FREQUENTLY ASKED QUESTIONS REGARDING IMPLEMENTATION OF NEW LAW GOVERNING APRN PRACTICE

1. How does the new law characterize the professional relationship between an APRN and a physician?

The new law does not use the terms "supervise" or "delegate" to describe the professional physician-APRN relationship. Instead, the new law uses the terms "work with" and "support", leaving it up to the individual APRN and physician to choose how they describe their clinical relationship within a "practice agreement" entered into by both parties. While there is no specific language that is required to be in a practice agreement, the document should clearly indicate the mutual intent of both parties and be consistent with the standard of care that each professional is held to by their respective practice acts.

2. Who must enter into practice agreements?

All APRNs (**except** CRNAs) performing medical acts must develop compliant practice agreements. S.C. Code Section 40-33-20(45) specifically refers to nurse practitioner, certified nurse-midwife and clinical nurse specialist as the categories of APRNs who must enter into practice agreements with either a physician and/or medical staff. However, in the case of CNMs, there is a provision allowing the "written policies and procedures" meeting certain standards to constitute a practice agreement for the purpose of fulfilling the requirements in the law.

3. Does a protocol under previous law suffice as a practice agreement under the new law?

No. While the new law incorporates the contents previously required for protocols, there are additional requirements for the new practice agreements.

4. **Do the new practice agreements have to be in place by July 1, 2018?**

Yes. The new law, Act No. 234 of 2018, took effect on July 1, 2018. It requires that a physician and an APRN practice pursuant to a practice agreement complying with the requirements of the new law as of that date.

5. What does the new law require for a physician to be eligible to enter into a practice agreement with an APRN?

The physician must either hold a permanent, active, and unrestricted authorization to practice medicine in South Carolina and must be actively practicing within the geographic boundaries of South Carolina or hold an active, unrestricted academic license to practice medicine in South Carolina and must be actively practicing within the geographic boundaries of South Carolina. The 45 mile geographical radius restriction in the old law was removed.

Another important requirement of the new law is that a physician cannot enter into a practice agreement with an APRN performing a medical act, task, or function that is outside the usual practice of the physician unless it is a medical act, task, or function for which the physician has had training or

experience. In the case of a medical act, task, or function that is outside of the usual practice of the physician and for which the physician has had no training or experience, the Medical Board can approve exceptions to this if they determine an exception is warranted and that quality of care and patient safety will be maintained.

6. Who is responsible for the development and execution of a practice agreement when both the physician and APRN are employed by a hospital system?

Regardless of the employment relationship, the practice agreement establishes the clinical relationship between the physician and APRN who sign it and must comply with their respective professional standards. The physician and APRN are jointly responsible for developing and executing the practice agreement. The practice agreement is a clinical document, not an employment contract. It is intended to be individualized for each APRN based on the APRN's education, training, and experience and on the type of practice and practice setting. Thus, there is no "one size fits all" standard document that can be used. If a template is provided by an employer, the document must be tailored to fit the specifics of the clinical practice of the APRN and physician working with that particular APRN.

Further, it is possible for an APRN to have multiple practice agreements governing his or her practice within a large hospital system. For example, if APRN Smith works in a hospital-owned pediatric practice on Monday, Wednesday and Friday where there is no need to prescribe controlled substances, the practice agreement for the pediatrician with whom the APRN is working should reflect that. If APRN Smith works in a family practice on Tuesday and Thursday owned by the same hospital system where there may be a need to prescribe controlled substances, the practice agreement governing clinical services in the family practice should reflect that. Although technically employed by one employer, ~~she~~ the APRN is working in two distinct clinical settings and should have separate practice agreements for both clinical settings.

7. Does the South Carolina Board of Nursing ("Board of Nursing") or the South Carolina Board of Medical Examiners ("Medical Board") have to give prior approval to the practice agreement?

No. There is no prior approval requirement. However, the Board of Nursing may request a copy of a practice agreement from an APRN and the Board of Medical Examiners may request a copy of a practice agreement from a physician. This copy must be provided to the requesting Board within 72 hours of the request. Failure to produce a practice agreement upon request may result in disciplinary action being taken against an APRN or a physician by their respective Board.

8. Do the Boards of Medical Examiners and Nursing plan to audit practice agreements?

Yes. The Board of Nursing previously audited APRN protocols biennially and will continue to audit practice agreements <u>for APRN compliance</u>. The new law authorizes the Board of Medical Examiners to audit the practice agreements <u>for physician compliance</u>. The Boards will conduct separate audits, utilizing their respective staff and resources. The Board of Nursing may request a copy of a practice agreement from an APRN and the Board of Medical Examiners may request a copy of a practice agreement from a physician. This copy must be provided to the requesting Board within 72 hours of the request. Failure to produce a practice agreement upon request may result in disciplinary action being taken against an APRN or a physician by their respective Board.

9. What will the Boards be looking for when auditing a practice agreement?

In order to determine whether the practice agreement complies with all statutory requirements, auditors performing this function for the Boards will compare the content of the practice agreement under audit to the following requirements of the applicable practice act.

In accordance with Section 40-33-34, at a minimum the practice agreement must include the following:

- name, address, and South Carolina license number of the nurse;
- name, address, and South Carolina license number of the physician;
- nature of practice and practice locations of the nurse and physician; (Note that, pursuant to Section 40-33-34(C), the nurse's nature of practice and/or practice locations must include some portion of the nurse's time practicing being spent either serving an underserved population or practicing in an underserved or rural area.) ('Underserved population' means a population residing in a rural or urban area, which includes, but is not limited to: (a) persons receiving Medicaid, Medicare, Department of Health and Environmental Health care, or free clinic care; (b) those residing in long-term care settings or receiving care from a licensed hospice; (c) those in institutions including, but not limited to, incarceration institutions and mental health institutions; and (d) persons including, but not limited to, the homeless, HIV patients, children, women, the economically disadvantaged, the uninsured, the underinsured, the developmentally disabled, the medically fragile, the mentally ill, migrants, military persons and their dependents, and veterans and their dependents.) ('Underserved or rural area' means an area determined by a federal or state agency authorized to determine such a designation.)
- date the practice agreement was entered into and dates the practice agreement was reviewed and amended; (Note that the original practice agreement and any amendments to it must be reviewed at least annually, dated and signed by the nurse and physician.); and
- description of how consultation with the physician is provided and provision for backup consultation if the physician is unavailable.
- describe the method of quality improvement process. Examples: discussion of cases, review of evidence-based guidelines, referral method of patients out of the scope of practice.

Also, the practice agreement must include the following additional information for the medical acts to be performed by the APRN (Evidence Based Guidelines/Websites for example):

- description of how the physician is readily available; which means how the physician is able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice
- medical conditions for which therapies may be initiated, continued, or modified;
- treatments that may be initiated, continued, or modified;
- drug therapies that may be prescribed; and
- situations that require direct evaluation by or referral to the physician such as health problems that exceed the scope of practice of the APRN.

CNM In addition to practicing under a practice agreement as outlined above, a CNM also may practice pursuant to written policies and procedures for practice developed and agreed to with a physician who is board certified or board eligible by the American College of Obstetricians and Gynecologists. The written policies and procedures constitute a practice agreement for purposes of

compliance with Section 40-33-34 and as long as they meet the following requirements:

- address medical aspects of care including prescriptive authority;
- contain transfer policies and details of the on-call agreement with the physician with whom the policies and procedures were developed and agreed. The details of the on-call agreement must include how the on-call physician (or other qualified physician properly designated as the on-call physician by the original on-call physician with whom the policies and procedures were developed and agreed) will be available to the CNM to provide medical assistance in person, by telecommunications, or by other electronic means.

10. **What are the possible consequences of not having a compliant practice agreement in place?**

The physician and the APRN will be subject to disciplinary action by their respective Board. The new law adds two new grounds of misconduct for both physicians and APRNs for engaging in practice without a compliant practice agreement in place and for failing to comply with their practice agreement. There is a range of penalties under existing law for misconduct, including public reprimands, monetary penalties, and other actions.

11. Will the Boards be posting any educational information on the new law or guidance on how to comply with the new law?

Yes. The Boards have already posted a brief overview of the new legislation on their respective webpages and provided a guidance document for reference in drafting a practice agreement.

On May 18, 2018, Governor McMaster signed R.203/S. 345 into law. This new law dramatically changes the manner in which advance practice registered nurses practice and places great emphasis on the specific language of the practice agreement executed by each APRN. The practice agreement must be tailored to reflect the clinical experience and setting of the individual APRN. In an effort to assist its licensees with the task of converting from protocols formerly used to the practice agreements required under the new law and to assure compliance with the new statutory requirements by July 1, 2018, the Board of Nursing approved a guidance document for convenient reference on May 18, 2018. This guidance document does not constitute legal advice and is not intended to encompass all the nuances of any particular APRN's clinical setting. It is merely a tool to assist an APRN and a collaborating physician in the development of a practice agreement that accurately reflects their professional relationship.

http://www.llr.state.sc.us/Pol/Nursing/Pdf/Sample%20Collaborative%20Written%20Practice%20Agreement.pdf

This document was approved by the Board of Nursing. While this document may provide some guidance, it does not encompass all requirements of the new law.

The Boards will continue to provide additional guidance.

12. How specific does the information in the practice agreement need to be? For example, with regard to prescriptive authority, is it sufficient to authorize an APRN to prescribe all drugs in a given controlled substance schedule?

With regard to prescriptive authority, the language in the practice agreement should be as specific as reasonably necessary for both parties to have a clear understanding of what drug therapies may be prescribed by an APRN in a given practice setting.

All authorized prescriptions by a nurse practitioner with prescriptive authority must comply with all applicable state and federal laws and executive orders. Per the SC Nurse Practice Act (2018), APRN may use prescriptive authority to prescribe or write orders for controlled medications in Schedule II-V. C-II narcotics may be prescribed for five days only and another prescription must not be written without the written agreement of the physician with whom the nurse practitioner has entered into a practice agreement, unless the prescription is written for patients in hospice or palliative care. C-II controlled non-narcotics medications can be prescribed for 30 days and for each renewal.

*Examples of C II-C V (**examples and not all inclusive lists**)

Examples of C-II medications: Hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyContin, Percocet), and fentanyl (Sublimaze, Duragesic). Other Schedule II narcotics include: morphine, opium, and codeine.
Examples of Schedule II stimulants: Amphetamine (Dexedrine, Adderall,) methamphetamine (Desoxyn), and methylphenidate (Ritalin).

Examples of C III medications: buprenorphine (Suboxone), Tylenol with Codeine), non-narcotics include: benzphetamine (Didrex), phendimetrazine, ketamine, and anabolic steroids such as Depo-Testosterone.

Examples of C IV medications: Alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion).

Examples of C V medications: cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC, Phenergan with Codeine), and ezogabine.

One must keep in mind however, that the prescriptive authority of an APRN is limited to drugs and devices utilized to treat medical problems within the specialty field of the nurse practitioner or clinical nurse specialist as prescribed in the practice agreement, so while it may be appropriate in some practices and in some specialty fields to authorize drugs by listing the entire controlled substance schedule, it may also be necessary to list certain drugs by category or even specific drug name in other practices or specialty fields.

For example, the prescriptive authority section of a practice agreement of an APRN who practices in a pediatric practice should look very different from that of an APRN who practices in a pain clinic.

Therefore, the language in practice agreements should not be boilerplate but should be tailored to the individual working relationship.

13. Is there a list of specific medical acts the new law authorizes an APRN to perform outside of a practice agreement?

There is a specific list of medical acts set out in the new law that APRNs may perform without the need for specific language in the practice agreement. This list of acts in this category are the following: (a) provide noncontrolled prescription drugs at an entity that provides free medical care for indigent patients; (b) certify that a student is unable to attend school but may benefit from receiving instruction given in his home or hospital; (c) refer a patient to physical therapy for treatment; (d) pronounce death and sign death certificates; (e) issue an order for a patient to receive appropriate services from a licensed hospice as defined in Chapter 71, Title 44; and (f) certify that an individual is handicapped and declare that the handicap is temporary or permanent for purposes of the individual's application for a placard. (S.C. Code Ann. § 40-33-34(D) (2) (a)-(e).)

An APRN may perform these acts unless the physician and APRN agree otherwise and include language in the practice agreement that clearly indicates one or more of the acts will not be performed by the APRN.

14. How does the new law change the geographic radius?

The new law eliminates the 45-mile geographic radius restriction. The physician working with the APRN, however, must be actively practicing within the geographic boundaries of South Carolina.

15. How does the new law change the ratio of physician to APRNs?

There are two ratio considerations in the new law: (1) the number of practice agreements a physician may enter into with an APRN and (2) the number of APRNs a physician may work with at any given time. The physician entering into multiple practice agreements is responsible for ensuring compliance with both ratio requirements.

The new law expands the number of practice agreements a physician may enter into from one physician to three (3) full-time equivalent ("FTE") APRNs to one physician to six (6) FTE APRNs. Thus, a physician could enter into practice agreements with more than six APRNs if one or more APRNs work part-time. Agreeing to sign a practice agreement as a backup physician does not count toward the number of practice agreements that a physician may enter into as the primary physician.

The new law, however, includes a second requirement related to ratio. It provides that a physician may not work with more than a total of six (6) APRNs or Physician Assistant ("PAs") or combination thereof in clinical practice at any one time. Thus, a physician might at a given time be working with three (3) APRNs and three (3) PAs and at another time be working with six (6) APRNs. This limitation of six (6) APRNs/PAs in clinical practice at any one time does apply to a backup physician filling in for the primary physician at that time.

The Joint Committee of the Nursing Board and Medical Board may approve exceptions to these requirements.

16. What does the new law provide with regard to APRNs practicing through telemedicine?

S.C. Code Ann. § 40-33-34(I) of the Nurse Practice Act, which is part of the new law, provides that APRNs may perform medical acts via telemedicine pursuant to a practice agreement. Thus, if an APRN plans to practice though telemedicine, the practice agreement must address that practice, including prescriptive authority. If the APRN will be establishing a nurse-patient relationship solely by means of telemedicine, there are specific statutory requirements and limitations that should be incorporated into the practice agreement. Most important are the requirements for prescribing medications if the relationship is established solely via telemedicine.

For example, an APRN may not prescribe medication via telemedicine if an in-person exam is necessary for diagnosis. The APRN must adhere to the same standard of care as a licensee employing more traditional in-person care. **If the practice agreement authorizes the APRN to prescribe medications in Schedules II and III or lifestyle medications, that prescriptive authority must also be approved by a joint committee of the Board of Nursing and the Medical Board prior to prescribing.**

Even if an APRN is authorized to prescribe controlled substances via telemedicine pursuant to a practice agreement and is approved by the joint committee, federal law may require an initial in-person exam prior to prescribing controlled substances. Physicians and APRNs should carefully review the requirements of the federal Ryan Haight Act in this regard. Also, there may be instances in which the standard of care for prescribing a particular controlled substance necessitates an in-person exam.

17. What does the new law provide with regard to APRNs prescribing controlled substances?

Notwithstanding the additional considerations APRNs must address prior to prescribing controlled substances via telemedicine, the new law significantly modified APRN prescriptive authority. S.C. Code Ann. § 40-33-34 (F) (1) sets forth the specific changes, which now include:

(1) The requirement that authorized prescriptions issued by an APRN must comply with all state and federal laws and executive orders;
(2) The requirement that all authorized prescriptions are limited to drugs and devices utilized to treat medical problems within the specialty field of the APRN prescribed in the practice agreement;
(3) The inclusion of Schedules III through V controlled substances if listed in the practice agreement and as authorized by Section 44-55-300;
(4) The inclusion of Schedules II nonnarcotic substances if listed in the practice agreement and as authorized in Section 44-53-300, provided, however, that each prescription must not exceed a thirty (30) day supply;
(5) The inclusion of Schedule II narcotic substances if listed in the practice agreement and as authorized by Section 44-53-300, provided, however, that the prescription must not exceed a five(5)-day supply and another prescription must not be written without the written agreement of the physician with whom the APRN has entered into a practice agreement, unless the prescription is written for patients in hospice or palliative care;
(6) The inclusion of Schedule II narcotic substances for patients in hospice or palliative care if listed in the practice agreement and as authorized by Section 44-53-300, provided, however, that each prescription must not exceed a thirty (30) day supply;

(7) The requirement that each prescription must be signed or electronically submitted by the APRN with the prescriber's identification number assigned by the board all prescribing numbers required by law. Written prescription forms must include the name, address and phone number of the APRN **and** physician. Electronic prescription forms must include the name, address, and phone number of the APRN, and, if possible, the physician, through the electronic system. All prescriptions must comply with Section 39-24-20. A prescription must designate a specific number of refills and may not include a nonspecific refill indication; and

(8) The authorized prescription must be documented in the patient record of the practice and must be available for review and audit purposes.

18. Is the pharmacist responsible for verifying the APRN's prescriptive authority before filling a prescription?

No. If the pharmacist is presented with a prescription that appears valid, the pharmacist is not required to verify the prescriptive authority provided in the practice agreement. The APRN and physician or medical staff who sign the practice agreement are responsible for ensuring that any prescriptions written fully comply with the terms of the practice agreement, state and federal law, executive orders, and Board policies. However, a pharmacist may decline to fill a prescription as authorized by the South Carolina Pharmacy Practice Act.