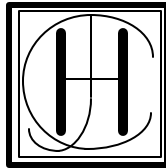


**REPORT OF THE  
JOINT COMMISSION ON HEALTH CARE**



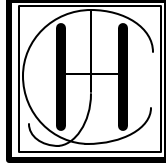
**PRESCRIPTIVE AUTHORITY OF  
NURSE PRACTITIONERS**

**(HB 818, 2000)**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**

Joint Commission on Health Care  
900 East Main Street, Suite 3072E  
P.O. Box 1322  
Richmond, Virginia 23218  
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## JOINT COMMISSION ON HEALTH CARE

Delegate Harvey B. Morgan  
Chairman

Kim Snead  
Executive Director

January 14, 2003

**TO:** The Honorable Mark R. Warner, Governor of Virginia  
and  
Members of the Virginia General Assembly

On behalf of the Joint Commission on Health Care, I respectfully submit a report on the prescriptive authority of nurse practitioners. An enactment clause in HB 818 of the 2000 General Assembly Session required the Joint Commission on Health Care to provide a final report on the issue prior to the 2004 General Assembly Session.

This, the final report of the Joint Commission on Health Care on prescriptive authority of nurse practitioners, is submitted for your consideration. The Joint Commission would like to recognize the assistance provided by a number of associations and state agencies in completing this study.

Respectfully submitted,

Kim Snead  
Executive Director



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**JOINT COMMISSION ON  
HEALTH CARE**

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The Honorable Harvey B. Morgan

**Vice Chairman**

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The Honorable R. Edward Houck  
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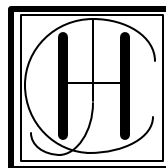
**Secretary of Health and Human Resources**

The Honorable Jane H. Woods

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**Executive Director**

Kim Snead





## Preface

House Bill 818 (HB 818) of the 2000 General Assembly Session expanded the prescriptive authority of nurse practitioners (NPs). Specifically, the prescriptive authority for NPs changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) providing for the authority to prescribe Schedules III-VI drugs. An enactment clause in HB 818 required the Joint Commission on Health Care (JCHC) to report on the issue of prescriptive authority for NPs prior to the 2004 General Assembly Session.

Prescriptive authority for nurse practitioners (NPs) is authorized in some form in each of the 50 states. The majority of states, including Virginia, allow NPs to prescribe drugs including controlled substances with some type of physician involvement. Approximately 74 percent (2,347) of NPs eligible to apply for prescriptive authority in Virginia have done so.

It was difficult to make conclusive judgments regarding mandated study issues because of a lack of Virginia-specific data. First, the Board of Nursing did not collect information regarding the practice locations of NPs and the changes to the written practice agreements between physicians and NPs. The lack of information concerning NP practice locations meant that the extent to which NPs practice in medically underserved areas could not be determined. Second, a number of studies conducted in the United States indicate that quality care is being provided by NPs and that patients are generally satisfied with the care they receive from NPs. However, Virginia specific information was only available anecdotally. Available data about disciplinary actions against NPs and NPs with prescriptive authority indicated there are relatively few complaints and sanctions involving NPs. These indicators suggest that NPs in Virginia are providing quality care and that patient satisfaction is likely to be relatively high. Third, because NPs only received the authority to move to Schedule III on July 1, 2003, no conclusive findings could be made regarding the authority to prescribe Schedule III controlled substances during this study.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. The Commission ultimately voted to introduce a resolution requiring the Board of Nursing to collect data regarding practice locations and levels of prescriptive authority for licensed nurse practitioners.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Board of Nursing, the Bureau of Insurance, the Department of Health, the Eastern Virginia Medical School Library, the Virginia Association of Health Plans, the Virginia Council of Nurse Practitioners, and the Virginia Health Care Foundation for their cooperation and assistance during this study.

Kim Snead  
Executive Director

December 2003





## Executive Summary

House Bill 818 (HB 818) of the 2000 General Assembly Session expanded the prescriptive authority of nurse practitioners (NPs). Specifically, the prescriptive authority for NPs changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) providing for the authority to prescribe Schedules III-VI drugs. An enactment clause in HB 818 required the Joint Commission on Health Care (JCHC) to report on the issue of prescriptive authority for NPs prior to the 2004 General Assembly Session. Specifically, the Commission is required by the enactment clause:

...to study nurse practitioner prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules III through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.

Based on research and analysis conducted during this review, JCHC staff found the following concerning NPs and NPs with prescriptive authority in Virginia:

- The number of nurse practitioners (NPs) in Virginia has more than doubled between 1994 and 2003. As of June 2003, the number of licensed NPs was 4,621 and the number of NPs with prescriptive authority was 2,347. Because one category of NPs, nurse anesthetists, is not eligible for prescriptive authority, the number of eligible NPs with prescriptive authority is approximately 74 percent.
- The Board of Nursing (BON), which collects information about NPs, does not collect information regarding the practice locations of NPs or the changes to the written practice agreements between physicians and NPs, which delineate the NPs' authority to prescribe medication. The lack of information concerning NP practice locations meant that the extent to which NPs practice in medically underserved areas could not be determined.
- A number of studies conducted in the United States have shown that quality care is being provided by NPs and that patient satisfaction exists with NP services generally. Available data about disciplinary actions against NPs and NPs with prescriptive authority in Virginia showed a low occurrence of complaints and sanctions. This finding indirectly suggests that Virginia NPs are providing quality care and that patient satisfaction is likely to be relatively high.
- All states allow some type of prescriptive authority for NPs. The majority of states, including Virginia, allow NPs to prescribe drugs including controlled substances with some type of physician

involvement. Five states allow NPs to prescribe drugs excluding controlled substances with physician involvement. And, 12 states allow NPs to independently prescribe drugs including controlled substances.

- Virginia is in a more restrictive category in regards to NP scope of practice. Virginia requires physician supervision for prescriptive authority and is one of only five states that have scope of practice authorized by both a board of nursing and a board of medicine.
- In addition, although Virginia does not provide NPs with mandated direct third-party reimbursement status or primary care provider status, the five states that border Virginia mandate both for NPs.

It should be noted that NPs only received the authority to move to Schedule III on July 1, 2003. Therefore, no conclusive findings could be made regarding the authority to prescribe Schedule III controlled substances during this study.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 29. The Commission ultimately voted to support an amended Option III, requiring the Board of Nursing to collect data regarding practice locations and levels of prescriptive authority for licensed nurse practitioners.

Kim Snead  
Executive Director

December 2003

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## **I. Authority for the Study/Organization of Report**

House Bill 818 (HB 818) of the 2000 General Assembly Session expanded the prescriptive authority of nurse practitioners. Specifically, the prescriptive authority for nurse practitioners changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) for the authority to prescribe Schedules III-VI drugs. The bill also removed the requirement that the Boards of Nursing and Medicine develop a formulary of the drugs that nurse practitioners were authorized to prescribe. This provision was changed to require the supervising physician and the nurse practitioner to develop a written agreement that lists the drugs that the nurse practitioner is or is not allowed to prescribe.

In addition, an enactment clause in HB 818 required the Joint Commission on Health Care to provide a preliminary report on the issue of prescriptive authority for nurse practitioners by July 1, 2003 and a final report on the issue prior to the 2004 General Assembly Session. Specifically, the Commission is required by the enactment clause:

...to study nurse practitioner prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules III through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.

HB 818 as passed by the General Assembly and approved by the Governor, became effective on July 1, 2000. A copy of the bill is provided in Appendix A.

### **ORGANIZATION OF THE REPORT**

This report includes three major sections. This section discussed the authority for the study. Section II presents background information on nurse practitioners in Virginia and includes a discussion of the laws and regulations governing nurse practitioners and their ability to have prescriptive authority. Section III will discuss issues related to nurse practitioner prescriptive authority including the mandated categories in HB 818, an overview of data collected by

the Board of Nursing, and a brief examination of NP prescriptive authority in other states.

## II. Background

With the aging of the population, the demand for health care providers is increasing. In addition, it has been found that there are Virginia communities that do not have adequate access to primary care. Some research has concluded that providing appropriate access to primary care will require the increased use of physician extenders such as nurse practitioners and physician assistants. This study focuses on the prescriptive authority of nurse practitioners which some see as a necessary provision in providing increased access to health care for individuals, especially in medically underserved areas. Specifically, the following sections provide an overview of nurse practitioners (NPs) in Virginia and the laws and regulations that impact them.

### **Overview of Nurse Practitioners in Virginia**

The sections that follow provide descriptive information regarding the number of nurse practitioners licensed in Virginia as well as the number of nurse practitioners that have prescriptive authority. Additional background information is provided regarding other general characteristics of NPs in this state.

***Growth in the number of nurse practitioners in Virginia has been substantial.*** The number of licensed NPs in Virginia has more than doubled between 1994 and 2003. As of June 12, 2003, there were approximately 4,621 licensed nurse practitioners in Virginia. Figure 1 provides an examination of the growth in the number of nurse practitioners between 1994 and 2003 by categorizing them into three categories. The three categories include nurse practitioners, nurse midwives, and nurse anesthetists. All three categories grew over the eight-year period.

**Figure 1**  
**The Number of Nurse Practitioners**  
**Licensed in Virginia in 1994 and 2003**

<b>Category of Practitioners:</b>	<b>1994</b>	<b>2003</b>
Certified Nurse Midwife	95	209
Certified Registered Nurse Anesthetist	1,097	1,437
All other Nurse Practitioners	1,148	2,975*
<b>Total</b>	<b>2,340</b>	<b>4,621</b>

Note: \* Indicates that this number is an approximation due to an effort to eliminate any duplication between categories.

Source: *Study of the Optimum use of Nurse Practitioners Pursuant to SJR 164 of 1994*, Report of the Joint Commission on Health Care, 1995 and *Commonwealth of Virginia Board of Nursing Statistical Information and Specialty Counts*, Department of Health Professions, 2003.

Additionally, Figure 2 provides a breakout of the number of licensed nurse practitioners by more specific categories. These categories generally follow those stipulated in the regulations governing the licensure of nurse practitioners.

Growth in the number of nurse practitioners was also experienced at the national level. The number of nurse practitioners at the national level grew from 49,857 in 1992 to 102,829, an increase of 106 percent. Therefore, it would appear that nurse practitioners are becoming more prevalent in the medical workforce. The growth in the number of nurse practitioners may also be partly due to the increase in their authority, such as being authorized to prescribe an increasing number of medications in many states.

***An increasing number of licensed nurse practitioners have prescriptive authority.*** According to data collected by the Department of Health Professions, 51 percent of licensed nurse practitioners (2,347) had prescriptive authority as of mid-June 2003. However, this percentage underestimates the actual percentage of nurse practitioners that have prescriptive authority due to the fact that nurse anesthetists are not eligible for prescriptive authority. Therefore, the percentage of eligible nurse practitioners with prescriptive authority would really be closer to 74 percent. It seems that a large number of nurse practitioners are taking advantage of the ability to prescribe allowable drugs.



**Figure 2**  
**Categories and Numbers of Nurse Practitioners**  
**Licensed in Virginia**

<b>Category:</b>	<b>2003</b>
Adult	512
Family	1,598
Pediatric	430
Family Planning	2
Obstetric/Gynecologic	167
Emergency	23
Geriatric	55
Certified Registered Nurse Anesthetist	1,437
Certified Nurse Midwife	209
School	1
Medical	1
Neonatal	110
Women's Health	89
Acute Care Nurse	96
Psych/Mental Health	11
<b>Total</b>	<b>4,741*</b>

\* This number is higher than the reported total of 4,621 licensed nurse practitioners because of duplication between categories. An individual nurse practitioner may be designated in more than one category.

Source: *Commonwealth of Virginia Board of Nursing Statistical Information and Specialty Counts*, Department of Health Professions, 2003.

***Most nurse practitioners are employed in the nursing field.*** A survey conducted by the Center for Survey Research at Virginia Tech in 2001 provides some other general descriptive information about nurse practitioners in Virginia. For example, 88 percent of licensed nurse practitioners that were in the survey sample were employed in the nursing field. The survey also found that the most common job settings of those licensed nurse practitioners working in the nursing field included hospitals (37 percent) and physician's offices (35 percent).

### **Virginia Laws and Regulations Governing Nurse Practitioners**

The following sections provide an overview of the laws and regulations governing the general licensure of nurse practitioners and those requirements to obtain prescriptive authority in Virginia. In both cases, the Board of Medicine and the Board of Nursing jointly develop regulations for nurse practitioners.

***Laws and regulations governing the licensure of nurse practitioners in Virginia.*** Authority to license nurse practitioners is given under § 54.1-2957 of the *Code of Virginia*. This section mandates that the Boards of Nursing and Medicine develop regulations for the licensure of nurse practitioners. This section of the *Code* also provides authority to issue a license by endorsement to an applicant that is licensed as a nurse practitioner in another state and to grant temporary licensure.

The regulations prescribed by § 54.1-2957 of the *Code* can be found under Title 18, 90-30-10 through 90-30-230 of the *Virginia Administrative Code*. The regulations include sections on categories of licensed nurse practitioners, qualifications for initial licensure, certifying agencies, renewal of licensure, continuing competency requirements, reinstatement of the license, the practice of licensed nurse practitioners, and disciplinary provisions. While this report will not go into detail about all of these sections, it is important to review several of them to provide background information on the requirements to be a nurse practitioner.

The first section that should be discussed is the requirement for initial licensure. The following provisions are the requirements that state that a nurse practitioner shall:

1. Be currently licensed as a registered nurse in Virginia;
2. Submit evidence of completion of an educational program designed to prepare nurse practitioners that is an approved program as defined in 18VAC90-30-10;
3. Submit evidence of professional certification by an agency identified in 18VAC90-30-90 as an agency accepted by the boards;
4. File the required application; and
5. Pay the application fee prescribed in 18VAC90-30-50.

While the requirements for initial licensure are mostly self-explanatory, several of the provisions need further explanation.

The second requirement for initial licensure, as mentioned above, is to complete an educational program that is part of an approved program. Approved programs are those that are “accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools, American College of Nurse Midwives, American Association of Colleges of Nursing or the National League for Nursing” or are part of a school of nursing or program that is jointly offered by a school of medicine and a school of nursing that grants a master's degree in nursing and has national accreditation that has been deemed appropriate by the Board of Nursing.

Additionally, the third requirement (to have professional certification) may be achieved through several certifying agencies that have been deemed acceptable. These agencies include the American College of Nurse Midwives Certification Council, American Nurses' Credentialing Center, Council on Certification of Nurse Anesthetists, National Certification Board of Pediatric Nurse Practitioners and Nurses, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, and the American Academy of Nurse Practitioners. Moreover, certification from another agency can be considered if it is based on an approved educational program and a passing score on an examination.

Another section related to being a NP includes the continuing competency requirements. To be eligible to renew their license NPs must either hold "current professional certification in the area of specialty practice" (from a certifying agency) or have completed "at least 40 hours of continuing education in the area of specialty practice" (approved by a certifying agency). This mandate became effective as of January 15, 2003 and it will apply to persons renewing their license on or after January 1, 2004. Nurse practitioners will be required to retain evidence of their compliance with this section for a four-year period. The Board of Nursing and the Board of Medicine are required to conduct random audits of at least one percent of its licenses for compliance with the continuing competency requirements.

A final stipulation regulating NPs that should be noted includes the requirement that NPs and their supervising physician have a written protocol that they develop jointly. This stipulation is under the section of the regulations that govern the practice of NPs. The written protocol "directs and describes the procedures to be followed and the delegated medical acts appropriate to the specialty practice area to be performed by the licensed nurse practitioner(s) in the care and management of patients."

***Laws and regulations governing prescriptive authority of nurse practitioners in Virginia.*** Under § 54.2957.01 of the *Code*, regulations governing nurse practitioner prescriptive authority are required to be developed by the Board of Nursing and the Board of Medicine. Additionally, the two entities are required to consult on the regulations with the Board of Pharmacy. This section of the *Code* addresses the prescription of "certain controlled substances and devices by licensed nurse practitioners" as well as other stipulations related to this authority.

For example, within this *Code* section, the timetable of when nurse practitioners become eligible to prescribe certain schedules of drugs is outlined. The following provides that timetable:

- (i) Schedules V and VI controlled substances on and after July 1, 2000;
- (ii) Schedules IV through VI on and after January 1, 2002; and
- (iii) Schedules III through VI controlled substances on and after July 1, 2003.

(This schedule was altered by HB 818 of the 2000 General Assembly Session). Figure 3 provides a brief description of Schedules I through VI. As noted above, NPs just received authority to prescribe schedule III drugs as of July 1, 2003.

An additional stipulation under this section of the *Code* requires that a nurse practitioner enter into a written agreement with a physician that governs which controlled substances the NP is authorized to prescribe and may include any restrictions that the supervising physician feels is appropriate. The *Code* stipulates that physicians may not direct any more than four NPs at any time. The physician is required to regularly practice at the location that the NP is using prescriptive authority unless the NP is a certified nurse midwife or the physician

<b>Figure 3</b> <b>Description of Schedules I through VI</b>
<b>Schedule I</b> - “high potential for abuse; and has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision.”
<b>Schedule II</b> - abuse of these controlled substances “may lead to severe psychic or physical dependence.”
<b>Schedule III</b> - abuse of these controlled substances “may lead to moderate or low physical dependence or high psychological dependence.” Example - certain anabolic steroids.
<b>Schedule IV</b> - abuse of these controlled substances “may lead to limited physical dependence or psychological dependence” relative to Schedule III. Example - Phenobarbital.
<b>Schedule V</b> - “limited physical dependence or psychological dependence liability” relative to Schedule IV. Example – Buprenorphine.
<b>Schedule VI</b> - basically all other controlled substances.
Source: Sections 54.1-3445 through 54.1-3455 of the <i>Code of Virginia</i> .

is employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services. In those situations, the physician must make periodic site visits to the facility, not less than quarterly.

The sections addressed in the *Code* are also more specifically addressed in the regulations governing NP prescriptive authority. The regulations required by § 54.2957.01 of the *Code* are included in Title 18, 90-40-10 through 90-40-140 of the *Virginia Administrative Code* and provide additional requirements for nurse practitioners. For example, the regulations supply stipulations on initial prescriptive authority, renewal of prescriptive authority, continuing competency requirements, reinstatement of prescriptive authority, fees for prescriptive authority, practice requirements, and discipline procedures. The following paragraphs will explain some of the stipulated requirements for prescriptive authority in more detail.

For initial approval of prescriptive authority, the applicant must meet the following requirements:

1. Hold a current, unrestricted license as a nurse practitioner in the Commonwealth of Virginia; and
2. Provide evidence of one of the following:
  - a. Continued professional certification as required for initial licensure as a nurse practitioner; or
  - b. Satisfactory completion of a graduate level course in pharmacology or pharmacotherapeutics obtained as part of the nurse practitioner education program within the five years prior to submission of the application; or
  - c. Practice as a nurse practitioner for no less than 1000 hours and 15 continuing education units related to the area of practice for each of the two years immediately prior to submission of the application; or
  - d. Thirty contact hours of education in pharmacology or pharmacotherapeutics acceptable to the boards taken within five years prior to submission of the application. The 30 contact hours may be obtained in a formal academic setting as a discrete offering or as noncredit continuing education offerings and shall include the following course content:
    - (1) Applicable federal and state laws;
    - (2) Prescription writing;
    - (3) Drug selection, dosage, and route;
    - (4) Drug interactions;
    - (5) Information resources; and
    - (6) Clinical application of pharmacology related to specific scope of practice.
3. Submit a practice agreement between the nurse practitioner and the supervising physician as required in 18VAC90-40-90 of this chapter. The practice agreement must be approved by the boards prior to issuance of prescriptive authority; and

4. File a completed application and pay the fees as required in 18VAC90-40-70 of this chapter.

However, to keep prescriptive authority, NPs must renew this authority biennially at the same time they are renewing their NP license. If there are any changes in the practice agreement with the physician, then a new agreement must be submitted.

Maintaining prescriptive authority also involves meeting continuing competency requirements. These requirements include eight hours of continuing education in pharmacology or pharmacotherapeutics over the biennial period (this is in addition to the 40 hours required for the general NP license). This mandate became effective as of January 15, 2003 and it will apply to persons renewing their license on or after January 1, 2004. As with the stipulations on the general NP license, the applicant must retain the evidence of compliance for a period of four years due to the random audit of at least one percent of its applicants for compliance.

Another area of importance is the practice requirements for prescriptive authority. As noted previously, a NP must have a practice agreement with a supervising physician. The agreement is required to contain a description of the drugs and devices that the NP is allowed to prescribe. The agreement must include the signature of the primary supervising physician and any secondary physician that might regularly be called upon. (This agreement is in addition to the written protocol required for general NP licensure, between a physician and a NP, which allows for procedures and delegated appropriate acts in the care of patients.) Supervising physicians are mandated to conduct monthly, random reviews of patient charts where the NP has prescribed a drug or device. For NPs who are allowed to operate at a separate location, the supervising physician must make site visits at least once a quarter.

### **Federal Laws and Regulations Governing Nurse Practitioners**

This section provides a brief listing of federal law and regulations that apply to NP practice as well as more detailed descriptions of the most important laws and regulations for this study. The federal government impacts NP practice through laws that have been enacted by Congress and regulations and/or policies set by federal agencies. It is important to note that federal law supercedes state law that is in conflict with the federal law's provisions. The

following areas have federal laws addressing NP practice according to Buppert (1999).

- care of patients covered by Medicare
- care of patients covered by Medicaid
- care of hospitalized patients insofar as participation by hospitals in the Medicare program is contingent on a hospital following certain regulations
- care of residents in nursing homes
- in-office and hospital laboratories, under the Clinical Laboratories Improvement Act (CLIA)
- self-referral by health providers, under the Stark Acts
- prescription of controlled substances, under the Drug Enforcement Administration (DEA)
- reporting of successful malpractice lawsuits against NPs to the National Practitioner Data Bank (NPDB)
- confidentiality information about patients
- discrimination in hiring and firing
- facility access for disabled people

A discussion of policies concerning patients covered by Medicaid and Medicare mostly pertains to definitions and reimbursement and is of importance to the examination of third-party reimbursement as mandated by this study. One example is that when the programs were passed, there were no NPs and the Social Security Act often refers to the term physician rather than being more inclusive with terms including other healthcare providers. The law has been amended over the years to include other healthcare providers. A more detailed discussion of these two programs concerning reimbursement is discussed in the following chapter.

Federal regulations in addressing the care provided in hospitals can impact NPs and NPs with prescriptive authority. In addressing care provided for Medicare patients, the Social Security Act stipulates that a physician must direct the care of hospitalized patients. However, physicians can delegate to other qualified healthcare personnel, which would likely include NPs. Similar provisions apply to patients covered by Medicare in nursing homes. In that setting, “..the care of residents of a skilled nursing facility must be under the supervision of a physician.” Again, physicians can assign tasks to other qualified healthcare providers. Other federal provisions of interest include the Clinical Laboratories Improvement Act (CLIA), which provides federal oversight of any office or hospital laboratory, and the Stark Act, which prohibits self-referral by providers to another entity in which they have a financial interest.

An area of oversight that is of particular importance to this study is that of the requirements under the Drug Enforcement Administration (DEA). The DEA has the authority to license all healthcare providers that are prescribing controlled substances or what is referred to as scheduled drugs. Under these provisions, NPs are licensed as mid-level practitioners. According to Buppert (1999), "The DEA will assign a NP a DEA number if the NP has no felony on record, if the NP has a practice site, and if state law permits NPs to prescribe controlled substances." Obtaining a DEA number is of great importance because the provider's DEA number must be on the prescription to be valid. This stipulation helps to minimize the ability of someone to steal a prescription pad and still be able to obtain fraudulent prescriptions because the DEA number will not be on the pad.



### **III. Overview of Issues Related to Nurse Practitioners and Prescriptive Authority**

As stated previously, HB 818 mandated the examination of a number of areas as they relate to nurse practitioner (NP) prescriptive authority. This chapter will examine patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction as they relate to NPs in general and specifically to the expansion of NP prescriptive authority. However, the chapter will first provide an overview of the data collected by the Board of Nursing and its relevance to this study, as well as, an overview of NP prescriptive authority in other states. Lastly, this chapter will provide conclusions and some possible policy options.

#### **Board of Nursing Does Not Collect Information on Practice Location**

Currently, the Board of Nursing (BON) collects data about the addresses of its licensees. However, BON staff stated that the address collected is typically the home address of the NP. Having only the home address makes it difficult to evaluate where NPs are practicing. Although the written practice agreement for NP prescriptive authority, lists a place of employment, the agreement form does not list the address where the nurse practitioner practices. Figure 4 provides a general guide to the areas of the Commonwealth where NPs were practicing based on a survey completed by Virginia Tech in 2001.

Having information regarding the practice location of nurse practitioners would allow a comparison to the primary health professional shortage areas. A federal designation of a Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA) “..is required for most of the key federal/state programs supporting the recruitment and retention of health care providers.” Most of the shortage areas are in rural parts of the state or underserved urban areas. Some examples of localities that have the primary care HPSA designation include Bland County, Grayson County, Downtown Portsmouth, and Scott County.

JCHC staff compared the NP addresses that were provided to the BON with the primary care HPSAs (as of September 2003). This comparison found that 321 NPs (of 3,592 NPs listing a Virginia address) listed addresses that were

**Figure 4**  
**Number of NPs per Virginia Region - 2001**

<b>Virginia Region</b>	<b>Number of Licensed NPs</b>
Northern Virginia	898
Blue Ridge	355
Central	682
Hampton Roads	691
Roanoke Area	357
Southwest	134
<b>Total</b>	<b>3,117</b>

Source: *Virginia Nurses Survey: 2001*, Virginia Tech Center for Survey Research, October 2001.  
 Note: Data was obtained from the Board of Nursing on May 5, 2001. NPs with out-of-state addresses were excluded as well as those individuals with incomplete addresses.

found to be in designated primary care HPSAs, or about nine percent of NPs listing a Virginia address. Additionally, 216 NPs with prescriptive authority listed addresses that were found to be in primary care HPSAs, or about six percent of NPs listing a Virginia address. Since the majority of addresses listed by NPs to the BON are the home address and not all NPs are likely to live in the same area that they work, this information likely reflects an inaccurate picture of the number of NPs in primary care HPSAs. Without information on practice addresses, it is impossible to determine whether the low number of NPs in primary care HPSAs is accurate. The collection of NP practice addresses would help to more accurately determine the number of NPs providing care in medically underserved areas and therefore, whether NPs are providing increased access to health care in those areas. However, it should be noted that access for some individuals has been increased just by the fact that NPs are in practice.

**Information Concerning Written Practice Agreements is not Automated**

The content of the written practice agreements between NPs and physicians could not be reviewed on a broad basis because the agreements are not automated. The original written practice agreement and updates are maintained in paper files. For the purpose of this study, it would have been relevant to discuss the number of NPs that updated their practice agreements after each subsequent increase in prescriptive authority. However, this information is not available for Schedules IV and V. JCHC staff requested that the BON keep manual track of the number of NPs that requested a change in the

practice agreement to prescribe Schedule III substances. BON staff report that this number is approximately 384 as of September 9, 2003.

Although nearly 400 NPs have received BON approval, most of these NPs have not been able to write Schedule III prescriptions pending Drug Enforcement Administration (DEA) approval. Originally, some NPs with prescriptive authority applied to DEA for the increase to Schedule III drugs and were approved (at the same time they applied to the BON with a change in the practice agreement). However, this approval from DEA has been rescinded temporarily and applicants after early July 2003 have been denied the change in status to prescribe Schedule III drugs by the DEA. Apparently, the DEA has been reviewing the phase-in of the increased authority by year rather than all at once. BON staff indicated that DEA has been given the relevant information again from the Board of Pharmacy and report that the DEA is likely to approve the change soon.

### **Disciplinary Data Indicates that Complaints and Sanctions Against NPs is Very Low**

The Board of Nursing collects disciplinary data concerning complaints and sanctions imposed against licensed NPs. Additionally, as a subcategory, this information is available for licensed NPs with prescriptive authority. Figure 5 summarizes the complaints for licensed NPs and licensed NPs with prescriptive authority for the time period of July 1, 2000 – June 30, 2003. This data indicates that the number of complaints against NPs is relatively low. The total of 171 complaints against NPs averages about one percent per year. Also, the 54 complaints against NPs with prescriptive authority is even less, averaging less than one percent for the three-year period. The categories of complaints that are most related to prescriptive authority include: drug-related other, prescription blanks, and standard of care- prescription related. Appendix B contains descriptions of the complaint categories.

An examination of sanction data also indicates that the number of sanctions imposed against NPs, and as a subset, NPs with prescriptive authority is also very low. For instance, the number of sanctions or actions imposed between July 1, 2000 – June 30, 2003 against NPs was 62, an average of less than one percent per year. The number of sanctions or actions imposed against NPs with prescriptive authority for that same time period was 29, again an average of less than one percent per year. Data related to sanctions is summarized in Figure 6.

**Figure 5**  
**Complaints Resulting in an Investigation - July 1, 2000 – June 30, 2003**

<b>Case Category</b>	<b>Licensed NP</b>	<b>Licensed NP w/Presc. Authority</b>
Abandonment	-	-
Abuse-Mistreatment of Patient	-	-
Action by Another Board/Entity	<b>2</b>	-
Advertising-Misleading	-	-
Business Practices/Issues	<b>2</b>	-
Compliance	<b>5</b>	-
Confidentiality-Breach	<b>3</b>	-
Continued Competency Requirements	-	-
Criminal Activity/Conviction	<b>1</b>	-
Dishonored Check	<b>1</b>	<b>1</b>
Disclosure	-	-
Drug Related-Dispensing Drugs-Violating DCA	-	-
Drug Related-Failure to Maintain Security	-	-
Drug Related-Obtaining Drugs by Fraud	<b>2</b>	-
Drug Related-Other	<b>2</b>	<b>2</b>
Drug Related-Personal Use	<b>3</b>	-
Fraud	<b>2</b>	-
Inability to Safely Practice-Impairment	<b>3</b>	<b>1</b>
Inability to Safely Practice-Incapacitated	-	-
Inability to Safely Practice-Other	-	-
Licensure Eligibility	<b>5</b>	-
Misappropriation of Property	-	-
Neglect	<b>2</b>	<b>1</b>
Other	<b>2</b>	<b>1</b>
Prescription Blanks	<b>8</b>	<b>35</b>
Program or Facility Eligibility	-	-
Records/Inspections/Audits	-	-
Records Release	-	-
Reinstatement	<b>1</b>	-
Required Report not Filed	-	-
Relationship	-	-
Self-referral of Patients	-	-
Standard of Care-Consent	<b>1</b>	-
Standard of Care-Diagnosis Related	<b>4</b>	-
Standard of Care-Equipment/Product	-	-
Standard of Care-IV and Blood Products	-	-
Standard of Care-Malpractice Reports	<b>3</b>	-
Standard of Care-Prescription Related	<b>7</b>	<b>4</b>
Standard of Care-Other	<b>2</b>	<b>2</b>
Standard of Care-Surgery	-	-
Standard of Care-Treatment Related	<b>20</b>	<b>1</b>
Supervision	-	-
Unlicensed Activity	<b>14</b>	<b>5</b>
<b>Total</b>	<b>171</b>	<b>54</b>

Source: *Licensed Nurse Practitioners Disciplinary Data, July 1, 2000 – June 30, 2003*, Virginia Board of Nursing.

**Figure 6**  
**Quantity and Type of Sanctions Imposed - July 1, 2000 – June 30, 2003**

<b>Sanction/Action Taken</b>	<b>Licensed NP</b>	<b>Licensed NP w/Presc. Authority</b>
Case Dismissed	7	-
Continued of Terms	4	2
Mandatory Suspension	8	2
Monetary Penalty	4	2
Probation	2	-
Reinstatement Denied	1	-
Reinstatement Granted	6	3
Reprimand	7	4
Suspension	14	12
Suspension Stayed	1	-
Terms Imposed	6	4
Violation but No Sanction	2	-
<b>Total:</b>	<b>62</b>	<b>29</b>

Source: *Licensed Nurse Practitioners Disciplinary Data, July 1, 2000 – June 30, 2003*, Virginia Board of Nursing.

These statistics show that there are very few disciplinary problems concerning licensed NPs and licensed NPs with prescriptive authority. Disciplinary data indirectly speaks to patient care and patient satisfaction which were mandated categories of examination for this study in regards to increased prescriptive authority of NPs. BON staff indicated that there have not been significant increases in complaints or sanctions since the increased prescriptive authority started being phased-in. Also, it should be noted that the final increase to Schedule III went into effect on July 1, 2003, therefore, there has not been enough time to analyze any trends that might result from this change (and due to the DEA situation NPs are not currently writing Schedule III prescriptions).

### **Overview of Policies Related to Prescriptive Authority in Other States**

In examining the impact that increased prescriptive authority of NPs has had on a number of categories in Virginia, it is important to examine the current status of NP prescriptive authority in other states. Figure 7 summarizes NP prescriptive authority by state. In general, the majority of states (33) allow NPs to prescribe drugs including controlled substances with some type of physician involvement. There are 12 states that allow NPs to independently prescribe drugs including controlled substances. Additionally, five states allow NPs to prescribe drugs excluding controlled substances with physician involvement. Virginia falls into the middle category which is characterized as not the most restrictive but not allowing full independence by NPs in the prescribing of drugs.



was completed by the Office of Technology and Assessment (OTA) in the late 1980s for the purpose of evaluating the contributions of NPs, certified nurse midwives (CNMs), and physician assistants in meeting health-care needs. The OTA study discussed ten studies that “..concluded that the quality of care provided by NPs and physicians were equivalent.” It is important to remember that many of the studies focused on specific areas of competence and used both process and outcome measures. Some of the process measures included “..the adequacy of the pediatric physical assessment, the adequacy of prescribing medications, and the degree of short and long-term patient compliance.” Some outcome measures included the following: “..resolution of acute problems, improvement in the patient’s physical, emotional, and social functional status, and reduction in pain or discomfort in pediatric patients.”

The OTA reviewed 14 additional studies that found differences in results in the quality of care between NPs and doctors (MDs). Twelve of the studies found “..that the relative quality of care given by NPs was better than that given by MDs.” One of the studies that found better quality of care by MDs included measures associated with the management of problems that needed technical solutions, an expected outcome in situations where MDs more technical training would be needed.

Other discussions on the quality of care given by NPs include the acknowledgement that early studies had some methodological problems. However, studies suggest “..that within areas of expertise, there are no important differences between NPs and primary care physicians regarding quality of care, number of visits per patient, use of the emergency room (ER), and prescribing.” Also, these discussions state that more recent studies of “..randomized clinical trials comparing NPs with primary care physicians found no major difference in selected patient outcomes..”.

As mentioned previously, the relatively low number of complaints and sanctions against NPs and NPs with prescriptive authority indirectly indicates that quality care is being provided by NPs in Virginia. Another indirect measure that supports that quality care is being provided by NPs is the low occurrence of successful malpractice suits against NPs nationally.

As part of this study, JCHC staff contacted several universities and other sources to inquire about Virginia-specific data regarding NPs and prescriptive authority. That inquiry revealed that Virginia NP specific data is lacking. It is important to consider that the expanded prescriptive authority is relatively new and this contributes to the lack of available data when trying to examine this issue specifically. Although, specific Virginia data is unavailable, some anecdotal information was collected that supports the premise that increased

prescriptive authority for NPs has had a positive impact on patient care. The following is a quote related to this topic:

I am a nurse practitioner who sees patients in nursing homes. One of the patients was vomiting repeatedly, and was extremely uncomfortable. I was able to take steps to ensure that she did not dehydrate, and the expanded prescriptive authority allowed me to immediately prescribe an antiemetic to help make her more comfortable and reduce the vomiting while we did the necessary tests. In this case, my ability to prescribe the necessary drugs probably prevented a potential hospitalization.

### **Research on Provider Relationships is Ambiguous**

As discussed in previous sections, an examination of other studies pertaining to NPs was conducted by the OTA. The assessment by OTA reported several findings that are relevant to provider relationships. For instance, it was found that doctors who “work with NPs express more satisfaction with NPs’ performance...than do physicians whose contact is indirect or nonexistent.” On the other hand, these studies also acknowledged that competition and fiscal concerns could make relationships between physicians and NPs strained. Therefore, it seems that relationships with providers are likely to be good when there is a direct working relationship between the providers. However, physicians as a group and NPs as a group might be at odds over larger policy issues, especially on questions of scope practice issues which give non-physicians more independence.

### **The Impact of Increased NP Prescriptive Authority on Provider Relationships is Unclear**

In attempting to examine the impact that increased NP prescriptive authority has had on provider relationships, both nationally and in Virginia, JCHC staff contacted relevant professional associations and researched statements by organizations. For example, the American Medical Association (AMA) has efforts to resist non-physician scope of practice issues, this includes expansion of prescriptive authority to non-physician providers. Medical society groups also frequently oppose expansions in scope of practice to non-physician providers. On the other hand, relationships between NPs and individual physicians with which they work appear to be better. An example of this relationship follows in a quote from a medical director at a clinic.

We have had one full-time paid NP and four part-time volunteer NP's during the past four years. In my opinion, their performance has been first-rate and dependable in all regards. They are very attentive to good patient care, responsive to direction, seek consultation appropriately, and are particularly dependable in



using their prescriptive authority. They are uniformly appreciated by their patients, and work consistently well with physicians.

## **Overview of Nurse Practitioner Reimbursement Categories**

This section provides an overview of NP reimbursement. Specifically, this section will examine the way different payers reimburse NPs in general and where possible the section will specifically address reimbursement in Virginia. For instance, there exists some difference in the way Medicare, Medicaid, indemnity insurance companies, managed care organizations, and businesses that contract for certain services choose to reimburse NPs. Additionally, since Medicaid is a federal program administered by the states, there can be quite a variation from state-to-state as to how reimbursement is handled.

***The Medicare Program.*** A significant change was made to the way NPs were reimbursed under Medicare as a result of the Balanced Budget Act (BBA) of 1997. This bill expanded previous Medicare eligibility to allow that NPs in all settings become eligible for direct Medicare reimbursement at the lesser of 85 percent of the physician rate under the fee schedule or 80 percent of the actual charge (under Medicare fee-for-service payments). NPs must apply to be a Medicare provider in order to receive direct reimbursement. The previous law on this issue had allowed for this direct reimbursement only to NPs who had practiced in rural areas. Although this change has allowed for direct Medicare reimbursement to NPs, one survey found that only 4.4 percent of NPs billed directly for their services. This is most likely a result of the provision that allows a NP to bill as “incident to” a physician. “Incident to” billing allows the service to still be billed under the physician’s name and at the physician rate under the fee schedule. Certain stipulations must be met to bill under the “incident to” provision.

Different criteria apply to Medicare payments for clients enrolled in managed care programs. To bill directly for services provided for Medicare patients with managed care coverage, the NP must apply to the managed care organization for admission to the organization’s provider panel. The managed care organization negotiates its rates with providers or groups of providers.

***The Medicaid Program.*** Because the Medicaid program is a federal program that is administered by the states, there is a great deal of variation in NP reimbursement. However, mandates under the Medicaid program allow family and pediatric NPs to bill the program directly within state limits. Under fee-for-service programs, NPs have to apply to a state Medicaid program to receive a Medicaid provider number. Depending on state law, the NP will receive 70 to 100 percent of the fee-for-service rate paid to a physician. Currently, under the

Virginia Medicaid program, family nurse practitioners, pediatric nurse practitioners, and certified nurse midwives receive reimbursement at 100 percent of the physician payment rate.

As with the Medicare program, if a state Medicaid program has a managed care program, the procedure to receive reimbursement is different. To bill directly for services, the NP has to apply to the managed care organization to request admittance to the provider panel. Again, the managed care organization negotiates its rates with providers or groups of providers. In Virginia, NPs can not be primary care providers under the Medallion program (one Medicaid managed care program) or be used as PCPs by the health maintenance organizations (HMOs) in the Medallion II program (another Medicaid managed care program).

**Indemnity Insurance Companies.** Indemnity insurance companies are companies that reimburse for the cost of medical care of individuals insured by the company but do not provide the medical care. These companies usually pay providers on a per-visit, per-procedure basis based on what is typically referred to as a “usual and customary” fee schedule. Receiving payment from an indemnity insurance company requires a NP to submit the appropriate billing form to the company (for the companies directly reimbursing NPs).

**Managed Care Organizations.** Managed care programs (apart from Medicare and Medicaid) typically are organizations that provide both health care services and payment for the services. To receive payments for MCO patients, the NP must apply to be on the provider panel and, as noted previously, the MCO then negotiates its payment rates with the provider, group of providers, practice, or other group. According to Buppert (1999),

NPs are gaining admission to MCO provider panels. With panel membership comes the designation *primary care provider* (PCP), a contract for providing care, credentialing, directory listing, and reimbursement.

However, it is important to note that not all MCOs allow NPs to be PCPs.

**Businesses that Contract for Direct Services.** Examples of this type of direct contract for services include colleges and universities as well as businesses for such items as occupational health services. A NP may choose to contract for these services. Negotiating rates and the terms of the services provided would be specific to the individual situation and involves a great deal of variability.

## **Potential Impacts of Increased Nurse Practitioner Prescriptive Authority on Reimbursement**

As mentioned previously, HB 818 (2000) expanded the prescriptive authority of nurse practitioners over a period of several years. This expansion increased the number of medications that nurse practitioners could prescribe which in turn has had some effect on the ability of NPs to provide greater service to patients, increasing the independence of NPs. For instance, in busy physician's offices where the physician may be at a different practice location, a NP could now write some prescriptions (that they previously did not have the authority to write) for patients without waiting for the physician. Increased independence in one area is often a catalyst for changes in other areas. For instance, in other states gains in prescriptive authority have come about with changes to reimbursement. These changes include NPs being recognized as mandated providers, which leads to more direct reimbursement from the different payer types. Another change has included mandates to include NPs as primary care providers and more inclusion on MCO provider panels.

Currently, the expansion of prescriptive authority for NPs in Virginia for the most part has not been accompanied by other expansions in mandated provider status and thus, more direct payment from various payers. However, nurse midwives received mandated provider status under Sections 38.2-3408 and 38.2-4221 of the *Code of Virginia* in HB 1360 of the 1997 session (carried over from 1996) as related to accident and sickness insurance companies. Under Section 38.2-4312 of the *Code of Virginia* pertaining to HMOs, this mandated provider status for nurse midwives is referred to only in that HMOs can not unreasonably discriminate against nurse midwives. According to Bureau of Insurance (BOI) staff, this provision does not mean that HMOs must contract with nurse midwives if the providers under contract are already providing the same services. According to a previous JCHC study of NPs,

Statutory inclusion as mandated providers would allow NPs to bill under their own names and receive direct reimbursement from state-regulated products for their services. In the present situation, NPs must bill for their services under their collaborating physicians' provider numbers. This system of "closeted billing" makes tracking of NP patient data impossible, does not recognize nurse practitioners for their professional services, and forces physicians to submit claims for services they have not personally performed.

However, as mentioned previously, some direct reimbursement of NPs is already allowed by both Medicare and Medicaid. Bureau of Insurance staff indicated anecdotally that accident and sickness insurance companies and managed care organizations, typically do not directly reimburse for NP services in Virginia. An informal inquiry by Virginia Association of Health Plans

reported that the reimbursement practices of their member plans vary. These findings included that some plans contracted directly with NPs, some plans identified NPs through a separate code, and some had NP services billed through the supervising physician.

A review of NP reimbursement practices in the states that border Virginia is included in Figure 8. The results show that Virginia allows for the least independence in NP reimbursement with respect to mandated direct third-party status. Furthermore, NP reimbursement in Virginia is also restricted by a lack of legislation granting NPs PCP status.

<b>Figure 8 Summary of Reimbursement Issues in Selected States</b>				
<b>State</b>	<b>Mandated Direct Third-Party Reimbursement</b>	<b>Direct Medicaid Reimbursement</b>	<b>Medicaid Reimbursement as % of Physician Payment</b>	<b>Primary Care Provider Status</b>
KY	✓	✓	75%*	✓
MD	✓	✓	100%	✓
NC	✓	✓	100%	✓
TN	✓	✓	100%	✓
VA	✗**	✓	100%	✗
WV	✓	✓	100%	✓***

Source: *Fifteenth Annual Legislative Update, The Nurse Practitioner, Volume 28, Number 1.*

Note: \*Denotes that one county has only managed care and the rate for that program is 100%..  
 \*\*Denotes that the mandated reimbursement does not apply to NPs but does apply to nurse midwives.  
 \*\*\*Denotes that the NP must have association with a physician that is listed on the managed care panel.

The topic of reimbursement is a very complicated issue. There are also some disincentives for changes in reimbursement for those NPs that operate in practices with physicians. For example, under Medicare NPs can reimburse directly for 85% of the physician’s charge under the fee-for-service program. However, if the NP bills their service “incident to” the physician then 100 percent

of the fee can be received. The following section discusses other limitations or barriers to more direct reimbursement of NPs in Virginia.

### **Limitations on Direct Nurse Practitioner Reimbursement**

While the increase in prescriptive authority has allowed some additional independence of NPs, stipulations in Virginia law and regulations still require that NPs have written agreements with physicians concerning the controlled substances that NPs can prescribe. Physicians must also regularly practice at a location that the NP is using the prescriptive authority or for certain categories of NPs, the physician is required to make periodic site visits to the location. Therefore, there are still limitations on the independence of NPs in Virginia.

These limitations on NP independence impact reimbursement such that managed care organizations and other insurers may be less likely to contract with NPs as primary providers or reimburse them directly when they are still somewhat dependent on physicians. NPs, other than the special category of nurse midwives, do not have mandated provider status which further impacts reimbursement.

### **Some Physician Practices were Impacted by Increased NP Prescriptive Authority**

According to Virginia Health Information (VHI), there are more than 28,000 licensed physicians in Virginia. The number of licensed NPs in Virginia is 4,621 and the number of NPs with prescriptive authority is 2,347. Therefore, the impact of increased prescriptive authority for less than 2,500 NPs would not seem to be particularly significant for the majority of physicians. However, physicians in practice were impacted in their day-to-day operations if they employed NPs when the NP prescriptive authority increased. Individuals contacted during this study suggested that the increased NP prescriptive authority was beneficial to physicians and NPs in that it reduced some burdens. For example, if the physician was at another satellite practice office, the NP now has more ability to write prescriptions that the doctor would not have to handle at a later time. This not only increases the efficiency of the practice but it improves patient satisfaction with being able to receive care and/or the prescriptions more quickly.

### **Studies Examining NPs Have Shown That Patients are Satisfied with Their Care**

An earlier section examined the quality of care or patient care which is closely intertwined with patient satisfaction. Also, as mentioned previously, the

Office of Technology Assessment (OTA) reviewed a number of studies that examined issues concerning the quality of care that patients received. Patient satisfaction was a secondary factor on which data was collected in a number of these studies. A majority of these studies found that patients were satisfied with the care they received from NPs, sometimes more satisfied than with MD care. Reasons provided for being more satisfied with NP care in relation to MD care related to “..the amount of information conveyed, the reduction of professional mystique, and the costs of care.” Additionally, “..recent randomized clinical trials comparing NPs with primary care physicians found no major differences in selected patient outcomes and higher patient satisfaction with NP care.”

### **Increased Prescriptive Authority Has Likely Increased Patient Satisfaction in Some Cases**

This documented satisfaction with NP visits by patients would be expected to increase for some patients with increased NP prescriptive authority due to the ability of an NP to provide an additional service. JCHC staff contacts for this study suggested that increased NP prescriptive authority “has lead to a reduction in patient hassle and that patients can now access medications more promptly.” Other examples of situations that would allow for action by a NP that would lead to increased satisfaction includes the quotes that follow.

I was the only professional in the rural doctor’s office where I work. A mother brought her preschool child in. The child’s allergies had recently worsened due to the time of the year, and his cough was interfering with his ability to sleep. Over the counter medicines were not successful in controlling the cough. I was able to prescribe a Schedule V cough medicine to control his cough that day, and he didn’t need to wait for a physician to write or call in a prescription.

A young patient with a history of migraine headaches called the office after the physician had left to make rounds at the hospital. She was in extreme pain, and wondered whether she should go to the emergency room or come to the office. I was able to direct her to the office because I could prescribe and administer the appropriate Schedule IV drug to provide her relief.

Lastly, the BON data on complaints and sanctions of NPs, including those with prescriptive authority, are relatively low. As mentioned previously, this indirectly suggests that there is likely to be patient satisfaction with NP services.

### **A More Definitive Assessment Would Require Additional Data**

As stated previously, the Board of Nursing (BON) collects some information about NPs. However, additional information regarding the practice locations of NPs and the changes to the written practice agreements between

physicians and NPs would have been beneficial for the purposes of this study. For example, data on where NPs practice would have allowed an examination of the extent to which NPs serve medically underserved areas. Additional data collected by the BON or another source would be necessary to comprehensively review the impact expanded prescriptive authority has had on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.





## **IV. Policy Options**

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to impacts associated with nurse practitioner prescriptive authority.

- Option I:**                    **Take no Action.**
- Option II:**                    **Require the Board of Nursing to collect additional data pertaining to nurse practitioners and the prescriptive authority of nurse practitioners. This data should be reported to the Joint Commission on an annual basis beginning in 2005.**
- Option III:**                    **Introduce a joint resolution directing the Board of Nursing and the Board of Medicine or other designated agencies to conduct an in-depth study on the impact that increased nurse practitioner prescriptive authority to prescribe Schedules III through VI controlled substances and devices has had on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.**
- Option IV:**                    **Introduce legislation to recommend that nurse practitioners be granted mandated provider status as related to accident and sickness insurance companies.**



**Appendix A:**

**House Bill 818 (2000 General Assembly Session)**



# VIRGINIA ACTS OF ASSEMBLY -- 2000 SESSION

## CHAPTER 924

*An Act to amend and reenact §§ 9-6.14:4.1, 54.1-2957.01, 54.1-3301, and 54.1-3303 of the Code of Virginia, relating to prescriptive authority of nurse practitioners.*

[H 818]

Approved April 9, 2000

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 9-6.14:4.1, 54.1-2957.01, 54.1-3301, and 54.1-3303 of the Code of Virginia are amended and reenacted as follows:**

§ 9-6.14:4.1. Exemptions and exclusions.

A. Although required to comply with § 9-6.18 of the Virginia Register Act (§ 9-6.15 et seq.), the following agencies are exempted from the provisions of this chapter, except to the extent that they are specifically made subject to §§ 9-6.14:14.1, 9-6.14:21 and 9-6.14:22:

1. The General Assembly.
2. Courts, any agency of the Supreme Court, and any agency which by the Constitution is expressly granted any of the powers of a court of record.
3. The Department of Game and Inland Fisheries in promulgating regulations regarding the management of wildlife and for all case decisions rendered pursuant to any provisions of Chapters 2 (§ 29.1-200 et seq.), 3 (§ 29.1-300 et seq.), 4 (§ 29.1-400 et seq.), 5 (§ 29.1-500 et seq.), and 7 (§ 29.1-700 et seq.) of Title 29.1.
4. The Virginia Housing Development Authority.
5. Municipal corporations, counties, and all local, regional or multijurisdictional authorities created under this Code, including those with federal authorities.
6. Educational institutions operated by the Commonwealth, provided that, with respect to § 9-6.14:22, such educational institutions shall be exempt from the publication requirements only with respect to regulations which pertain to (i) their academic affairs; (ii) the selection, tenure, promotion and disciplining of faculty and employees; (iii) the selection of students; and (iv) rules of conduct and disciplining of students.
7. The Milk Commission in promulgating regulations regarding (i) producers' licenses and bases, (ii) classification and allocation of milk, computation of sales and shrinkage, and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.
8. The Virginia Resources Authority.
9. Agencies expressly exempted by any other provision of this Code.
10. The Virginia Voluntary Formulary Board in formulating recommendations regarding amendments to the Formulary pursuant to § 32.1-81.
11. [Repealed.]
12. The Department of General Services in promulgating standards for the inspection of buildings for asbestos pursuant to § 2.1-526.14.
- 13., 14. [Repealed.]
15. The State Council of Higher Education for Virginia, in developing, issuing, and revising guidelines pursuant to § 23-9.6:2.
16. The Commissioner of Agriculture and Consumer Services in adopting regulations pursuant to subsection B of § 3.1-726.
17. The Commissioner of Agriculture and Consumer Services and the Board of Agriculture and Consumer Services in promulgating regulations pursuant to subsections B and C of § 3.1-106.4, subsection B of § 3.1-126.12:1, § 3.1-271.1, § 3.1-398, subsections B and C of § 3.1-828.4, and subsection A of § 3.1-884.21:1.
18. The Board of Optometry when specifying therapeutic pharmaceutical agents, treatment guidelines, and diseases and abnormal conditions of the human eye and its adnexa for TPA-certification of optometrists pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of Title 54.1.
19. The Board of Medicine, in consultation with the Board of Pharmacy, when promulgating

amendments to the Physician Assistant Formulary established pursuant to § 54.1-2952.1.

~~20. The Boards of Medicine and Nursing in promulgating amendments to the Nurse Practitioner Formulary established pursuant to § 54.1-2957.01.~~

~~21. 20. The Virginia War Memorial Foundation.~~

~~22. 21. The Virginia Medicaid Prior Authorization Advisory Committee in making recommendations to the Board of Medical Assistance Services regarding prior authorization for prescription drug coverage pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.~~

~~23. 22. The State Board of Education, in developing, issuing, and revising guidelines pursuant to § 22.1-280.3.~~

~~24. 23. The Virginia Racing Commission, when acting by and through its duly appointed stewards or in matters related to any specific race meeting.~~

~~25. 24. The Virginia Small Business Financing Authority.~~

~~26. 25. The Virginia Economic Development Partnership Authority.~~

~~27. 26. The Board of Agriculture and Consumer Services in adopting, amending or repealing regulations pursuant to subsection A (ii) of § 59.1-156.~~

~~28. 27. The Insurance Continuing Education Board pursuant to § 38.2-1867.~~

~~29. 28. The Board of Health in promulgating the list of diseases that shall be reported to the Department of Health pursuant to § 32.1-35.~~

B. Agency action relating to the following subjects is exempted from the provisions of this chapter:

1. Money or damage claims against the Commonwealth or agencies thereof.
2. The award or denial of state contracts, as well as decisions regarding compliance therewith.
3. The location, design, specifications or construction of public buildings or other facilities.
4. Grants of state or federal funds or property.
5. The chartering of corporations.
6. Customary military, naval or police functions.
7. The selection, tenure, dismissal, direction or control of any officer or employee of an agency of the Commonwealth.
8. The conduct of elections or eligibility to vote.
9. Inmates of prisons or other such facilities or parolees therefrom.
10. The custody of persons in, or sought to be placed in, mental, penal or other state institutions as well as the treatment, supervision, or discharge of such persons.
11. Traffic signs, markers or control devices.
12. Instructions for application or renewal of a license, certificate, or registration required by law.
13. Content of, or rules for the conduct of, any examination required by law.
14. The administration of a pool or pools authorized by Article 7.1 (§ 2.1-234.9:1 et seq.) of Chapter 14 of Title 2.1.
15. Any rules for the conduct of specific lottery games, so long as such rules are not inconsistent with duly adopted regulations of the State Lottery Board, and provided that such regulations are published and posted.
16. Orders condemning or closing any shellfish, finfish, or crustacea growing area and the shellfish, finfish or crustacea located thereon pursuant to Article 2 (§ 28.2-803 et seq.) of Chapter 8 of Title 28.2.
17. Any operating procedures for review of child deaths developed by the State Child Fatality Review Team pursuant to § 32.1-283.1.
18. The regulations for the implementation of the Health Practitioners' Intervention Program and the activities of the Intervention Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.
19. The process of reviewing and ranking grant applications submitted to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 32.1-73.1 et seq.) of Chapter 2 of Title 32.1.
20. Loans from the Small Business Environmental Compliance Assistance Fund pursuant to Article 4 (§ 10.1-1197.1 et seq.) of Chapter 11.1 of Title 10.1.
21. The Virginia Breeders Fund created pursuant to § 59.1-372.

22. The types of pari-mutuel wagering pools available for live or simulcast horse racing.

23. The administration of medication or other substances foreign to the natural horse.

C. The following agency actions otherwise subject to this chapter and § 9-6.18 of the Virginia Register Act are excluded from the operation of Article 2 (§ 9-6.14:7.1 et seq.) of this chapter:

1. Agency orders or regulations fixing rates or prices.

2. Regulations which establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations which consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations which:

(a) Are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved;

(b) Are required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

(c) Are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing; notice of the proposed adoption of these regulations and the Registrar's above determination shall be published in the Virginia Register not less than thirty days prior to the effective date thereof.

5. Regulations which an agency finds are necessitated by an emergency situation. For the purposes of this subdivision, "emergency situation" means (i) a situation involving an imminent threat to public health or safety or (ii) a situation in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation shall be effective in 280 days or less from enactment of the law or the appropriation act or the effective date of the federal regulation, and the regulation is not exempt under the provisions of subdivision C 4 of this section. In such cases, the agency shall state in writing the nature of the emergency and of the necessity for such action and may adopt such regulations. Pursuant to § 9-6.14:9, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. Such regulations shall be limited to no more than twelve months in duration. During the twelve-month period, an agency may issue additional emergency regulations as needed addressing the subject matter of the initial emergency regulation, but any such additional emergency regulations shall not be effective beyond the twelve-month period from the effective date of the initial emergency regulation. If the agency wishes to continue regulating the subject matter governed by the emergency regulation beyond the twelve-month limitation, a regulation to replace the emergency regulation shall be promulgated in accordance with Article 2 (§ 9-6.14:7.1 et seq.) of this chapter. The Notice of Intended Regulatory Action to promulgate a replacement regulation shall be filed with the Registrar within sixty days of the effective date of the emergency regulation and published as soon as practicable, and the proposed replacement regulation shall be filed with the Registrar within 180 days after the effective date of the emergency regulation and published as soon as practicable.

6. [Repealed.]

7. Preliminary program permit fees of the Department of Environmental Quality assessed pursuant to subsection C of § 10.1-1322.2.

8. Regulations of the Pesticide Control Board adopted pursuant to subsection B of § 3.1-249.51 or clause (v) or (vi) of subsection C of § 3.1-249.53 after having been considered at two or more Board meetings and one public hearing.

9. Regulations of the regulatory boards served by (i) the Department of Labor and Industry pursuant to Title 40.1 and (ii) the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 which are limited to reducing fees charged to regulants and applicants.

10. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Mines, Minerals and Energy authorized pursuant to §§ 45.1-161.82 and 45.1-161.292:55.

11. General permits issued by the State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 if the Board: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

12. General permits issued by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1 if the Board: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

13. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

14. Regulations of the Board of the Virginia Higher Education Tuition Trust Fund promulgated pursuant to § 23-38.77.

15. The development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307 if the Commission: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

Whenever regulations are adopted under this subsection, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this subsection shall be in accordance with the provisions of § 9-6.14:9.3, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 9-6.14:9.

D. The following agency actions otherwise subject to this chapter are excluded from the operation of Article 3 (§ 9-6.14:11 et seq.) of this chapter:

1. The assessment of taxes or penalties and other rulings in individual cases in connection with the administration of the tax laws.

2. The award or denial of claims for workers' compensation.

3. The grant or denial of public assistance.

4. Temporary injunctive or summary orders authorized by law.

5. The determination of claims for unemployment compensation or special unemployment.

6. The suspension of any license, certificate, registration or authority granted any person by the Department of Health Professions or the Department of Professional and Occupational Regulation for the dishonor, by a bank or financial institution named, of any check, money draft or similar instrument used in payment of a fee required by statute or regulation.

E. Appeals from decisions of the Governor's Employment and Training Department otherwise subject to this chapter are excluded from the operation of Article 4 (§ 9-6.14:15 et seq.) of this chapter.

F. The Marine Resources Commission, otherwise subject to this chapter and § 9-6.18 of the Virginia Register Act, is excluded from the operation of subdivision C 5 of this section and of Article 2 (§ 9-6.14:7.1 et seq.) of this chapter.

G. A regulation for which an exemption is claimed under this section and which is placed before a



board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

H. The Joint Legislative Audit and Review Commission shall conduct a review periodically of exemptions and exclusions authorized by this section. The purpose of this review shall be to assess whether there are any exemptions or exclusions which should be discontinued or modified.

I. Minor changes to regulations being published in the Virginia Administrative Code under the Virginia Register Act, Chapter 1.2 (§ 9-6.15 et seq.) of this title, made by the Virginia Code Commission pursuant to § 9-77.10:1 shall be exempt from the provisions of this chapter.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. *In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) of this title, a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe ~~Schedule VI~~ controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) of this title as follows: (i) Schedules V and VI controlled substances on and after July 1, 2000; (ii) Schedules IV through VI on and after January 1, 2002; and (iii) Schedules III through VI controlled substances on and after July 1, 2003. Nurse practitioners shall have such prescriptive authority upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician which provides for the direction and supervision by such physician of the prescriptive practices of the nurse practitioner. Such written agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the physician providing direction and supervision.*

B. It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written agreement between the licensed nurse practitioner and the licensed physician.

C. The Board of Nursing and the Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The Board of Medicine and the Board of Nursing shall be assisted in this process by an advisory committee composed of two representatives of the Board of Nursing and one nurse practitioner appointed by the Board of Nursing, and four physicians, three of whom shall be members of the Board of Medicine appointed by the Board of Medicine. The fourth physician member shall be jointly appointed by the Boards of Medicine and Nursing. Regulations promulgated pursuant to this section shall include, at a minimum, (i) ~~the formulary of the specific Schedule VI drugs and devices that nurse practitioners are eligible to prescribe pursuant to this section to the extent, and in the manner, authorized in a written protocol between the nurse practitioner and the supervising physician such requirements as may be necessary to ensure continued nurse practitioner competency which may include continuing education, testing, and/or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients,~~ and (ii) requirements for periodic site visits by physicians who supervise and direct nurse practitioners who provide services at a location other than where the physician regularly practices.

In order to maintain a current and appropriate list of specific Schedule VI drugs and devices, the Boards of Medicine and Nursing may, from time to time, amend the Formulary required by this subsection and, as provided in § 9-6.14:4.1, shall be exempted from the Administrative Process Act (§ 9-6.14:1 et seq.) when so doing. The Boards shall, however, jointly conduct public hearings prior to making such amendments to the Formulary. Thirty days prior to conducting such hearing, the Boards shall give written notice by mail of the date, time, and place of the hearings to all currently licensed nurse practitioners and any other persons requesting to be notified of the hearings and publish notice of its intention to amend the Formulary in the Virginia Register of Regulations. Interested parties shall be given reasonable opportunity to be heard and present information prior to

final adoption of any amendments. Proposed and final amendments of the list shall also be published, pursuant to § 9-6.14:22, in the Virginia Register of Regulations. Final amendments to the Formulary shall become effective upon filing with the Registrar of Regulations.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to his patients the name, address and telephone number of the supervising physician, and that he is a licensed nurse practitioner.

2. Physicians, other than physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than four nurse practitioners. In the case of nurse practitioners, other than certified nurse midwives, the supervising physician shall regularly practice in any location in which the nurse practitioner exercises prescriptive authority pursuant to this section. A separate office for the nurse practitioner shall not be established. In the case of certified nurse midwives, the supervising physician either shall regularly practice in the location in which the certified nurse midwife practices, or in the event that the certified nurse midwife has established a separate office, the supervising physician shall be required to make periodic site visits as required by regulations promulgated pursuant to this section.

3. Physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than four nurse practitioners who provide services on behalf of such entities. Such physicians either shall regularly practice in such settings or shall make periodic site visits to such settings as required by regulations promulgated pursuant to this section.

F. This section shall not prohibit a licensed nurse practitioner from administering ~~Schedule VI~~ controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of ~~Schedule VI~~ controlled substances in compliance with the provisions of this section.

§ 54.1-3301. Exceptions.

This chapter shall not be construed to:

1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, in the compounding of his prescriptions or the purchase and possession of drugs as he may require;

2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, from administering or supplying to his patients the medicines that he deems proper under the conditions of § 54.1-3303;

3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34 (§ 54.1-3400 et seq.) of this title;

4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34 (§ 54.1-3400 et seq.) of this title;

5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the regulations of the Board;

6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from purchasing, possessing or administering controlled substances to his own patients or providing controlled substances to his own patients in a bona fide medical emergency or providing manufacturers' professional samples to his own patients;

7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic pharmaceutical agents, from purchasing, possessing or administering those controlled substances as specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own patients those controlled substances as specified in § 54.1-3222 and the TPA formulary or providing manufacturers' samples of these drugs to his own patients; or

8. Interfere with any ~~licensed nurse practitioner or~~ physician assistant with prescriptive authority

receiving and dispensing to his own patients manufacturers' professional samples of those Schedule VI controlled substances and devices which he is authorized to prescribe.

*9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe according to his practice setting and a written agreement with a physician.*

This section shall not be construed as exempting any person from the licensure, registration, permitting and record keeping requirements of this chapter or Chapter 34 of this title.

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

B. No prescription shall be filled which does not result from a bona fide practitioner-patient-pharmacist relationship. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription.

In order to determine whether a prescription which appears questionable to the pharmacist results from a bona fide practitioner-patient-pharmacist relationship, the pharmacist shall contact the prescribing practitioner or his agent and verify the identity of the patient and name and quantity of the drug prescribed. The person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

C. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine authorized to issue such prescription if the prescription complies with the requirements of this chapter and Chapter 34 (§ 54.1-3400 et seq.) of this title, known as the "Drug Control Act," except that out-of-state prescriptions are not required to comply with the provisions of subsection A of § 32.1-87 and subsection C of § 54.1-3408 which establish a prescription blank format accommodating the Virginia Voluntary Formulary.

D. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § 54.1-2957.01 may issue prescriptions or provide manufacturers' professional samples for ~~Schedule VI~~ controlled substances and devices as set forth in Chapter 34 of this title in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

E. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to § 54.1-2952.1 may issue prescriptions or provide manufacturers' professional samples for Schedule VI controlled substances and devices as set forth in Chapter 34 of this title in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

F. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title may issue prescriptions in good faith or provide manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § 54.1-3223, which shall be limited to oral analgesics included in Schedules III and VI, as defined in §§ 54.1-3450 and 54.1-3455 of the Drug Control Act (§ 54.1-3400 et seq.),

when appropriate to relieve ocular pain, and topically applied Schedule VI drugs, as defined in § 54.1-3455 of the Drug Control Act.

**2. That the Joint Commission on Health Care shall, with the full cooperation of the Medical Society of Virginia, the Old Dominion Medical Society, the Board of Medicine, the Board of Nursing, and nurse practitioner associations, study nurse practitioner prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules III through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment. A preliminary report on this study shall be provided by the Joint Commission to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by July 1, 2003. The Joint Commission shall complete its work in time to submit its written findings and recommendations to the Governor and 2004 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.**

**Appendix B:**

**Description of the Board of Nursing Complaint Categories**



**Case Categories** are description of the nature of the allegation committed by the respondent:

1. **Abandonment- *inappropriate termination of provider/patient relationship/responsibility, discontinuance without sufficient notice***
2. **Abuse- *mistreatment of a patient***
  - Inappropriate/unwanted physical contact- *touching without clinical reason or patient/parental consent*
  - Physical abuse with injury- *mistreatment of patient resulting in harm*
  - Physical abuse without injury- *mistreatment of patient with no apparent harm*
  - Psychological abuse
  - Sexual abuse- *rape, molestation, or other such act committed in the course of a professional relationship*
  - Verbal abuse/indecent/profanity- *i.e., use of foul or offensive language, threats, insults, degrading comments, cursing*
  - Other
3. **Action by another board**
  - Revocation or suspension by another state or jurisdiction
  - Disciplinary action by another state or jurisdiction- *other than revocation or suspension*
  - Other
4. **Advertising- *information disseminated or placed before the public that is deceptive or misleading***
  - Claim of superiority
  - Deceptive or misleading ad
  - Failure to disclose full fee when advertising discount
  - Failure to include disclaimer
  - Failure to post required sign
  - Improper use of a trade/firm/fictitious name
  - Inappropriate use of specialty or board certification
  - Omission of required wording/ad elements not identified above
  - Other
5. **Business practices/issues- *i.e., practice in a mercantile establishment, failure to properly register name***
6. **Compliance**
  - Probation violation
  - Violation of a term of a board order other than probation
  - Other
7. **Confidentiality- *disclosing unauthorized client information without permission or necessity***
8. **Continued Competency Requirements-*continuing education requirement not met***

Failure to obtain required CEUs  
Failure to document requirements  
Failure to meet practice requirement  
Other

**9. Criminal Activity-Felony- *commission of a felony crime or court declared guilty o***

**10. Criminal Activity-Misdemeanor- *commission of a misdemeanor crime or court declared guilty of criminal offense, act or omission contrary to established laws***

Conviction of a misdemeanor crime other than moral turpitude  
Crime involving moral turpitude- *Involving deception, trickery, forgery, lying, cheating, stealing*  
Misdemeanor charges pending-*arrested, charged, indicted but not yet convicted and/or sentenced*  
Other

**11. Default on guaranteed student loan- *neglect to pay education debt or perform required service***

**12. Disclosure-*Failure to provide required information or terms***

Fee  
Contract or term of contract  
General price list  
Itemized statement of services rendered  
Treatment plan or estimate

**13. Drug related -*Dispensing in violation of Drug Control Act***

Dispensing without bonafide relationship  
Dispensing/prescribing for other than medicinal/therapeutic purposes  
Excessive dispensing/prescribing  
Filling or refilling not in accordance with dosage instructions  
Knowingly filling an invalid prescription  
Other

**14. Drug related -*Failure to maintain security of controlled substances***

**15. Drug related -*Personal use***

**16. Drug related-*Obtaining/attempting to obtain by fraud***

Drug Adulteration- *the addition or substitution of an impure or weaker substance in a formulated product or container*  
Drug distribution or sale  
Falsification of records- *obtaining or attempting to obtain controlled substance by falsifying patient records, facility documents*  
Patient deprivation  
Prescription Forgery- *forging a prescription to obtain or attempt to obtain a controlled substance (either in writing or by phone)*



Stealing controlled substance  
Other.

**17. Drug related –Other**

**18. Fraud- intentional false portrayal of facts, either by words or conduct**

Falsification of licensing documents- *knowingly giving untrue information on application or renewal*  
Falsification of renewal documents- *knowingly giving untrue information on a renewal application*  
Falsification/alteration of records- *untrue, changed or removed documentation*  
Fee splitting/kickbacks- *portion of \$ received given as consideration for special treatment*  
Mishandling of pre-need funds- *failure to keep adequate records, misappropriation of funds*  
Patient billing issues- *i.e., failure to refund, charge for service not provided or completed, upcoding, generic vs. brand*  
Performance of unwarranted/unjustified services- *requiring/providing unnecessary and/or unwanted services*  
Other

**19. Inability to safely practice-Impairment**

Impairment due to use of alcohol  
Impairment due to use of illegal substances or drugs  
Impairment due to use of prescription drugs  
Other

**20. Inability to safely practice-Incapacitated**

Adjudicated incapacitated  
Incapacitated due to mental condition/illness  
Incapacitated due to physical condition/illness  
Other

**21. Inability to safely practice-Other**

**22. Licensure eligibility- Application for initial licensure contains cause for denial and requires approval/denial by Board**

**23. Misappropriation of property- stealing or use of property without authorization**

**24. Neglect- failure to do what a reasonable, prudent person would do in a similar situation**

Neglect with injury  
Neglect without injury  
Other

**25. Other-allegation is not defined by any other case category**

**26. Prescription blanks-** *blanks do not meet code format requirement 54.1-3408*

**27. Program or Facility Eligibility-** *Program or facility do not meet statutes or  
28. regulations required for approval by the Board*

**29. Records/Inspections/Audits-** *violations of 54.1 -2803, 3404, 3405, 3804, 3005,  
3013, 3014*

Inspection related deficiencies or facility violations  
Failure to maintain complete and accurate records  
Education program deficiencies  
Other

**30. Records release-** *failure to release or respond to records release request pursuant  
to Code 32.1- 127.1:03*

**31.Reinstatement**

**32.Required Report not filed**

**33. Relationship-** *i.e., boundary issues, dual, sexual or other inappropriate relationship*

**34. Self-referral of patients-** *sending or directing a patient to self or family owned  
entity, prompting patient to use self owned service*

**35.Solicitation-** *to entice or persuade with intent to influence the choice of service*

**36.Standard of Care –Consent**

Failure to inform patient of risks/benefits/alternatives to treatment or surgery  
Failure to obtain consent-*failure to obtain permission to perform treatment or surgery*  
Other

**37.Standard of Care-Diagnosis**

Delay in diagnosis-*failure to diagnose in a timely manner*  
Failure to diagnose- *failure to diagnose the disease or the condition*  
Wrong diagnosis- *incorrect determination of patient condition*  
Other

**38.Standard of Care -Equipment/Product**

Failure to inspect/monitor/maintain equipment properly  
Improper patient instruction on use of equipment/product  
Improper use of equipment- *intentional use of faulty equipment or use for other than  
approved uses*  
Other

**39.Standard of Care -IV and blood products**

Failure to monitor/administer properly

Wrong solution/type  
Other

#### **40. Standard of Care -Malpractice reports**

Judgment  
Settlement  
Other

#### **41. Standard of Care -Medication/Prescription**

Administration error- *"5 rights" not observed*  
Dispensing error- *pharmacist makes an error in filling a prescription*  
Failure to offer/provide counseling  
Improper management of medication regimen  
Labeling error- *right medication, wrong label*  
Prescribing error- *practitioner makes an error in prescribing*  
Writing a prescription without a bonafide relationship- *writing a prescription without a medical record which contains a history and physical, diagnostic tests when indicated, a working diagnosis and treatment plan, and documentation of medications prescribed*  
Other

#### **42. Standard of Care -Surgery**

Anesthesia management- *administration of improper anesthesia*  
Improper management of surgical patient  
Improper performance of surgery/surgical error- *i.e., retained foreign object*  
Unnecessary surgery- *surgery performed was not warranted for the patient condition*  
Other

#### **43. Standard of Care -Treatment**

- *Alternative treatment- treatment for which there is no accepted therapeutic purpose and/or scientific support*  
Delay in treatment- *failure to initiate treatment in a timely manner*  
Dissatisfaction with treatment  
Failure to monitor patient's condition  
Failure to offer or provide patient education/counseling  
Failure to refer/obtain consult  
Failure to report change in patient's condition- *did not report to the appropriate health care practitioner significant change in the patient's condition*  
Failure to respond to a patient's request or needs  
Failure to treat- *did not treat a known condition*  
Improper performance of a treatment/procedure- *correct treatment done incorrectly*  
Improper/inadequate infection control practices- *practices not within the acceptable standards*  
Incorrect treatment- *treatment provided was inappropriate for diagnosis*  
Rough handling/treatment- *excessive physical force*  
Rudeness  
Unnecessary treatment- *treatment provided was not warranted for condition*  
Unsanitary/inappropriate conditions or practices  
Other

#### **44. Standard of Care -Other**

**45. Supervision- neglect and/or oversight in supervisory role**

**46. Unlicensed activity- practicing a profession or occupation without holding a valid license as required by statute or regulation**

**Aiding and/or abetting unlicensed activity- assisting or allowing non-licensed person to perform functions, which require a licensed certificate or registration**

**DEA registration revoked, expired or invalid**

**Does not hold a current valid license, not qualified**

**Facility operating without a permit**

**Practice beyond the scope of license- performing service not allowed under license held**

**Practice on a revoked or suspended license- practice with invalid license**

**Practice on lapsed/expired license- invalid license**

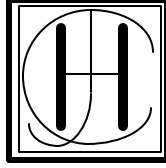
**Qualified to practice but does not have a valid VA license (e.g. licensed in another state but not licensed in Virginia)**

**Other**

**Appendix C:**

**Summary of Public Comments**





## JOINT COMMISSION ON HEALTH CARE

### SUMMARY OF PUBLIC COMMENTS Nurse Practitioner Prescriptive Authority

#### COMMENTS RECEIVED ON OPTIONS ADDRESSING NURSE PRACTITIONER PRESCRIPTIVE AUTHORITY

Two comments were received in response to the JCHC report addressing nurse practitioner prescriptive authority. Comments were submitted by the following:

- Virginia Association of Health Plans
- Virginia Council of Nurse Practitioners

#### POLICY OPTIONS PRESENTED FOR CONSIDERATION

- Option I:** Take no action.
- Option II:** Require the Board of Nursing to collect additional data pertaining to nurse practitioners and the prescriptive authority of nurse practitioners. This data should be reported to the Joint Commission on an annual basis beginning in 2005.
- Option III:** Introduce a joint resolution directing the Board of Nursing and the Board of Medicine or other designated agencies to conduct an in-depth study on the impact that increased nurse practitioner prescriptive authority to prescribe Schedules III through VI controlled substances and devices has had on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.

**Option IV:** Introduce legislation to recommend that nurse practitioners be granted mandated provider status as related to accident and sickness insurance companies.

**SUMMARY OF COMMENTS**

As shown in the summary Table below, one of two comments directly **supported Option I**. It should also be noted that one comment was received in **opposition to Option III** and one comment was received in opposition to **Option IV**.

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<b>SUMMARY OF COMMENTS RECEIVED ON OPTIONS</b>		
<b><u>Policy Option</u></b>	<b>Number of Comments in Support</b>	<b>Number of Comments in Opposition</b>
<b>I</b> – Take no action.	<b>1</b>	<b>0</b>
<b>II</b> – Require the Board of Nursing to collect additional data...	<b>0</b>	<b>0</b>
<b>III</b> – Introduce a joint resolution directing the Board of Nursing and the Board of Medicine, or other designated agencies to conduct an in-depth study.	<b>0</b>	<b>1</b>
<b>IV</b> – Introduce legislation to recommend that nurse practitioners be granted mandated provider status...	<b>0</b>	<b>1</b>

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**Summary of Individual Comments**

**Virginia Council of Nurse Practitioners**

Elaine Ferrary, the President of the Virginia Council of Nurse Practitioners, commented in support of Option I and in opposition to Option III.



Ms. Ferrary stated the following in support of Option I, “VCNP supports this action. There is no evidence that increased prescriptive authority has threatened patient safety or patient satisfaction. There is no need to make any immediate changes to the prescriptive authority law.”

Ms. Ferrary summarized the Council’s opposition to Option III by saying, “If there were any indications that problems exist in any of these areas, this kind of intensive study and its related costs might be warranted. Since no indications exist, VCNP opposes this option.”

The Council also provided comments on Options II and IV. With regard to Option II Ms. Ferrary stated, “The Board of Nursing is considering ways to increase the information collected on all nurses, including nurse practitioners, as a way of increasing nursing workforce data. This may become more feasible with electronic license renewal that the Board also is exploring since it could be accomplished with minimal additional cost. VCNP would suggest allowing the Board’s process to continue before placing additional requirements on them legislatively.” With regard to Option IV, the granting of mandated provider status, Ms. Ferrary indicated that Option IV “...may be one that should be put on hold for some period of time.”

### **Virginia Association of Health Plans**

Joy M. Lombard, Director of Policy for the Virginia Association of Health Plans, commented in opposition to Option IV. Ms. Lombard summarized the Association’s opposition to Option IV by stating the following, “Nurse practitioners provide valuable services, which are currently reimbursed by managed care companies. In the absence of evidence of a problem accessing prescriptions, we respectfully recommend that you oppose Policy Option IV.”



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# **JOINT COMMISSION ON HEALTH CARE**

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**Executive Director**

Kim Snead

**Senior Health Policy Analyst**

April R. Kees

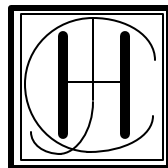
**Intern**

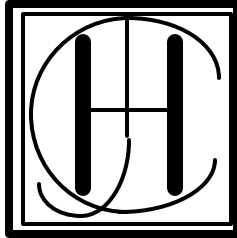
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