order" as:

(1) An order to be filled by a pharmacist for prescription medication issued and signed by a practitioner in the authorized course of his or her professional practice; or

(2) An order transmitted to a pharmacist through word of mouth, note, telephone, or other means of communication directed by such practitioner.

K.S.A. 65-1626(t) defines "practitioner" as a person licensed to practice medicine and surgery, dentists, podiatrists, or other persons licensed, registered or otherwise authorized by law to administer, prescribe, and use prescription only drugs in the course of professional practice or research.

While the definition of practitioner does not expressly include ARNP's and PA's, there is certainly room for inclusion in its general provision. An ARNP, in conjunction with a physician, and a PA, under the supervision and direction of a physician, are lawfully authorized to administer and use prescription only drugs. I would assert, that under standing orders, the authority to prescribe likewise exists for ARNP's and PA's.

I would, therefore, conclude, that an ARNP and a PA may, pursuant to standing orders/protocol, issue prescription for prescription only medications for non-controlled substances.

LEE/csn

Prescribing Behaviors of Primary Care Nurse Practitioners

Janet Rosenaur, RN, MS, Dennyse Stanford, RN, MS, Walter Morgan, MD, MPH, and Barbara Curtin, RN, MSN

Abstract: The prescribing practices of 18 primary care nurse practitioners (NPs) with 1,683 patients over a six-month period were examined through a randomly selected audit of over 1,700 prescriptions. The results showed that NPs prescribed a very limited number of well known, relatively simple drugs to a young, female healthy population. The prescription/visit rate was 0.26. Most drugs were initiated for the first time rather than refilled. There was minimal physician consultation regarding drug use during the visit. The results provide evidence of the ability of nurse practitioners to prescribe drugs and should aid in the further legalization of this aspect of the primary care role. (*Am J Public Health* 1984; 74:10–13.)

Introduction

Despite the growing body of empirical work on the nurse practitioner (NP) in primary care, there is a paucity of published longitudinal studies describing their prescribing practices. Repicky, *et al*, in a national survey that involved 341 NPs in an ambulatory setting, report practices that emphasize prevention focusing upon minor to moderately severe health problems, and serving a predominantly under age 30, female population.[1] Nearly 20 per cent of the NP encounters were classified as health maintenance. Over 21 per cent of patients had drugs prescribed, but no details about specific drugs were reported.

Munroe, *et al*, in an urban university-affiliated ambulatory care facility, analyzed 1,000 prescriptions written by six N.P. faculty from a selected formulary in a six month study,[2] finding:

- the patient population was predominately female, 16–30 years of age;
- the number of prescriptions was approximately one-third the number written in a primary care medical practice;
- the majority of prescriptions were for primary prevention and fell in the categories of "comfort," "mucocutaneous discomfort" and "contraception";
- antibiotics constituted the largest category of prescriptions written for secondary prevention;
- a chart audit revealed that 98–99 per cent of NP prescriptions were appropriate, consistent with the study protocol, and safe.

The State of California in 1977 approved legislation* that allowed nurse practitioners, physician assistants, and clinical pharmacists enrolled in special projects to prescribe and or dispense drugs. The study reported here examines the prescribing practices of 18 primary care nurse practitioners; it asks the following questions:

What are the sex, age, and health characteristics of the patients receiving prescriptions?

What are the most frequently prescribed drugs?

What are the most common conditions for which drugs are prescribed?

Are there differences in prescribing related to type of NP or patient characteristics?

What activities most commonly occur during prescribing (initiating or refilling a drug, consulting with MD or pharmacist, ordering laboratory tests)?

Methods

Sample/Procedures

The prescribing behaviors of 18 primary care nurse practitioners were studied over a six-month period. This sample represents all of the practitioners who had volunteered and met the criteria to participate in a four-year prescribing project developed by a consortium of three practitioner programs.** Criteria for participation included passing a pharmacology pretest, availability of a physician preceptor and pharmacist consultant. Ten participants were family nurse practitioners (FNP), three were women's health nurse practitioners (WNP), three were pediatric nurse practitioners (PNP), and two were adult nurse practitioners (ANP). The NPs could prescribe only from a project developed formulary of 257 drugs and devices. All scheduled, controlled substances (narcotics, tranquilizers, sedatives) were excluded, but otherwise the formulary was estimated to represent 90 per cent of all drugs commonly used in primary care practice. No specific treatment protocols were developed for this study. Each NP and MD team incorporated the prescription of drugs from the formulary into existing guidelines being used in that setting for NP practice. All 18 practitioners, at the initiation of the study period, had been prescribing for a minimum of one year under California's legislation.

A total of 1,716 prescriptions representing 1,683 patient visits from July through December 1980 were included in the study. A carbon copy of every prescription written was submitted to the consortium faculty monthly, together with a list of all drugs the patient was currently taking and all current health conditions. These were audited for accuracy of format and the quality and appropriateness of drug selection.

Using a table of random numbers, 20 prescriptions were selected for inclusion in the study from each practitioner's

*California Assembly Bill 717 (AB717)

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Editor's Note: See also related editorial p 6 this issue.

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**University of California, San Francisco (UCSF), University of California, Davis (UCD), Sonoma State University (SSU): Health Manpower Pilot Project 115 (HMPP#115).

#1 att pg. 10

3-20-9

TABLE 1—NP Characteristics (N = 18)

Characteristics	N
Basic Nursing Preparation	
B.S.	8
M.S.	6
Diploma	4
Sex	
Women	15
Men	3
NP Preparation	
C.E.	14
B.S.	3
M.S.	1
Years in Nursing	
10 or more	14
5–10	4
Years as NP	
5 or more	13
3–4	5
Practice Setting*	
Private Practice	9
Community Clinic	6
Health Department	1
College Health	1
Public Health Service	1
Practice Location	
Metropolitan**	10
Non-Metropolitan	8
% of Time Working	
Full-Time	11
Half-Time or Less	7

*Six FNPs worked in private practice and four were employed in community clinics; two PNPs were employed in private practice and one in a health department. One ANP worked in college health and one for the Public Health Service on an Indian Reservation. Two WNPs were employed in community clinics and one in private practice.

**Metropolitan counties, as defined by US Census, are those with more than 50,000 inhabitants or with a single city of that size.

group of monthly prescription reports.*** The ICHPPC/H-IDCA diagnostic classification system was adapted for use in coding the diagnosis for which a drug was prescribed. Other concurrent health conditions of the patient listed on the prescription were coded as either a self-limiting or chronic illness. No data were collected on patients not requiring a prescription nor on the physician consultant's practice. Descriptive data were collected on each prescriber through a mailed questionnaire.

Results

Demographic data for the 18 practitioners (Table 1) reveal an experienced, well-educated group of individuals, the majority of whom work full time in private practices located mostly in metropolitan areas.

As a total group, the practitioners see many patients for whom no drug is prescribed. The ANPs and PNPs see the least number of patients per month and also prescribe the fewest drugs. The majority of patients (86 per cent) in the sample received only one prescription per visit while 13 per cent and 1 per cent of the patients received two and three prescriptions per visit, respectively. Most practitioners consult directly with a physician and utilize the telephone for pharmacist consultation.

In the six-month study period, there were a total of 14,361 patient visits for all practitioners and a total of 3,790

***There were four part-time (3 FNPs, 1 PNP) practitioners who routinely wrote under 20 prescriptions each month, therefore their entire monthly output was included.

TABLE 2—Type of Health Condition Category by Which a Drug is Prescribed by Type of NP

Type of NP	N	Prevention (%)	Self-Limiting Illness (%)	Chronic Illness
ANP	206	27	59	14
FNP	900	16	69	14
PNP	233	35	64	1
WNP	316	50	43	7
TOTAL	1,655	26	62	12

x^2 = 101, d.f. = 6, $p < .001$

prescriptions written, resulting in a study average of 0.26 prescriptions written per visit (WNP = 0.24, PNP = 0.32, ANP = 0.31, FNP = 0.26).

The 1,683 patients for whom drugs were prescribed had a mean age of 23.‡ Less than 5 per cent of the total population were older than 60 years of age. Practitioners saw a predominantly female population (WNP = 100 per cent, ANP = 80.3 per cent, FNP = 67.6 per cent) with the exception of the PNP group whose caseload was evenly divided between the two sexes.

The patient population seen by the study sample was quite healthy; 68.7 per cent of the study population reported no other health problem than the one for which a drug was prescribed. The 106 different health conditions were categorized into three groups. The indication for a prescription in 26 per cent of the patients was Prevention‡‡; in 12 per cent a Chronic Illness; and in 62 per cent a Self-Limiting Illness (Table 2). Of the entire patient population, 12.8 per cent had one additional self-limiting illness, 12.5 per cent had a combination of both chronic and self-limiting illness, and 12.5 per cent had one additional chronic illness; the remaining 6.1 per cent had a combination of both chronic and self-limiting illness, or more than one self-limiting or chronic illness. Table 2 displays the distribution of prescriptions among the three types of conditions according to type of NP.

Table 3 presents the distribution of the 10 most frequently occurring health conditions by NP type. Three groups of practitioners (WNPs, ANPs, and FNPs) prescribe a drug most frequently for contraceptive purposes. The PNP and WNP groups, consistent with their drug usage, prescribe for a narrow range of health conditions, with the top 10 accounting for 90 per cent of all conditions for which they prescribe drugs. The diagnostic categories most commonly seen by the ANP and FNP are very similar.

There are 181 different drugs, drug categories, or devices prescribed by the total study group. Table 4 indicates frequency distribution of the 10 most commonly prescribed drugs or devices by type of nurse practitioner.

The majority of patients (56.4 per cent) were taking only one drug; 32.5 per cent were taking two, and 11.1 per cent were taking three. The distribution of these patients among the four NP groups was similar. An analysis of variance revealed no significant differences with regard to sex, health condition, or type of prescriber activity. A significantly higher percentage of women than men were taking three

‡The mean age of patients seen by the PNP group was 3.7 years, while the mean age of patients seen by the other three groups ranged from 25.7 to 27.3 years of age.

‡‡Prevention as a reason for seeking care was defined by the study to include well child care, contraception, prenatal care, and dental health.

TABLE 3—Ten Most Frequently Occurring Health Conditions by Type of NP (N-1,254

WNP	% (N-285)	PNP	% (N-211)	FNP	% (N-579)	ANP	% (N-179)
Contraception	42	Otitis Media	38	Contraception	11	Contraception	27
Vaginitis	31	Well Child Care	34	Vaginitis	8	Otitis Media	9
Prenatal Care	8	URI	4	Otitis Media	7	Dermatitis	8
Dysmenorrhea	4	Dermatitis	4	Bronchitis	6	Cystitis	7
Nausea	1	Asthma	3	Hypertension	6	URI	7
Menopause	1	Conjunctivitis	2	Cystitis	5	Hypertension	7
Cystitis	1	Thrush	1	Dermatitis	5	Vaginitis	5
Bronchitis	1	Pneumonia	1	URI	5	Pharyngitis	4
Anemia	1	Anemia	1	Pharyngitis	4	Bronchitis	3
Salpingitis	1	Acne	1	Well Child Care	4	DJD	2
TOTAL %	90		90		62		79

drugs, and there was slightly more consultation with the physician for patients using three drugs.

Of all drugs prescribed, 85.5 per cent were initiated as new prescriptions while 14.5 per cent were refills. Consultation with a physician regarding the selection of a particular drug during the visit occurred in only 5 per cent of all patient encounters. Consultation with the pharmacist, at the time of the visit, occurred less than 1 per cent of the time. There were significant differences among the four practitioner groups with regard to consultation with the physician. The PNP group consulted the most (16 per cent), whereas the WNP group consulted the least (<1 per cent); the ANP group consulted 6 per cent of the time and the FNP group consulted 4 per cent of the time.

Laboratory tests related to the prescription of a particular drug were ordered over 11 per cent of the time in the entire group. The PNP and WNP groups ordered no laboratory studies, whereas the ANP group ordered laboratory work 10 per cent of the time and the FNP group 19 per cent of the time.

Discussion

The nurse practitioners in this study prescribed a very limited number of well known, relatively simple drugs to a young, predominantly healthy female population, a finding similar to both the Repicky[1] and Munroe[2] studies.

One would expect the PNPs and WNPs to work with relatively healthy populations where many visits would be focused on health promotion rather than illness treatment. However, the ANPs and FNPs are also seeing large numbers of patients, predominantly women, for prevention-related drug or device prescription, primarily family planning. For all three of the NP types who see adults, contraception is the most frequently occurring diagnosis for which a drug or device is prescribed, and three out of the first top 10 most frequently seen diagnoses relate to women's health concerns.

Consistent with the characteristics of the patient population is the finding that hypertension, asthma, and degenerative joint disease (DJD) were the only chronic illnesses in the 10 most frequently occurring conditions for which a drug is prescribed. Previous studies have indicated that ANPs and FNPs in a primary care practice with a physician tend to see more of the maternal-child health group, while physicians see more of the multi-problem/older patient group.‡‡‡ The lack of older adults is unusual and the ANP patient profile may be related to the type of setting where the two ANPs were employed. The provider triage or patient self-selection for the nurse practitioner may also reflect nursing's better preparation in and focus on health promotion and wellness care. This study provides only a partial picture of NP practice. There are no data on the patient visits in which no drugs were prescribed.

The relatively low percentage of consultation activity with the physician is an interesting finding. Consultation in a busy practice frequently occurs prior to a particular patient visit often covering general care issues. The study group was instructed to only record this activity if the NPs consulted during the visit in relation to the selection of a particular drug or drug dosage. This procedure may cause an underestimation in the amount of actual consultation occurring. Since all NPs had been in practice over three years and 15 had remained in the same practice, it is conceivable that they

‡‡‡O'Hara-Devereaux M, Andrus LH, Quilter-Dervin P, Dervin J: Co-Practice: Family Nurse Practitioner-Family Physician. Unpublished report to Robert Wood Johnson and Kellogg Foundations, 1982.

TABLE 4—Ten Most Frequently Prescribed Drugs by Type of NP (N1051)

WNP	% (N-234)	PNP	% (N-192)	FNP	% (N-487)	ANP	% (N-138)
Diaphragm	19	Fluoride	26	Ampicillin	7	BCP	17
BCP	14	Amoxicillin	21	Actifed	7	Diaphragm	11
Betadine	7	Ampicillin	11	Erythromycin	7	Erythromycin	7
Monistat	7	Tri-Vi-Flor	6	BCP	7	Drixoral	5
Flagyl	6	Hydrocortisone	4	Penicillin	7	Penicillin	4
Vitamins	6	Erythromycin	3	Tetracycline	5	Gantanol	4
Contraceptive Jelly Cream	5	Dimetapp	3	Diaphragm	4	Lotrimin	4
Lotrimin	4	Septra	3	Benadryl	3	HCTZ	4
IUD	4	Mycostatin	3	Tri-Vi-Flor	3	Tetracycline	3
Motrin	3	Theophylline	2	Cortisporin	3	Sudafed	3
TOTAL %	74		82		52		61

P. H & W attm #1 pg. 11 3-20-9

needed little consultation because they had already developed many processes of care agreements with their consultants and would be very familiar with the general group of patient problems and the appropriate pharmaceutical regimen. The higher percentage of physician consultation in the PNP group may be the result of the more critical dosage/age requirements in children. Finally, if a physician were consulted, conceivably the physician may have written the prescription, and would not use project forms.

The nearly nonexistent consultation with a pharmacist probably reflects underestimation of actual consultation. NPs were required to document on-site consultation only if it occurred at the time of the visit. Other data required by the larger State project demonstrated a great deal of telephone consultation with pharmacists.*

There are many areas where further research is needed. The small number of NPs in each type prohibits generalizing the findings of this study. It would be important to repeat the study with a larger number of practitioners who were not specially selected. It would also be useful to study the physician colleague's practice to explore the possible influences bearing upon the nurse practitioner selection of particular drugs, the use of non-pharmaceutical measures, and the selection of patients. Such studies are useful to educational programs in planning the pharmaceutical and disease management aspects of their curriculum. They also provide legislators and nurse practitioner advocates with data about nurse practitioner prescribing practices that aid in the legal recognition of this function in California and other states.

*Pharmacist Conference Form E_5 (HMPP#115) (data collected on frequency of pharmacist consultation).

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1. Repicky P, Mendenhall R, Neville R: Professional activities of nurse practitioners in adult ambulatory care settings. Nurse Practitioner 1980; 5: 2:27-40.
2. Munroe D, Pohl J, Gardner HH, Bell RE: Prescribing patterns of nurse practitioners. Am J Nursing 1982, 82: 10:1538-1540.

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Primary Care Research in 1982

Primary Care Research in 1982; now available, is a collection of primary care research abstracts submitted to the Ambulatory Pediatrics Association, the North American Primary Care Research Group, the Society for Adolescent Medicine, the Society of Teachers of Family Medicine, and the Society for Research and Education in Primary Care Internal Medicine.

The research is presented in seven sections including medical education, practice, psychosocial medicine, health care delivery, patient education, clinical issues and clinical epidemiology and clinical decision-making. The 470 abstracts have been indexed and key words are added. A cumulative index from 1980 through 1982 is included.

The purpose of the volume is to disseminate work in primary care, to provide a succinct view of the state of primary care research, and to inform members of each society of the efforts of the others.

Primary Care Research in 1982 is being made available below cost thanks to the Rockefeller Foundation. To get it, simply write to: Mack Lipkin, Jr., MD, Department of Medicine, New York University School of Medicine, 550 First Avenue, New York, NY 10016—marked Attention: New Bellevue-16S. Please enclose a check for $5 for shipping and handling made out to NYU/Primary Care Research. Order now, as supplies are limited.

THE NURSE PRACTITIONER
THE AMERICAN JOURNAL OF PRIMARY HEALTH CARE

AN NP EXCLUSIVE

How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice

Editor's Note: *This article presents the results of a survey designed to see how states compare on three key questions regarding legal and prescriptive authority and reimbursement policies. Such a nationwide comparison of these important issues has heretofore been lacking in recent literature. Limited quantities of this article are available for $2 each. Please make your check payable to* The Nurse Practitioner, *3000 Northup Way, Suite 200, Box 96043, Bellevue, WA 98004. — Linda J. Pearson, R.N., M.S.N., C-F.N.P.*

Legal authority, reimbursement policies and prescriptive authority for nurse practitioners vary from state to state. This prompted *The Nurse Practitioner: The American Journal of Primary Health Care* to compile a table listing current legislative information on advanced nursing practice in all 50 states (plus Washington, D.C.) to facilitate a comparison between the states. While compiling this table was no easy task, the credit and many thanks must go to the many nurses around the nation who answered by phone or letter *The Nurse Practitioner*'s request to report on their state.

Every attempt has been made to produce an up-to-date, accurate accounting on each state. For most of the states, the interpretation of its statute was obtained from a representative of the state nursing organization's NP Special Interest Group, from a representative of an NP organization within the state, or from a member of the State Board of Nursing. Information was verified wherever possible, with our state contacts. The Journal welcomes feedback and will print any validated corrections or updates.

Respondents were asked to report on the status of legal authority in their state, the status of third-party reimbursement for RNs and NPs within the state, and the status of prescriptive authority within the state (see Table 1, pp. 28-34). The table includes a key to abbreviations used.

It is interesting to note differences among the states in how they authorize advanced practice for NPs. *The Nurse Practitioner* survey found that in 34 states **NPs are regulated by the Board of Nursing through specific regulations. In eight states NPs function under a broad Nurse Practice Act scope of practice, and in eight other states NPs are regulated by both the Board of Nursing and the Board of Medicine.** In one state NPs are authorized to practice under the Education Act.

The status of third-party reimbursement for NPs also varies among the states. In 19 states **third-party reimbursement to NPs is legislatively addressed and in 14 other states NPs are currently working intently on obtaining legislative authorization. In six states NPs are receiving direct reimbursement from insurance companies in spite of no legislative authorization.** Twelve states have not addressed the third-party reimbursement question.

In 28 states NPs **currently have legislative authority to prescribe** (three of these states are working on final implementation of the authorizing rules and regulations). Where the phrase "no current legislative authority" is listed for a particular state, NPs are still prescribing (see *The Nurse Practitioner,* November 1986, 11:11, "NPs Write Prescriptions Regardless of Enabling Legislation," pp. 6-7).

Almost every respondent from states without prescriptive authority explained that the majority of NPs in their state still obtain prescriptions for their patients through one or more of the following mechanisms: 1) by asking a physician to write a specific script for the NP's patient; 2) by calling in the prescription under the physician's name; 3) by co-signing the physician's prescription pad; 4) by using pre-signed prescriptive pads; and/or 5) by using protocols jointly worked out with the NP, physician colleague and dispensing pharmacist.

#1 pg 12 3-20-9

TABLE 1
Legal Authority, Reimbursement and Prescriptive Authority for Advanced Nursing by State

	Practice (see key)	Reimbursement (see key)	Rx (see key)
Alabama	Covered under the administrative code of the NPA; the BON promulgated R&Rs for specialty practice (NPs, CNMs and CRNAs) in 1982.	Third-party reimbursement legislation drafted in 1986; passed the House but failed to get out of committee in the Senate. The bill has not been reintroduced.	No current legislative authority.
Alaska	NPs have statutory authority to practice as NPs.	A non-discriminatory clause in the Insurance Law allows for third-party reimbursement to NPs.	NPs have independent prescriptive authority including controlled drugs (Schedule II-V).
Arizona	A definition for NPs is outlined in the BON R&Rs addressing extended nursing practice. Currently only NPs are addressed.	Registered NPs and other certified registered nurses can receive third-party reimbursement under law effective until 1990. NPs plan on lobbying to renew law.	NPs have full prescriptive and dispensing authority upon application and fulfillment of criteria established by the BON. The enabling statute allowing CNPs to prescribe is in the pharmacy statute with corresponding R&Rs in the NPA. NPs are provided their own DEA # and may prescribe Schedule II and III drugs (limited to a 48-hour supply per patient) and Schedule IV and V (a one-month supply with no refills per patient). Other drugs may be refilled five times or up to one year before the patient must see an MD for medication re-evaluation.
Arkansas	NPA legitimizes practice for NPs, CRNAs and CNMs; there are separate R&Rs for NPs.	Some private carriers do reimburse RNs directly; Medicaid reimburses CNMs directly, but not NPs.	No current legislative authority; Board of Pharmacy did pass a special waiver for a limited number of drugs for women's health NPs who work for the Department of Health. These prescriptions are pre-printed and cannot be altered. The NPs sign a physician's name and then their own.
California	The BON issues certificates to CNMs and CRNAs. NPs who meet the BON requirements are so designated on their licenses.	Psychiatric clinical nurse specialists are eligible to receive third-party reimbursement. On a pilot basis, NPs are eligible to receive Medicaid reimbursement for services delivered in nursing homes.	NPs who have satisfactorily completed at least six months of MD-supervised experience in furnishing drugs or devices *and* who have satisfactorily completed a course in pharmacology *and* who have been issued a furnishing number by the BON may furnish certain drugs or devices incidental to the provision of family planning services.
Colorado	There is no title protection or specifications for advanced practice within the NPA. The act is broad to cover NPs; scope of advanced practice is based on RN's own determination of education and amount of physician supervision necessary to safely conduct practice.	New legislation allows third-party reimbursement to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to another health care provider (i.e., a fiscally neutral bill).	No current legislative authority for RNs prescribing.

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CRNA - Certified Registered Nurse Anesthetist
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NPA - Nurse Practice Act
ARNP - Advanced Registered Nurse Practitioner

Practice - Respondents answered question, "What is the status of legal authority for advanced practice in your state?"
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Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

	Practice	Reimbursement	Rx
Connecticut	Though advanced practice is not recognized in NPA, nurses in advanced practice must be certified, based on a declaratory ruling by the BON.	Nurses in advanced practice are reimbursed for services rendered based on state statute.	There is no current legislative authority for nurses in advanced practice to prescribe; however, legislation will be introduced in the 1989 session (opening the NPA) in order to introduce advanced practice and prescriptive authority legislation.
Delaware	In 1985 the NPA was amended to require the BON to write R&Rs for expanded-role nurses. The implementation (by the end of 1989) of R&Rs will require mandatory BON listing of NPs — they will be titled ARNPs.	CNMs obtained legislative authority under the Board of Health for third-party reimbursement in October 1988. Other advanced practice RNs intend to petition soon for authority.	All RNs can apply (with their delegating physician) to a joint-practice committee of the BON and BOM to have their protocols (including a list of prescriptive drugs to be prescribed by the RN) approved. Accepted protocols must be re-evaluated every year.
District of Columbia	NP practice is defined in the Health Occupations Revision Act (1986); NPs are under jurisdiction of the BON. NPs must work in collaboration with physicians or osteopaths.	There is no current legislative authority for NPs to receive third-party reimbursement. However, legislation is currently pending for mental health clinical specialists.	The D.C. statute provides for prescriptive authority for NPs. R&Rs are currently pending.
Florida	NPs are certified by the BON as "Advanced Registered Nurse Practitioners."	NPs receive Medicaid and Champus reimbursement. Mental health clinical specialists, CNMs and CRNAs receive third-party reimbursement.	Prescriptive privileges were obtained for NPs in May 1988 as a result of a decision by the BON/BOM joint committee; controlled substances are excluded.
Georgia	The NPA gives authority to the BON to set R&Rs for NPs, CRNAs, CNMs and clinical specialists in psych/mental health. The current R&Rs specify that NPs should work within protocols that have been jointly developed by the NP and collaborating MD or agency. The protocols are not currently evaluated by any state licensing board; in the 1989 session the NPA is being opened to clarify "protocols." The BON expects agencies to have a policy statement for the NP's scope of practice consistent with general geographic location, and appropriate for the NP's level of education, experience and on-site evaluation.	NPs are not approved providers because there is no legislative statute for third-party reimbursement.	No current legislative authority, though language in proposed NPA (to be introduced in 1989) will, if passed, grant prescriptive authority to NPs.
Hawaii	There is no specific language for advanced practice in the NPA.	NPs are reimbursed for federal programs (i.e., Champus) only.	No current legislative authority.
Idaho	Legality for the NP is jointly promulgated by BON and BOM. Nursing is evaluating proper timing of the goal to introduce legislation eliminating the requirement for joint promulgation of R&Rs.	No current legislation for direct third-party reimbursement for NPs or RNs; the Idaho Nurses' Association is actively working to change this. Certified NPs may apply for a Medicaid reimbursement number.	Prescribing is allowable for certified NPs with written practice protocols; NPs may not prescribe controlled substances.
Illinois	The NPA's definition of nursing practice contains no reference to advanced practice, though NPA legislative transcript (1984) intent includes all nursing specialties. Nursing practice must stay within "the scope permitted by law and within the RN's own educational preparation and competencies."	There is no third-party reimbursement unless the NP works in a certified rural health clinic — the NP can then directly bill both Medicare and Medicaid.	No current legislative authority.

PH&W attm #1 pg 13 3-20-9

	Practice	Reimbursement	Rx
Indiana	NP practice is defined in NPA with qualifications "as determined by BON"; the BON has not yet adopted R&Rs.	NPs cannot directly receive third-party reimbursement.	No current legislative authority.
Iowa	Advanced-practice administrative rules are in the NPA. ARNPs are licensed by the BON.	There is "permissive option" legislation which permits third-party reimbursement for NPs.	No current legislative authority.
Kansas	Advanced practice recognition is voluntary for ARNPs (CNMs, NPs and clinical nurse specialists). There is mandatory recognition for CRNAs.	NPs can be reimbursed by Medicaid for assessment screening and case management of technology-dependent children. Third-party payers reimburse CRNAs and CNMs.	NPs may prescribe under jointly adopted protocols between the nurse and physician. The BON will adopt R&Rs for permanent regulations allowing for ARNPs to prescribe following jointly agreed upon protocols with "the responsible physician," excluding controlled substances.
Kentucky	State law licenses ARNPs (including nurse practitioners, nurse midwives and nurse anesthetists).	State law is lenient in directly reimbursing NPs in primary care and rural health centers. Direct physician contact is required in private settings.	A 1988 bill allowing ARNPs to prescribe was narrowly defeated in legislative committee. NPs are gearing up for reintroduction in the interim session in early 1989.
Louisiana	R&Rs for NPs are promulgated by the BON.	There is only Medicaid reimbursement for CNMs.	No current legislative authority.
Maine	Specific regulations for NPs granted by BON; NPs are seeking revision this year with the goal of minimal regulation for advanced practice.	None for NPs but legislation was adopted to include reimbursement to master's-prepared, certified psych/mental health nurse specialists only.	Prescriptive authority is approved by BOM (NPs have their own DEA #). Limits in prescribing formulary by exclusion (i.e., narcotics).
Maryland	NPs are certified to practice through the BON; requirements include passing a nationally certified exam and written agreement with a responsible MD (the agreement is reviewed by an equally represented joint MD/NP committee).	Per legislation passed in 1986, all nurses are entitled to reimbursement for services as long as they are practicing within their legal scope of practice. Medicare is pending; approval by the state legislature is anticipated shortly.	NPs prescribe medications as agreed upon in writing with physicians. The NP uses his or her own signature on the prescriptive pad; a list of NPs "certified to practice" is sent to pharmacists. There was a question several years ago whether the pharmacy regulations allowed "filling" of scripts written by NPs, but the attorney general's opinion was that NP scripts were as acceptable as any other provider's.

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	Practice	Reimbursement	Rx
Massachusetts	Since 1975, nurses with additional education approved by the BON may perform certain additional acts under R&Rs approved by the BON and BOM. This includes NPs, CNMs, CRNAs and psychiatric nurse/mental health clinical specialists.	Psychiatric nurse/mental health clinical specialists and midwives are currently reimbursed due to state law. Bills are pending before the Legislature on reimbursement for NPs and CRNAs.	NPs, after registering with the Department of Public Health, may prescribe for patients in long-term-care facilities as well as for chronic-disease patients in their homes, if this would avoid their being institutionalized.
Michigan	The BON has R&Rs for nurse specialty certification — only nurses certified in a specialty field may present themselves to the public as nurse specialists using the title of nurse anesthetist, CNM and NP.	Two attempts so far to get legislative enactment have failed; however, several nurses have obtained a provider number and are receiving direct reimbursement.	A January 1980 attorney general decision interpreted the statutes to allow physicians to delegate the prescribing of drugs to RNs.
Minnesota	NP authority to practice is covered under a broad NPA; there is no separate category for advanced practice.	CNMs and CRNAs already have legislative authority for reimbursement. NPs and clinical nurse specialists in psych/mental health just received legislative authority for reimbursement in the 1988 legislative session.	CNMs just received authority to prescribe in 1988. NPs hope to try in the next few years for their own prescriptive authority.
Mississippi	NPs are regulated by the BON. R&Rs regarding NP practice are jointly promulgated by BON and BOM. A BON-sanctioned committee structure (consisting of NPs and consulting MDs) evaluates (every two years) each NP's "protocols" (written statement of the types of medical diagnoses and treatments anticipated for their practice).	CRNAs and NPs (in rural health clinics) receive federal funding reimbursement. NPs have worked hard to obtain legislative enablement for Medicaid reimbursement, but so far no success. The third-party reimbursement law for NPs was first passed in the early '80s but that law had a "sunset" clause and required an MD sponsor co-signature on the form. The '88 legislative session removed the "sunset" clause but retained requirement for MD co-signature.	NPs have statutory prescriptive authority granted by BON; the prescriptive authority is based on the accepted "protocol" which lists the treatments and medications the NP expects to prescribe in his or her practice. NPs are not allowed to prescribe controlled substances.
Missouri	Advanced practice is permitted based on broad language of the NPA, and a decision by the Missouri Supreme Court.	Medicaid reimburses CNMs directly with no direct reimbursement for other nurses. Blue Cross/Blue Shield has a statutory non-discriminatory policy for licensed health care providers. Whether other types of insurance reimburse NPs depends on the company policy.	There is no statutory prescriptive authority. Authority is granted through standing orders/protocols with cooperating physicians.
Montana	Nurse specialists (NPs, CNMs and CRNAs) are recognized by the BON to practice after completion of specific curriculum requirements plus successful completion of a certifying exam by a recognized certifying body.	Nurse specialists have third-party reimbursement for all the areas and services for which a policy would reimburse an MD.	No current legislation authorizing prescriptive authority; however, nurse specialists are working hard on this issue and are identifying the changes needed and the most effective way to make the necessary changes.
Nebraska	NPs are certified as CNPs on approval by the BON and BOM. CNPs and MDs must have joint approval of their "practice agreement" contract. The practice agreement must include the NP's scope of practice and the practice arrangement with the MD. NPs must have written protocols for clinical entities seen. Changes must go through the Department of Health (BON).	Except where federally mandated there is no state legislation for third-party nursing reimbursement.	NPs may prescribe as specified on the "practice agreement" form. Drugs prescribed must be listed on NPs' protocols and may not include Schedule II drugs. The NP must use an Rx pad containing the MD's name preprinted at the top; the signature contains NP name/MD name.

attm #1
Pg 14
3-20-9

	Practice	Reimbursement	Rx
Nevada	An advanced practitioner of nursing (APN) is recognized by BON (title includes CNMs). Applicant must have graduated from a year or longer program, be accredited by a board-approved organization, and submit a signed agreement (including the scope of practice and protocols) between the APN and the collaborating MD. After 1988 all APN applicants must hold a BSN and after 1995 must hold an MSN. The BOM has R&Rs for MDs working with APNs.	NPs and CRNAs have received third-party reimbursement since 1985. Some other nurses in private practice also receive third-party payment.	APNs may prescribe (since 1983) if they submit to the BON documentation of 1,000 hours as an APN under a supervising MD and a signed statement from the MD. The APN can then prescribe any meds (excluding controlled substances) listed in his or her protocol (developed by the supervising MD at the site and updated yearly).
New Hampshire	NPs are registered with the BON as ARNPs (if they are a graduate of an NP program and have passed a certifying exam acceptable to the board).	All major insurance companies must by law reimburse ARNPs (not all RNs). Some insurers reimburse ARNPs at 100 percent and others at 90 percent. The law does not apply to companies that are self-insurers.	An ARNP who functions in connection with protocols established jointly with a "collaborative physician" may prescribe medications from the official formulary which has been jointly agreed upon by the BON and BOM. ARNPs are assigned DEA #s.
New Jersey	NPs practice under RN licensure with BON guidelines for primary care NPs.	There is third-party reimbursement (for services traditionally reimbursed to MDs) for RNs and NPs who are not employed as salaried personnel.	Legislation is currently pending which will authorize prescriptive privileges for NPs.
New Mexico	NPs have been defined in the NPA for more than 10 years. Functions and responsibilities are detailed in the R&Rs from the BON.	Reimbursement has been in effect for CNMs and CRNAs. Statutory authority for third-party reimbursement was passed in 1987 for clinical nurse specialists and NPs.	NPs have prescriptive privileges with their own signature in accordance to written protocols with physician supervision. NPs are listed at the BON, Board of Pharmacy and BOM.
New York	Specific legislation amending the Education Act to authorize NPs' title and scope of practice will become effective April 1, 1989.	Reimbursement mechanisms are under discussion with state agencies for NPs to be recognized providers for Medicaid participants. NPs believe that the existing model ("obstetrician and CNM") will be applicable to "NP and collaborating physician."	The new law specifies Rx authority for NPs in a collaborative relationship with MD and with written practice agreement and protocols. The law states "prescribed drugs, devices and immunizing agents" without restriction (i.e., controlled substances). Regulations to implement the new law are being developed.
North Carolina	NPs apply to a Joint Practice Subcommittee of the BOM and the BON to obtain approval to practice as an NP. NPs may own their own private practice as long as they contract with an MD (not necessarily on site) to act as medical backup.	NPs receive Champus payment only.	NPs may write prescriptions with limited refills from an approved list of drug categories (i.e., no narcotics or chemotherapy medications). Authority to prescribe (NP is assigned a prescriptive #) is given at time of approval to practice as an NP.
North Dakota	Advanced practice for NPs and clinical nurse specialists is regulated by the BON after demonstrated advanced education and certification.	A bill for nurse reimbursement was passed in the 1985 legislature but amended to make it useless. The bill will be reintroduced in the 1989 legislative session.	No current legislative authority.

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	Practice	Reimbursement	Rx
Ohio	With the 1988 revised NPA the BON now has authority to establish criteria for specialty certification of RNs with advanced education and experience. No R&Rs have been developed to date.	Some RNs including NPs are receiving reimbursement as a result of direct negotiations with insurance companies; there is no proposed legislation at this time.	There has been no legislation introduced.
Oklahoma	NPs are defined in NPA and regulated by BON; NPs must have successfully completed a program approved by BON.	There is no current legislation for third-party reimbursement for NPs.	There is no current legislative authority.
Oregon	Authority for NP practice is granted through the NPA and regulated by BON. Scope of practice is very broadly defined in statute; a master's degree is required for entry into NP practice.	NPs are directly reimbursed by third-party payers by law. Exceptions include HMOs, PPOs, etc., which has been a problem. The Oregon Supreme Court recently ruled that Worker's Compensation insurance must consider NPs as independent health care providers and reimburse them without physician referral or supervision.	NPs have prescribing authority which is regulated by BON. A council consisting of NPs, MDs and pharmacists determines the formulary from which NPs can prescribe. NPs must have a postgraduate pharmacology course to be certified to prescribe.
Pennsylvania	Expanded-role nurses can function and practice under the 1974 NPA. When an NP's practice is composed of both the nursing and medical model (a decision determined by the individual licensee), the NP requests a joint review (by the BON and BOM). The BON and BOM use jointly promulgated R&Rs to determine if the NP is recognized as a certified RN practitioner (CRNP). The BON (looking at the current community standard of nursing practice) provides informed opinions on individual RN requests of their scope of nursing practice; these answers help each nurse determine whether his or her practice is nursing- or medical-model-based.	Reimbursement exists for the following six categories of RNs: enterostomal therapists, CRNAs, CRNPs, clinical specialists, psychiatric nurses, and community health nurses. Reimbursement is dependent on whether or not the third-party insurance policy covers billed services.	NPs have petitioned the BON to meet with the BOM to set up R&Rs. Prescriptive authority is possible within the current law but not yet implemented through R&Rs.
Rhode Island	Advanced practice is covered under the NPA.	Currently, psychiatric clinical specialists are the only directly reimbursed group.	Legislation passed in the 1988 session will allow CNMs to prescribe.
South Carolina	Advanced-practice nurses must be officially recognized by the BON and must have MD preceptors to practice in the extended role.	No current legislation; NP groups are intently looking at how to introduce reimbursement legislation into the Legislature.	No current prescriptive authority but a written proposal to allow advanced-practice RNs to prescribe is currently being negotiated with the BOM.
South Dakota	NPs must apply to a joint committee between the BON and BOM and osteopathic examiners in order to become certified nurse practitioners (CNPs). The joint board committee contains an equal representation of nurses and MDs. CNPs must work under the supervision of an MD.	The insurance law since the early '80s specifies that NPs and CNMs can receive third-party reimbursement. The most prominent payer, Blue Cross/Blue Shield, has assigned provider numbers to NPs.	CNPs may prescribe because prescribing is considered a delegated medical function. CNPs and their supervising MD must submit their "practice agreement" (including the list of medications the CNPs will prescribe, and the CNPs' scope of practice) to the joint board; the agreement is filed with the BON.
Tennessee	RNs functioning in an expanded role assume personal responsibility for their acts. RNs who manage the medical aspects of a patient's care must have written medical protocols, jointly developed by the nurse and the sponsoring MD(s). The detail of medical protocols varies in relation to the complexity of the situations covered and the preparation of the RN using them.	Legislation providing for direct Medicaid reimbursement was passed for CRNAs in 1987 and for CNAs in 1988. There is no law to mandate reimbursement from private payers, though some NPs receive reimbursement on an individual basis.	Master's-prepared NPs who are certified through ANA, ACNM and NAACOG and who have specified pharmacology courses may apply to BON for a "certificate of fitness" with privileges to write and sign prescriptions and/or issue non-controlled legend drugs. "Certificate of fitness" must also be approved by the Primary Care Advisory Board for the site of practice, and recorded by Division of Health related boards.

attm #1
Pg. 15
3-20-09

	Practice	Reimbursement	Rx
Texas	Advanced practice (CNM, CRNA, clinical nurse specialists and all NPs) is regulated by the BON under the title of "Advanced Registered Nurse Practitioners."	There is no direct third-party reimbursement except CNMs have Medicaid reimbursement.	No current legislative authority.
Utah	NPs are licensed by BON; since 1987 all NPs must be master's-prepared.	There are no restrictions prohibiting third-party reimbursement to NPs. NPs are reimbursed by some insurance companies; NPs have not organized to challenge the others.	All NPs in practice with an MD can apply for prescriptive privileges. The MD need be only in telephone contact with the NP (i.e., does not need to be in the office). Protocols are developed by the MD and NP and are submitted for approval to the prescriptive board consisting of three NPs, three MDs and a pharmacist.
Vermont	Advanced practice is controlled by BON under NPA with exceptions addressed within the R&Rs in the administrative text.	Blue Cross/Blue Shield reimburses NPs and CNMs utilizing a provider number.	No current legislative authority.
Virginia	The Medical Practice Act authorizes advanced practice under R&Rs jointly promulgated by BON and BOM (includes NPs, CNMs, clinical specialists and CNAs).	There is no current legislative requirement to pay NPs. Third-party reimbursement for CNS in psych/mental health will be up for legislative action this year.	No current legislative authority.
Washington	Advanced practice is authorized by the BON R&Rs for ARNPs.	There is reimbursement for nursing services since 1974 for disability and in 1981-83 for health care contractors.	Legislation for prescriptive authority is authorized under the BON and entails additional certification beyond the ARNP.
West Virginia	NPA addresses nurse midwives and nurse anesthetists only; other nurses in advanced practice operate according to NPA which is subject to interpretation.	There is third-party reimbursement legislation for NPs; however, the R&Rs have never been promulgated.	No prescriptive privileges at this time; however, NPs are intently researching the issue.
Wisconsin	NPs function under an NPA with a broad description of nursing practice; there is no specific definition of advanced practice.	None specified legislatively. Champus reimburses NPs, and home health RNs bill under their own provider number. NPs are working on legislation for reimbursement for nursing home visits; however, the current political makeup of the Senate precludes this at this time.	No current legislative authority.
Wyoming	The NPA gives authority for BON to recognize advanced-practice nurses after demonstrated advanced education and certification.	NPs are planning to introduce reimbursement legislation into the Legislature in the January 1989 session.	No current legislative authority.

Key to Abbreviations Used in Table

BON - Board of Nursing
BOM - Board of Medicine
CNM - Certified Nurse Midwife
CRNA - Certified Registered Nurse Anesthetist
R&Rs - Rules and Regulations
NPA - Nurse Practice Act
ARNP - Advanced Registered Nurse Practitioner

Practice - Respondents answered question, "What is the status of legal authority for advanced practice in your state?"
Reimbursement - Respondents answered question, "What is the status of reimbursement for nursing services in your state, including NPs?"
Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

Linda J. Pearson, R.N., M.S.N., C.-F.N.P.,
Editorial Director

NPs Write Prescriptions Regardless of Enabling Legislation

Last summer we sent out a questionnaire with the June issue of *The Nurse Practitioner*. From the responses to this questionnaire, we planned to select approximately 200 nurse practitioners from all regions of the country and from a variety of practice sites to participate in an ongoing research project. We had no idea that the response would be so great. Within the first two months of sending out the questionnaire, we received a total of 1,929 responses. There were an additional 171 responses that arrived too late for data analysis. And questionnaires keep dribbling in even now. We collected a wealth of information, and decided to analyze the most interesting data and share it with you. Of the 1,929 tabulated responses, we had to remove 241 from the analysis because the questionnaires were incomplete.

Table 1 shows the number of respondents from each state grouped by region. Although we received a significant number of responses from each region, the East was the most heavily represented. The majority of respondents work in ambulatory clinics or offices and see patients of all ages.

Prescriptive Practice in States With and Without Laws Granting Prescriptive Privileges

The most fascinating data we gathered concerned the methods used by respondents to obtain prescriptive products for clients. We divided the respondents into two groups: those from states with some sort of prescribing law and those from states without a prescribing law. We wanted to see if there were any significant differences in the prescriptive practices of these two populations. Figure 1 shows the percentage of each prescriptive method used by all the NPs.

The method of calling the prescription into the pharmacy is used approximately as often by NPs in states with prescribing laws as in those without. Similar findings are also evident among NPs from states with prescribing laws and from states without prescribing laws who write a prescription on a presigned prescription pad. It's interesting to note that whether or not a state has a prescribing law doesn't seem to affect those prescribing methods.

More of those nurse practitioners who reported that they write a prescription and then get a physician's signature and those who reported that they write the prescription then sign the physician's/NP's name came from states without enabling legislation. Clearly, physicians and pharmacists recognize that nurse practitioners' patients need prescriptive products.

It is not surprising that more NPs who reported using their own prescriptive authority came from states with prescribing laws. NPs in states without enabling legislation reported that they used this method if they worked in institutional settings (HMOs, veteran's hospitals or the military) where they had the authority to prescribe. Distributing stocked medications to clients was not a method reported frequently by either group, but it is used more frequently by NPs from states without prescribing laws.

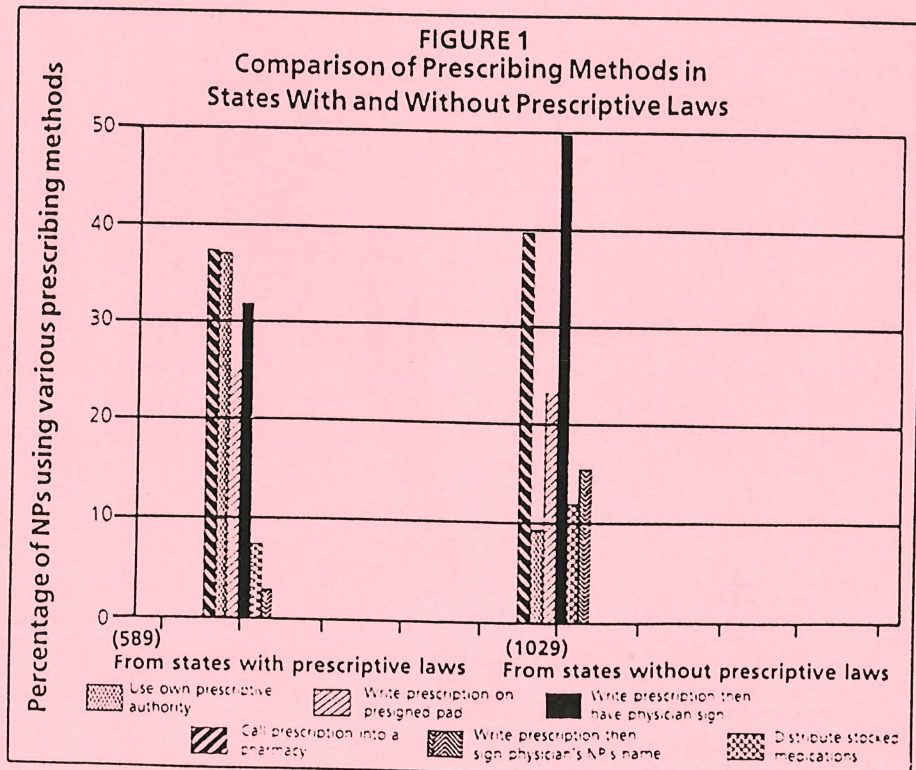


FIGURE 1
Comparison of Prescribing Methods in States With and Without Prescriptive Laws

Comparison of Prescriptive Methods by Region

Figure 2 shows the data on prescriptive methods used by respondents from the five regions. It is interesting to note that the respondents from the West reported that they write the prescription and then get a physician's signature more than respondents in any other region. The relative percentage of prescriptive method choice is very similar in the West and the East.

From the data in Table 1, it is possible to calculate the percentage of NPs within each region who come from states with prescribing laws (the West, 10 percent; Mountain states, 59 percent; the Midwest, 14 percent; the South, 27 percent; and the East, 57 percent). The Mountain states region has the highest percentage of respondents reporting use of their own prescriptive authority. Even though the percentage of respondents from states with prescribing laws in the East is almost as high as in the Mountain states region, the NPs in the Mountain states use their own prescriptive authority more often.

Respondents from the Midwest reported that they write the prescription and sign the physician's name far more than NPs in any other region. NPs from all the regions reported distributing stocked medications with approximately the same frequency.

Conclusion

The questionnaires generated a tremendous amount of data about our readership's prescribing habits. Analysis of all the implications would require volumes. We have presented the data here so that you can take from it what you find most interesting or helpful.

One thing is very clear from the responses we received. Nurse practitioners who need prescriptions for their clients find ways to obtain them regardless of the laws. We all know that practice precedes the law. Legislators must be made aware of the tremendous burdens some restrictive laws place on the NPs who are delivering safe, client-oriented, cost-effective primary ...th care. Perhaps our data will ...rompt state legislators to write laws validating the prescriptive practices of NPs. If so, it will have been an unintended accomplishment. We will continue in our efforts to describe nurse practitioner practice so that law makers, the public and other health care providers can better appreciate the important role NPs play in this country's health care system. We thank you for your help towards these ends. ○

TABLE 1
Respondent Demographics

Numbers in ( ) represent the number of respondents from each region and state.

Western Region (198)
Alaska (3)
California (179)
Hawaii (0)
Oregon (0)
Washington (6)
Nevada (10)

Mountain States Region (175)
Idaho (15)
Montana (5)
Wyoming (8)
Colorado (59)
New Mexico (20)
Arizona (47)
Utah (21)

Midwestern Region (325)
Minnesota (36)
Wisconsin (48)
Illinois (68)
Iowa (10)
Missouri (20)
Michigan (42)
Indiana (39)
Ohio (22)
Kansas (17)
Oklahoma (10)
Nebraska (5)
North Dakota (4)
South Dakota (4)

Canada (2)

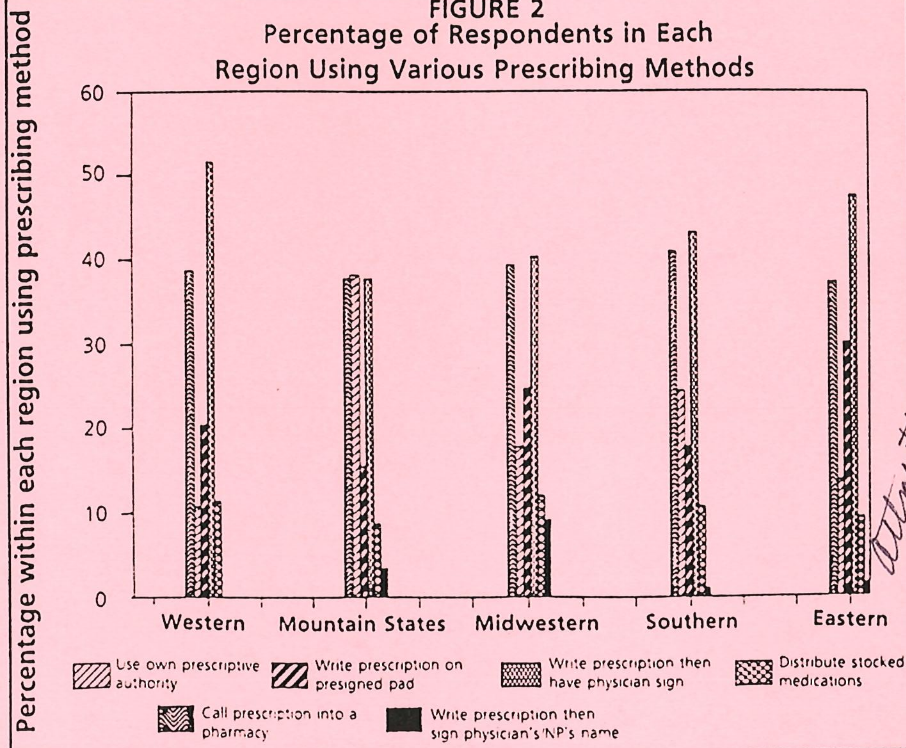
Southern Region (358)
Arkansas (8)
Louisiana (7)
Mississippi (8)
Texas (74)
Alabama (17)
Georgia (43)
Florida (77)
Kentucky (26)
North Carolina (53)
South Carolina (10)
Tennessee (35)

Eastern Region (628)
West Virginia (10)
Virginia (48)
Maryland (69)
Rhode Island (13)
New Jersey (32)
Pennsylvania (85)
Maine (16)
Washington, D.C. (7)
New York (150)
Massachusetts (129)
Connecticut (38)
New Hampshire (18)
Vermont (9)
Delaware (4)

Sites
Ambulatory Clinic/Office (892)
Hospital Outpatient Clinic (190)
Hospital Inpatient Clinic (94)
Occupational Health (88)
Public Health (148)
School Health (134)
Teaching (50)
Nursing Home/Hospice (48)
HMO/VA Service (41)

Patient Population
All Ages (662)
Women Only (294)
Children Age 0-6 (6)
Children School-Age (33)
Children Age 0-18 (178)
Adults Only (391)
Older Adults Only (122)

FIGURE 2
Percentage of Respondents in Each Region Using Various Prescribing Methods



ARNP's - Nurse Practitioners - Prescribing under Standing Orders and Protocol

K.A.R. 60-11-104a. Protocols or guidelines, defined; Requirements:

(a) When used in this article, the term "protocols or guidelines" means written documents containing a precise and detailed medical plan of care.

(b) Each protocol or guideline shall, at a minimum:

(1) Contain the name, license, and certificate number of the nurse clinician or nurse practitioner and the name and license number of the responsible physician who have adopted the protocol or guideline;

(2) show the date the protocol or guideline was adopted, and state the minimum frequency the protocol or guideline is to be reviewed by the nurse and physician;

(3) specify all prescription-only drugs for which the nurse clinician or practitioner is permitted to write a prescription order without direct authorization from the responsible physician;

(4) specify under what circumstances, and how soon, the responsible physician must be contacted after a prescription order is written by the nurse clinician or practitioner.

(c) This regulation shall not be construed to authorize a nurse clinician or practitioner to issue a prescription order for a controlled substance unless otherwise authorized by law to do so.

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse from transmitting a prescription order, or from administering a prescription-only drug pursuant to a lawful direction of a person licensed to practice medicine and surgery, dentistry, or nurse practitioner or clinician.

(e) When used in this section, terms shall be construed to have the meanings set forth in the pharmacy act, K.S.A. 1987 Supp. 65-1626.

(Authorized by K.S.A. 65-1129 and 65-1130, implementing K.S.A. 65-1130; effective, T__________, __________.)

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Attm #1
Pg 18
3-20-9

PERMANENT REGULATIONS
K.A.R. 60-11-104a

ARNP's - Nurse Practitioners - Prescribing under Standing Orders and Protocol

K.A.R. 60-11-104a. Protocols or guidelines, defined:
Requirements:

(a) When used in this article, the term "protocols or guidelines" means written documents containing a precise and detailed medical plan of care.

(b) Each protocol or guideline shall, at a minimum:

(1) Contain the name, signature of the nurse clinician or nurse practitioner and the name and signature of the responsible physician who have adopted the protocol or guideline;

(2) show the date the protocol or guideline was adopted or last reviewed:

(3) specify all prescription-only drugs for which the nurse clinician or nurse practitioner is permitted to write a prescription order without direct authorization from the responsible physician.

(4) specify under what circumstances, and how soon, the responsible physician must be contacted after a prescription order is written by the nurse clinician or nurse practitioner.

(5) be maintained in an 8½ by 11 looseleaf notebook containing all protocols adopted by the nurse and doctor and kept at the nurse's principal place of practice. The notebook shall include a cover page containing:

(A) the name, license number, certificate number and telephone number of the NP/NC and the responsible physician.

(B) the name, address and telephone number of a designated physician who agrees to direct and supervise the nurse clinician or nurse practitioner. The absence or unavailability of the responsible physician.

(C) the minimum frequency the protocols or guidelines are to be reviewed by the nurse and physician, but such time shall be not less than one year.

(D) the minimum frequency for which prescription orders are reviewed and patient charts are co-signed,and such time shall not be more than thirty days.

(c) This regulation shall not be construed to authorize a nurse clinician or nurse practitioner to issue a prescription order for a controlled substance.

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse or advanced registered nurse practitioner from transmitting a prescription order orally or telephonically, or from administering a prescription-only drug pursuant to a lawful direction of a person licensed to practice medicine and surgery, dentistry, or nurse practitioner or clinician.

(e) When used in this section terms shall be construed to have the meanings set forth in the pharmacy act, K.S.A. 1987 Supp 1626. (Authorized by K.S.A. 65-1129 and 65-1130: implementing K.S.A. 65-113-: effective, T-60-9-12-88, Sept. 12, 1988; P ____________________.)

PH&W
Attm #1
pg. 19
3-20-9

The University of Kansas Medical Center
School of Medicine-Wichita

Obstetrics-Gynecology
at HCA/Wesley Medical Center

March 20, 1989

Chairperson Littlejohn, staff, and committee members, I appreciate this opportunity to speak before you today regarding Senate Bill 23 and its effects on my profession, collaborating physicians and the consumers we serve.

I am Joleen Zivnuska. I am the legislative chairman for the ARNP Task Force and am an OB/GYN Nurse Practitioner at the OB/GYN Clinic, Department of OB/GYN at HCA Wesley Medical Center, University of Kansas School of Medicine - Wichita. We serve primarily poverty level, indigent consumers in the Sedgwick County area, as well as many rural consumers, some which are driving four hours to our clinic to obtain available and affordable health care.

You have received a copy of Dr. Dan Roberts' letter to the Sedgwick County delegation in which he urges them to support legislation which gives Nurse Practitioners prescriptive privileges per protocol (hereafter referred to as transmitting per protocol). It also describes the deleterious effects on health care, especially to poverty level consumers, if these were denied.

Transmitting per protocol has been an accepted part of practice for over a decade, however, recently there has been an effort within the medical community to clarify and codify the understandings under which Nurse Practitioners have been practicing. To give an illustration of what "transmitting per protocol" means in our setting -

> If I examine a patient and determine she has candida vaginitis, I follow the protocol which has been developed with Dr. Roberts, which lists the drugs he desires to be used to treat candida vaginitis. I do not originate the choice of treatment from any drug available on the market, but rather give Dr. Roberts drug of choice. I am limited to the drugs which are listed on our protocol.

Appendix A is an example of such a protocol. Note the very controlled, detailed outline of this protocol which serves to protect the consumer, physician, pharmacist, and ARNP.

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Attm #2
3-20-9

550 N. Hillside • Wichita, Kansas 67214-4976 • (316) 688-3180
Main Campus, Lawrence • Medical Center, Kansas City and Wichita

We have been transmitting prescriptions per protocol for over a decade without any compromise of patient care. This has been an established part of practice, however, we need to codify the existing practice into law.

A senate subcommittee, Kansas State Board of Nursing, Kansas State Nurses Association and the Kansas Medical Society have worked collaboratively on the language of SB 23. The proposed bill avoids two extremes in interpretation:

1) The proposed statute is explicit in allowing Nurse Practitioners to transmit **per protocol** as they have already been doing for over the last decade.

2) The statute **limits** Nurse Practitioners' **authority to transmit per protocol** only in conjunction with the attending physician and **expressly prohibits independent prescriptive authority.**

My colleagues and I endorse SB 23 and request you pass it out of your committee in its present form.

Nurse Practitioners of the state of Kansas are an integral part of the health care delivery system, especially among the underserved and indigent population. Authority for transmitting prescriptions per protocol will ensure that these services will continue.

I have the confidence of my collaborating physicians, appreciation of poverty level consumers, and I trust your support of our vital role in providing health care to low income Kansans.

Joleen Zivnuska, RNC, ARNP

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pg2
3-20-9

The University of Kansas Medical Center
School of Medicine-Wichita

Obstetrics-Gynecology
at HCA/Wesley Medical Center

January 3, 1989

To: Sedgwick County Legislative Delegation

From: Daniel K. Roberts, M.D., Ph.D.
Professor and Chairman, Department of Ob-Gyn
Chief, Ob-Gyn Service

Dear Legislators:

I assume sometime during the next legislative session you will have an opportunity to vote on a bill regarding the ability of nurse practitioners to write prescription per protocol. I urge you to support such legislation.

Nurse practitioners prescribe per protocols which have been jointly developed with their supervisory physician.

I have worked closely with Nurse Practitioners for 15 years and have full confidence in their ability to deliver excellent care to the patient population we jointly serve.

Health care is becoming increasingly unaffordable for many low income families. I am expressly concerned regarding the inability for many to obtain prenatal care if it were not available through our Maternal and Infant Projects at local Health Departments and University Teaching Clinics. Again, I emphasize that if these were reduced, our number of women presenting to our hospitals for delivery with no prenatal care would be greatly increased.

The prenatal care these Nurse Practitioners help to provide can make the difference between a healthy infant and one with long term sequela whose treatment will be financed by public assistance.

If Nurse Practitioners were denied the right to prescribe per protocol, it would have a deleterious effect on health care in Kansas especially among the poverty level consumers who do not have access to private care. Some of the present services which would be adversely effected are: Maternal and Infant Projects, Family Planning and Sexually Transmitted Disease Clinics, Well Child

Attm #2
Pg. 3
3-20-9

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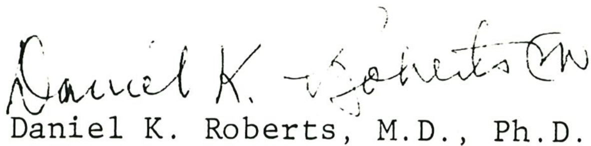
and Immunization Clinics, Adolescent Health Care Services and TB Clinics in our local Health Departments, Planned Parenthood Clinics, and Student Health Services at all of our Regent Universities.

The number of women seen by our Ob-Gyn Residency Program at Wesley Medical Center would be significantly reduced if Nurse Practitioners could not prescribe per protocol.

Any reduction in the capacity of our program could cause an extreme hardship on the ever increasing indigent population who do not have access to other health care facilities.

I, therefore, urge you to take positive action to insure the continuation of Nurse Practitioners prescription authority per protocol established by and with the supervision of a physician.



Daniel K. Roberts, M.D., Ph.D.

DKR:rms

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pg 4
3-20-9

Appendix A

WESLEY MEDICAL CENTER
WESLEY OB/GYN CLINIC

Nurse Practitioner Treatment Protocol for Candida Vaginitis

Causative agent fungus C. Albicans may consist of two parts: (1) mycelia, which are long filamentous structures that are usually branched, or (2) canidia, which are buds, usually the size of leukocytes, but which may vary considerably in size.

S: Vulvar itching and burning, white curd-like discharge.

O: Thick white curd-like discharge, intense vulvar and vaginal pruritus and burning, rash from yeast may be present on the vulva and thigh. There may be evidence of erythema and excoriation of the skin secondary to scratching. The vaginal introitus may be inflamed and congested.

A: KOH slide for mycelia or canidia buds

P: Pregnant and non-pregnant
1) Clotrimazole (Gyne-Lotrimin), one vaginal tablet or one applicator vaginal cream per vagina hs X 7
2) Miconazole nitrate (Monistat), one applicator vaginally hs X 7
3) Monistat Dual Pak, one suppository vaginally, cream to vulva hs X 3
4) Nystatin, 500,000 units po bid x 14 - vaginal tablet 100,000 units hs X 14
5) Terconazole (Terazol) one supp. vaginally hs X 3 - vaginal cream by applicator hs X 7

TEACHING

Avoid tight or nonabsorbent clothing. Encourage cotton lined crotch panties. Avoid frequent douching, hygiene sprays and deodorants. Wipe from front to back. Complete full course of medication.

Date 9-1-88

Nurse Practitioner Signature

Sylvia Q. Carson, RNC, ARNP
Coleen M. Zvrnuska RNC, ARNP
Connie R. Luty RNC, ARNP
Debbie L. Wendt RNC, ARNP

D K Roberts MD
Physician Signature

PH&W
Attm #2
Pg. 5
3-20-9

Rural Communities Served With Prenatal Care in 1988
Through Nurse Practitioner-Assisted OB/GYN Clinics at HCA Wesley

Abbyville
Alma
Altamont
Alvin
Amorita
Anthony
Arkansas City
Atlanta
Attica
Beloit
Buhler
Burlington
Burrton
Chanute
Clearwater
Coats
Coffeyville
Colby
Columbus
Colwich
Cunningham
Dodge City
El Dorado
Elkhart
Ellis
Emporia
Eureka
Erie
Ford
Fowler
Fredonia
Garden City
Great Bend
Grenola
Harper
Hays
Hoisington
Holcomb
Howard
Hoxie
Hutchinson
Inman
Jetmore
LaHarpe
Larned
Lindsburgh
Longton
Lucas
Lyons
Manhattan
Mankato
Marion
Mayfield
Meade
McPherson
Medicine Lodge
Montezuma
Mulvane
Newton
Norton
Olpe
Osage City
Parsons
Pittsburg
Pratt
Pretty Prairie
Protection
Reading Rock
Rose Hill
Russell
Salina
Sedan
Scott City
Sharon
Soloman
Stafford
Sterling
Toronto
Towanda
Ulysses
Valley Center
Wakeeney
Wamego
Waverly
Winfield
Wellington

PH&W
Attm. #2
Pg 6
3-20-9

PROTOCOL: ACUTE PURULENT OTITIS MEDIA
STUDENT HEALTH SERVICES
PITTSBURG STATE UNIVERSITY

I. **Definition.** Infection in the middle ear, with accumulation of seropurulent or purulent fluid in the middle-ear cavity.

II. **Etiology.** The majority of cases are due to bacterial infection. It is not possible clinically to identify those patients with sterile exudate.

III. **Clinical features**

A. **Symptoms**

1. Earache.

2. Symptoms of an upper respiratory infection.

3. Fever.

4. Decreased hearing.

5. Sometimes, no symptoms.

B. **Signs**

1. Bulging of any portion of the tympanic membrane with accumulation of exudate in the middle-ear cavity.

2. Disappearance of the malleus (bony landmarks). The short process is often lost first.

3. Perforation of the tympanic membrane, resulting in the presence of exudate in the external canal and distortion of the tympanic membrane. (This must be distinguished from primary otitis externa without otitis media, which is more common in the adult.)

4. Bullae of the tympanic membrane.

5. Decreased or absent movement of the tympanic membrane with insufflation.

Note: Injection or erythema of the tympanic membrane and disappearance or distortion of the light reflex may accompany these signs but are not alone sufficient to diagnose acute purulent otitis media.

IV. **Laboratory studies.** None.

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pg. 7
3-20-9

V. Differential diagnosis

A. Erythema of the tympanic membrane associated with an upper respiratory tract infection.

B. Serous otitis media.

C. Otitis externa.

VI. **Treatment.** Ask whether patient is allergic to the medication chosen.

A. Amoxicillin capsules, 250 mg 3 times a day for 10 days.

or

B. If patient is allergic to penicillin derivatives, treat with 80 mg trimethoprim, 400 mg sulfamethoxazole tablets, two tablets 2 times a day for 10 days.

VII. Complications

A. Chronic serous otitis media (persistent middle ear effusion).

B. Persistent purulent otitis media.

C. Mastoiditis.

D. Chronic otitis media with perforation of the tympanic membrane.

E. Extension into the central nervous system, leading to meningitis or brain abscess.

F. Cholesteatoma formation associated with chronic otitis media and marginal or pars flaccida perforation.

VIII. **Consultation-referral**

A. Ruptured tympanic membrane.

B. Severe pain.

C. Failure to improve symptomatically in 48 hours.

D. Signs of meningitis, such as:

1. Lethargy.
2. Extreme irritability.

3. Nuchal rigidity

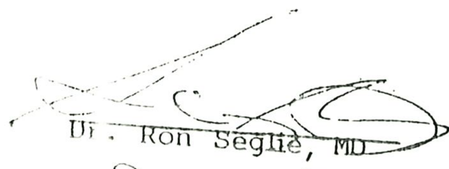
E. Persistent purulent otitis media, despite adequate course of antibiotics.

F. More than two episodes of purulent otitis media.

G. Suspicion of mastoiditis (pain, tenderness, or edema in the post-auricular area in older children and adults).

H. Chronic otitis media with persistent intermittent drainage through perforation of the tympanic membrane.

IX. Follow-up. Examination in 3 weeks.



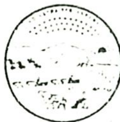
Dr. Ron Seglie, MD

Cherie Branson, RN, ARNP, MS

PX/AW
Attm #2
Pg. 8
3-20-9

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929



Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Bonnie Howard, R.N., M.A.
Practice Specialist

Janette Pucci, R.N., M.S.N.
Educational Specialist

TO: The Honorable Representative Marvin Littlejohn, Chairman, and Members of the House Public Health & Welfare Committee

FROM: Dr. Lois R. Scibetta, Executive Administrator

RE: Senate Bill 23

DATE: March 20, 1989

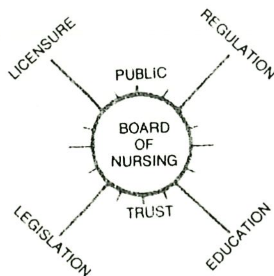
I regret that I will be out of town at the time of this hearing, however, my colleagues Janette Pucci and Pat Johnson will be presenting these comments on behalf of the Board of Nursing.

Thank you for this opportunity to comment on Senate Bill 23, as amended by the Senate. The changes made by the Senate Committee, deletion of lines 73-75, and the addition of (d), lines 76-87 clarify the aspect of the prescription of medications.

The Board would again like to affirm the fact that it was never the intent of the Board to seek prescriptive powers for ARNPs. The intent of the Board was to clarify the written protocols and/or standing orders.

In lines 206-212 (p.6) the definition of "Practitioner" has been modified, to include those who may "prescribe" under the Pharmacy Act. The Advanced Registered Nurse Practitioner is not included in this definition. It is the understanding of the Board, that the Advanced Registered Nurse Practitioner may transmit prescriptive orders pursuant to a written protocol, as authorized by a responsible physician (lines 76-78), and further that these orders will be filled by the pharmacist, under the conditions described above.

For the purpose of clarification, "Scientific Investigator," is not defined per se. Is this group regulated or licensed in any way?



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With the conditions stated above, the Board would recommend that SB 23, as amended by the Senate, be reported out favorably by the House Committee.

We will be happy to respond to questions, Mr. Chairman.

LRS:bph

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3-20-9

March 20, 1989

Representative Marvin L. Littlejohn, Chairman
House Public Health and Welfare Committee

Representative Littlejohn, Members of the Committee:

Thank you for the opportunity to speak in support of S.B. 23 as amended and passed by the Senate.

My name is Patsy Quint, I am a nurse clinician working in an industrial setting. I speak today as the state chairman of the KSNA Advanced Practice Conference Group, and chairman of District 6 (Sumner and Sedgwick Counties) Advanced Practice Group.

I want to say how much we appreciate the support of nursing and health care issues that members of the House have given over the years, in particular, Representative Littlejohn.

We urge your support of S.B. 23 as passed by the Senate. This will clarify the language regarding transmission of prescription orders, pursuant to written protocol jointly developed by the ARNP and the physician for the medical plan of care.

We are not seeking independent prescriptive privilege, only to be able to follow a precise protocol, which is some what like the old standing order of the physician.

I would share with you the outcome of a vote taken December 3, 1988, at the state meeting of the Advanced Practice Conference Group,held in Wichita. The 21 nurse clinicians in attendance, unanimously voted NO to the question "Do you want full prescriptive power?" and YES to "Do you prefer to practice under protocol?"

It is my hope that this committee will be responsive to the needs of the consumers of health care and the cost effectiveness of allowing the ARNP to continue to assist in meeting those needs.

Thank you again, for allowing me this time.

Patsy F. Quint, RN./C.,COHN., Chairman
KSNA Advanced Practice Conference Group

2805 So. 147th.St. East
Wichita, Kansas 67232

(316) 733-1915

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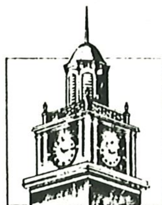

The
Wichita
State University
Student Health Services

March 15, 1989

Representative Marvin Littlejohn
State Capital Building
Topeka, KS 66612

Dear Representative Littlejohn,

I am writing to urge your support of Senate Bill No. 23 as passed by the Senate. The passage of this bill would have a favorable impact upon the health care provided by nurse practitioner (ARNP's) in the college health setting.

There are seven ARNP's currently serving students at four different Kansas Regent's universities. We have all met the educational requirements as defined by 60-11-103(1). Services are being provided by these nurses to an approximate student/faculty/staff population of 61,023 consumers.

At The Wichita State University four ARNP's are employed. The ARNP's, using written protocols, work closely with part time physicians. The passage of Senate Bill No. 23 would allow us to continue to deliver quality and low cost health care to our students.

Sincerely,

Wanda Maltby, R.N.,C., ARNP

WM:yh

enc. 1. Protocols - Strep Throat
2. Protocols - Urinary Tract Infection

PH&W
attm #5
3-20-9

Protocols

PHARYNGITIS GROUP A BETA STREP

SUBJECTIVE:
Sore throat
Fever
Tender cervical glands

OBJECTIVE:
Pharynx and tonsillar areas red.
Fever
Anterior cervical glands
Throat culture positive for Beta Strep, Group A

ASSESSMENT:
Pharyngitis-Beta Strep Group A

PLAN:
Penicillin V, 250 mg. #40, one q.i.d. for ten days
OR
if ALLERGIC to PENICILLIN:
Erythromycin, 250 mg. #40, one q.i.d. for ten days.

Warm saline gargles, increase fluids (1 glass of water every hour while awake)
Aspirin or acetaminophen, 2 tablets q 4 hours prn for pain and/or fever.
Rest

PATIENT EDUCATION:

1. Avoid contact with hospital patients, children, debilitated or ill persons until on antibiotic therapy for 48 hours.

2. Close contacts should have strep screen culture if become symptomatic.

DATE 23 June 87 SIGNED [signature]

11/3/88 [initials]

PH&W attm #5 pg 2 3-20-9

3/87

Protocols

URINARY TRACT INFECTION

SUBJECTIVE: Patient complaints include one or all of these symptoms:

frequency of urination
dysuria, especially at end of urination
urgency
nocturia
hematuria
supra-pubic pain with urination
low grade fever
malaise

OBJECTIVE: Fever of less than 100 degrees

Blood Pressure: within normal limits

Abdomen: especially supra-pubic area may be slightly tender to palpation

Pelvic: may be needed to rule out vaginitis if symptoms are vague or urinalysis borderline.

Urinalysis, clean voided mid-stream specimen:
Chemistry may show one or all of these findings:

blood present
protein present
nitrite positive
leukocyte positive

Microscopic Exam: WBC: 6-8 or more/Hi pw field without excessive debris such as increased epithilial cells.

RCB: may be present.

Bacteria: present.

A. FIRST TIME (Uncomplicated UTI) --
Single Dose Therapy

Rationale for single dose therapy: In bladder infections the infection is a superficial infection, and antibiotics are delivered in a high concentration to the site of infection.

ASSESSMENT & PLAN:

PLAN for A:
(1) Amoxicillin 3.0 gm. STAT

OR

Amoxicillin 500 mg 2 caps, bid x 2 days.

OR

Bactrim D S 2 tabs. STAT. Single dose.

PH&W
Attm # 5
Pg 3
3-20-9

UTI Con't

(2) Repeat UA in 1 week and if pyuria and/or patient symptomatic, obtain urine culture and sensitivity.

B. RECURRENT UTIs- each episode is caused by DIFFERENT bacteria
bladder source of infection
easily eradicated with one course of appropriate antibiotic

C. RELAPSING UTIs- each episode is caused by the SAME bacteria
kidney source of infection
often difficult to eradicate, requiring prolonged antibiotic course

PLAN for B & C:

1. If fever over 100 degrees, chills, CVA tenderness and/or appears acutely ill; refer to physician.

2. Macrodantin, 100 mg. #30, 1 capsule four times a day; with food or milk.

Bactrim DS #~~14~~ 10 OR, 1 tablet two times a day. ---> Drug of choice

OR IF SENSITIVE TO MACRODANTIN AND BACTRIM

Amoxicillin 500mg. #21, 1 capsule three times a day.

3. May check urinalysis mid-therapy for clearing.

4. Urinalysis several days post therapy, if pos get Urine Culture & Sensitivity.

5. If patient symptomatic post therapy, obtain urine Culture & Sensitivity.

PATIENT EDUCATION:

Patient Ed Handout
or
Force fluids, particularly water
Females: urinate before and after intercourse
Avoid coffee, tea, coke and alcohol
Avoid holding urine in bladder for long periods of time
Avoid bubble baths
Wipe front to back

DATE 11/5/87 11/8/88 SIGNED [signature]

attm 5 pg 4
3-20-9

11/87

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 20, 1989

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society *Chip Wheelen*

SUBJECT: Senate Bill 23, As Amended by Senate Committee

The Kansas Medical Society appreciates this opportunity to offer our endorsement of the provisions of SB 23 as amended by Senate Committee. This bill would legitimize rules and regulations that have already been adopted by the State Board of Nursing. It was the KMS that questioned whether rules and regulations adopted by the Nursing Board to allow advanced registered nurse practitioners to prescribe pursuant to protocol was in compliance with statutory authorization. This is, afterall, an important consideration because the prescribing of medication is a function of the practice of medicine and surgery. It is our opinion that the practice of medicine and surgery can only be delegated in accordance with statutory authorization to do so.

While the language contained in SB 23 would accomplish these goals for purposes of amending the Nurse Practice Act, it is important to keep in mind that it should also be necessary to amend the Healing Arts Act in order to allow physicians to delegate prescribing to ARNPs. It is our understanding that it was indeed the intent of the Senate Committee to amend the Healing Arts Act to accommodate this purpose but for a number of reasons that was not done. Therefore we respectfully request that this Committee consider adding a new section to SB 23 or adding a section to one of the bills amending the Healing Arts Act to authorize physicians to delegate prescribing to ARNPs pursuant to protocol. Suggested language has been drafted by the General Counsel for the State Board of Healing Arts and we endorse that proposal.

Thank you for considering our comments. We respectfully request that you recommend SB 23 for passage.

CW:nb

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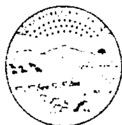
3-20-9

Kansas State Board of Pharmacy

LANDON STATE OFFICE BUILDING
900 JACKSON AVENUE, ROOM 513
TOPEKA, KANSAS 66612-1220
PHONE (913) 296-4056

STATE OF KANSAS



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SENATE BILL 23

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

1:30 p.m.- March 20, 1989

Mr. Chairman, members of the Committee, I am Tom Hitchcock, Executive Secretary for the Kansas State Board of Pharmacy. I appear before you today on behalf of the Board in support of Senate Bill 23.

Although this bill was introduced at the request of the Board of Healing Arts, the Board of Pharmacy agrees with Healing Arts that advanced registered nurse practitioners (ARNP) may not prescribe drugs but may only transmit prescription orders pursuant to a written protocol as authorized by a responsible physician. Also, the Pharmacy Board agrees with the clarification definition of the term "Practitioner" as it appears in the pharmacy and controlled substances act.

The Board of Pharmacy respectfully requests the favorable passage out of committee of Senate Bill 23.

Thank you.

PH&W
Attm #7
3-20-9

Office of
RICHARD G. GANNON, EXECUTIVE DIRECTOR
CHARLENE K. ABBOTT, ADMINISTRATIVE ASSISTANT
LAWRENCE T. BUENING, JR., GENERAL COUNSEL
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State of Kansas

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(913) 296-7413

Board of Healing Arts

TO: House Committee on Public Health & Welfare

FROM: Richard G. Gannon, Executive Director

DATE: March 20, 1989

RE: **TESTIMONY ON SENATE BILL NO. 183**

Thank you for the opportunity to appear and present testimony on SB 183 which was authorized by the State Board of Healing Arts. The primary purpose of SB 183, particularly certain provisions in Sections 2 and 3, is to provide greater authority to the Board to insure that the responsible physicians for physicians' assistants provide adequate supervision and direction. I realize concerns about this bill have been expressed to the legislature. Since the introduction of this bill in the Senate, we have spent considerable time meeting with the PAs and their representatives and I feel the bill as amended provides a mutually acceptable resolution to any prior objections.

As noted by committee staff during the briefing on this bill, in 1972 the Board was first directed to maintain a registry of PAs. Substantial amendments and additions to the PA laws were made in 1975 and 1978. As a result, the PA laws have evolved and are now similar to the registration laws for other ancillary health care providers regulated by the Board such as physical therapists.

Under present law, a PA cannot be initially registered without having a responsible physician. Whenever employment of a PA ceases, the responsible physician is required to notify the Board of this termination. However, the name of the PA is not to be removed from the register maintained by the Board unless that PA has not been employed as a PA for at least five years. Therefore, following initial registration, PAs may retain their registration with the Board even though they may not have a responsible physician. However, they may not function as a physician assistant without again having a responsible physician.

The medical associations and the Board have uniformly agreed that, whenever possible, PAs should be supervised in the presence of a

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JOHN P. WHITE, D.O., PITTSBURG

physician. In light of the demographics of our state, it has also been understood that the optimal standard of care cannot always be achieved. However, it is also felt that the activities of a PA should be the responsibility of a physician licensed to practice medicine and surgery and ultimate control of the PA should be through the responsible physician.

Since becoming Executive Director of the Board on July 11, 1988, I have observed some situations which have caused great concern among the Board members. Certainly, the problems and concerns have dealt with only a minority of the registered physicians' assistants. Yet, these problems do exist and the Board is without adequate legislation to fully resolve these problems. For instance, I have seen a case in which a physician's assistant has established his own professional corporation, maintains a medical clinic and has simply hired a responsible physician in order to comply with the statutes. In another case, physicians' assistants have been left alone to run the doctor's office while the physician was out of state and out of communication with the PAs leaving no designated or backup physician to provide consultation and guidance to the PAs. The Board's purpose in seeking introduction of SB 183 was to bring these issues before the legislature so that these type of problems can be resolved and the citizens of the State of Kansas can be assured of quality medical care provided by either a duly licensed physician or someone acting under the physician's direction and control.

Section 1 of the bill deals with the renewal process and fees. This language is similar to that approved by this committee and the House in its passage of HB 2161 relating to physical therapists. Presently, the statutes call for a renewal fee which is not to exceed $10.00. Two dollars of this goes to the State General Revenue Fund, leaving the Board with $8.00 in revenue for each PA renewal processed. It is obvious this fee cannot even cover printing, postage and handling of the renewal applications. Adoption of Section 1 would enable the Board to create rules and regulations setting reasonable fees for the category specified.

Section 2(a)(3) at lines 107 through 111 would require the proposed responsible physician for a PA to submit a request to the Board. It is anticipated that whatever form the request would take would require the responsible physician to provide a detailed list of the tasks the responsible physician intends to delegate to the PA and also a detailed list of all prescription drugs for which the PA may transmit a prescription order. There was not intent on the part of the Board in proposing this language or the language in Section 3 to arbitrarily deny a physician the ability to employ a PA or to dictate where the PA may work. Rather, the intent of these changes is simply to insure that proper supervision and direction will be

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provided and that responsibilities are not being delegated which the PA does not have adequate training and experience to perform. Section 3 would enable the Board to deny the requests submitted by the responsible physician if, in the Board's opinion, the tasks delegated and the drugs for which the PA may transmit prescription orders were not appropriate in light of the circumstances and the PA's training and education.

Section 4 of the bill was added after meetings with various PAs and their lobbyists. Under present laws, every profession regulated by the Board except PAs have either a permanent statutory examining or advisory council or committee. Although PAs may be a more "dependent" practitioner than the other professions regulated by the Board, it was mutually agreed that the PA profession should have a council to provide advice, consultation and recommendations to the Board regarding its profession.

Again, this bill represents a compromise between the Board and the PAs and I believe is agreeable to all concerned.

Thank you again for the opportunity to appear before you and I would be happy to respond to any questions.

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pg. 3
3-20-9

KANSAS ACADEMY OF PHYSICIANS' ASSISTANTS

TO: House Committee on Public Health and Welfare

SUBJECT: Senate Bill No. 183

Mr. Chairman and Members of the Committee:

My name is Jacque Oakes representing the Kansas Academy of Physicians' Assistants.

The profession of Physicians' Assistants was first recognized and defined by the Kansas Legislature in 1972. In 1978 the Legislature instituted a system of registering Physicians' Assistants with the Board of Healing Arts. Before a name can be added to the register, the applicant must meet the necessary educational requirements, pass an examination, and be under the sponsorship of a responsible physician.

Currently, there are approximately 130 physicians' assistants registered in the state of Kansas. After removing instructors and inactive registrants, Kansas has 110 active physicians' assistants. Attached is a breakdown of these 110 by the areas in Kansas they serve. The present distribution has approximately 65% of the registered physicians' assistants outside of the major metropolitan areas.

We are here today in support of Senate Bill No. 183. At the time of the hearing on this bill in the Senate Committee, we had several concerns. But after a very beneficial meeting with the Board of Healing Arts, we are able to report that those concerns were discussed and that the proposed new language changes have been clarified.

We also support the increased fees because a portion of these fees will enable the physicians' assistants to establish a proposed impaired physicians' assistants' program.

We heartily endorse the advisory council. The Senate Committee's amendment as recommended by the Board of Healing Arts would create a new five member physicians' assistants' council to advise the Board of Healing Arts in carrying out the provisions of their statutes and rules and regulations. This council will also be very helpful in keeping effective lines of communication open between the Board of Healing Arts, physicians, and physicians' assistants.

We commend the Board of Healing Arts on their work. We stongly support the Board's efforts to ensure Kansans that health care providers are adhering to all standards set either by statutes or rules and regulations.

Thank you for the opportunity to speak to you today.

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BREAKDOWN OF 110 ACTIVE PHYSICIAN ASSISTANTS IN KANSAS

65% (72 PAs) practice fulltime or maintain clinics in the following counties:

Allen	Atchison	Barber
Barton	Brown	Butler
Chautauqua	Cheyenne	Clark
Cloud	Coffey	Cowley
Crawford	Dickinson	Doniphan
Douglas	Elk	Ellis
Ellsworth	Ford	Grant
Greeley	Greenwood	Hamilton
Harper	Harvey	Hodgeman
Kingman	Labette	Lane
Leavenworth	Lyon	Marion
McPherson	Montgomery	Neosho
Ness	Osborne	Phillips
Pottawatomie	Reno	Rice
Riley	Rooks	Russell
Saline	Seward	Smith
Stevens	Wilson	Woodson

(13 of the above physician assistants are registered through the Board of Healing Arts as practicing in an urban area.)

35% (38 PAs) are located in Johnson, Shawnee, Sedgwick and Wyandotte Counties; and although some are in private practice with their sponsoring physicians, some work through the Sedgwick County Sheriff's office, the veteran's hospitals, and other underserved areas of the urban community.

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