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FINAL REPORT OF THE SENATE STUDY COMMITTEE ON EVALUATING AND SIMPLIFYING PHYSICIAN OVERSIGHT OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES (SR 202)

Committee Members

Senator Chuck Hufstetler
Chair
District 52

Senator Gloria Butler
District 55

Senator Kay Kirkpatrick
District 32

Senator Renee Unterman
District 45

Senator Ben Watson
District 1

Prepared by the Senate Research Office, 2019

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STUDY COMMITTEE CREATION, FOCUS, AND DUTIES

The Senate Study Committee on Evaluating and Simplifying Physician Oversight of Physician Assistants and Advance Practice Registered Nurses (the “Study Committee”) was created with the adoption of Senate Resolution 202 during the 2019 Legislative Session of the Georgia General Assembly.¹ The Study Committee was charged with evaluating current state laws relating to physician oversight of physician assistants and advanced practice registered nurses to determine how such physician oversight could be simplified and streamlined. In addition to current practices in Georgia, the Study Committee reviewed regulatory frameworks in other states.

The Study Committee and its authorizing resolution recognize that state laws governing physician oversight of physician assistants (“PAs”) and advanced practice registered nurses (“APRNs”) are complex and difficult to navigate in the practice environment. Oversight of these two vital health care professions is governed by multiple state licensure boards, and revisions to state law and regulation can be challenging to implement. During testimony, the Study Committee heard from medical professionals, researchers, and academia concerning the current practice and workforce environment for PAs and APRNs.

Additionally, health care quality and access is a national issue along with the increasing costs of services. The current federal administration has made health care reform a top priority and a recent review conducted by the U.S. departments of Health & Human Services, Treasury, and Labor showcased state regulatory practices as one potential source for lasting reforms.² In some cases, PAs and APRNs can “effectively provide some of the same healthcare services as physicians, in addition to providing complementary services.”³ Scope of practice statutes and rules are cited as barriers to the marketplace and competition, but necessary to ensure quality of care. A review of current practices, as envisioned by the Study Committee’s authorizing resolution, can help discover potential reforms.

Senator Chuck Hufstetler of the 52nd served as Chair of the Study Committee. The other legislative members were Senator Gloria Butler of the 55th, Senator Kay Kirkpatrick of the 32nd, Senator Renee Unterman of the 45th, and Senator Ben Watson of the 1st. The Georgia House of Representatives hosted a study committee to review the same regulatory systems, chaired by Representative Mark Newton. By agreement between Chairman Hufstetler and Chairman Newton, both study committees met together to hear testimony as a convenience to the members and to the public.

The following legislative staff members were assigned to the Study Committee: James Beal, Senate Research Office; Elisabeth Fletcher, Senate Press Office; Betsy Howerton, Legislative Counsel; and Diego Santana, Senator Hufstetler’s office.

¹ See SR 202. Available at: <http://www.legis.ga.gov/Legislation/en-US/display/20192020/SR/202>.

² U.S. DEP’T OF HEALTH & HUMAN SERVICES, REFORMING AMERICA’S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 32-33 (December 3, 2019). Conducted pursuant to E.O. 13813 (October 12, 2017). Available here: <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>.

³ *Id.*

BACKGROUND

Georgia is home to more than 5,200 licensed PAs and 15,400 advance practice registered nurses APRNs, 12,400 of those APRNs being nurse practitioners.⁴ Both professions practice under supervision by a licensed physician, with ongoing regulation and oversight governed by the Georgia Composite Medical Board (for PAs and nominally for prescribing APRNs) and the Board of Nursing (for APRNs).

To practice as a PA, a written job description agreed to between a supervising physician and PA detailing the scope of the PA's practice is required in Georgia. Where prescriptive authority is delegated, state law allows PAs to prescribe controlled substances, but limits this to only controlled substances scheduled III, IV, and V. This regulation falls into the minority of states as 44 states plus the District of Colombia allow PAs to prescribe Schedule II controlled substances. Schedule II controlled substances includes hydrocodones. As to supervisory ratios, a physician may enter into agreements with no more than four PAs and supervise no more than two at any one time, except in a group practice where up to four PAs may be supervised at any one time. PAs in Georgia are licensed by the Georgia Composite Medical Board ("GCMB").

APRNs practice according to a written protocol agreement between a physician and the APRN. State law allows APRNs to prescribe controlled substances pursuant to the written protocol, but limits prescribing authority to schedules III, IV, and V. This regulation falls into the minority of states as 45 states allow APRNs to prescribe Schedule II controlled substances. As to supervisory ratios, a physician may enter into agreements with no more than eight APRNs and supervise no more than four at any one time. There are five types of APRNs recognized:

1. Nurse-midwives;
2. Certified registered nurse anesthetists ("CRNAs");
3. Clinical nurse specialists in psychiatric/mental health;
4. Clinical nurse specialists; and
5. Nurse practitioners.

APRNs are licensed by the Board of Nursing. GCMB approves protocols which delegate prescriptive authority to an APRN for the limited purpose of determining whether the protocol meets acceptable standards.

In 2019, there were three bills introduced regarding PA and APRN practice: Senate Bill 168 concerning APRNs in EMS systems⁵ which was signed into law, and House Bill 409⁶ and Senate Bill 109⁷ both of which propose to remove restrictions on APRNs ordering radiographic imaging tests. Neither bill concerning radiographic imaging tests passed their respective chambers and remain pending for consideration in the upcoming 2020 legislative session.

⁴ See Appendix I, *Senate PA/APRN Presentation*, Senate Research Office.

⁵ See Senate Bill 168 (2019). Available at: <http://www.legis.ga.gov/Legislation/20192020/186854.pdf>.

⁶ See House Bill 409 (2019). Available at: <http://www.legis.ga.gov/Legislation/20192020/182265.pdf>.

⁷ See Senate Bill 109 (2019). Available at: <http://www.legis.ga.gov/Legislation/20192020/183209.pdf>.

SUMMARY OF TESTIMONY AND DISCUSSION

Meeting One – August 28, 2019

The Study Committee's first meeting was held at the State Capitol. The purpose of this first meeting was for the members to understand the basics of current practices in Georgia and the objectives of each profession. In order to accomplish this, the Chairman requested Mr. James Beal with the Senate Research Office to present background information on the scope of current PA and APRN practice which is memorialized in this report's Background section. Furthermore, the Chairman called on the following individuals to provide testimony:

- **Dr. Rutledge Forney**, Medical Association of Georgia ("MAG");
- **Dr. Carmen Kavali**, MAG;
- **Mr. Tom Bauer**, Georgia Association of Physician Assistants ("GAPA");
- **Dr. Michelle Nelson**, Coalition of Advance Practice Registered Nurses ("CAPRN"); and
- **Ms. Christy Dunkleberger**, Georgia Association of Nurse Anesthetists.

a. Physicians' Education, Training, and Positions

Doctors Forney and Kavali explained MAG's various positions on PA and APRN practice. Given the supervisory role that physicians play, physicians are responsible for the medical acts performed by an APRN or PA within the scope of delegated acts. MAG advocates for the continued practice of APRNs and PAs under physician supervision and opposes allowing either to practice independently. MAG also opposes allowing APRNs and PAs to prescribe Schedule II controlled substances.

Additionally, MAG opposes the unrestricted ordering of radiographic imaging tests by APRNs. Current law allows APRNs to order radiographic imaging tests only in emergency situations.⁸ Dr. Forney testified that allowing APRNs to order such tests will lead to its misuse, and the cost to perform and interpret the tests will increase. Georgia is the only state that statutorily restricts APRNs from ordering such tests.

Dr. Kavali testified to contemporary models for the delivery of care, namely team-based care which provides integration amongst providers' services and specialties. Her testimony explained the heightened training of physicians: approximately 6,000 hours of clinicals coming out of medical school, 15,000 hours by the time physicians may independently practice after residency, and 20,000 hours to specialize. Physicians also pass at least three board exams in the first ten years of practice with continued learning and reexamination required thereafter. Dr. Kavali touched on the training an APRN nurse practitioner receives, in many cases 500 hours of training either hands-on with patients or shadowing. In some cases, there are online schools for nursing.

b. PA Practice and Positions

GAPA presented testimony and data on PA practice, and advocated for changes to state law governing the profession's scope.⁹ According to Department of Labor statistics included in the presentation, the demand for PAs increased 300 percent between 2011 and 2014, with an expected employment increase of 30 percent by 2024. In addition to the overview of current law provided by Senate Research, GAPA pointed out that physicians delegating prescriptive authority to PAs are required by law to conduct chart reviews. State law requires these reviews within 30 days of

⁸ O.C.G.A. § 43-34-25.

⁹ See Appendix II, *GAPA Presentation*, Georgia Association of Physician Assistants.

the prescription being issued, and the review must be conducted on at least 50 percent of a sampling of the charts.

The American Association of Physician Assistants described six elements for modern PA practice:

1. Full prescriptive authority;
2. Adaptable collaboration requirements;
3. "Licensure" as the regulatory term;
4. Supervision ratio determined at the practice level;
5. Scope of practice determined at the practice level; and
6. Cosignature requirements determined at the practice level.

Georgia law on PA practice incorporates "licensure" terminology and adaptable collaboration requirements. Overall, GAPA's presentation requests the Study Committee review the law governing the following areas of the Physician Assistant Act¹⁰:

1. Chart review;
2. Supervision ratios;
3. Oversight of a PA's job description;
4. Prescriptive authority, specifically elimination of the prohibition on Schedule II;
5. Limiting language governing where a PA may physically practice in relation to the supervising physician;
6. Outdated language such as a PA being "licensed to" a physician and provisions which predate a recognized PA profession such as those governing death certificates and handicap certification;
7. Removing the required PA notification to a patient that the patient may see the physician prior to the PA writing a prescription;
8. Provisions governing reimbursement from public programs; and
9. Amending state law so as to designate PAs as primary health care providers.

In regards to the language governing handicap certification, GAPA relayed a story that in Thomas County a local official refuses to issue handicap parking decals when a PA is the one certifying an individual's handicap.

In response to discussion by House members concerning the ongoing opioid crisis and allowing more providers to prescribe Schedule II controlled substances prescriptions, it was noted that West Virginia has the highest rate of opioid abuse in the country. West Virginia is one of the few states, along with Georgia, to restrict PAs and APRNs prescribing Schedule II. While data may show there's a problem, allowing PAs and APRNs to prescribe may not be the cause of the problem. It was pointed out that prescribing PAs must be registered with Georgia's Prescription Drug Monitoring Program.

In regards to civil liability and malpractice, PAs may practice under their own medical malpractice coverage, under coverage provided by the physician, or some other source depending on the employer. Hospitals may also carry their own malpractice insurance and cover employees.

c. APRN Practice and Positions

CAPRN testified as to legislative changes her group feels as necessary to provide increased access to care. The Study Committee heard that there are two areas where APRN practice can be streamlined:

¹⁰ O.C.G.A. § 43-34-100 *et seq.*

1. Retiring the current protocol agreements under which APRNs practice; and
2. Maintaining and further consolidating the oversight provided by the Board of Nursing.

As to the protocol agreements, CAPRN encourages policymakers to consider efficiency and business costs. In large group practices, APRNs often have to seek protocol agreements with multiple physicians, creating delays in care and wasting resources which APRNs feel is unnecessary in light of their heightened education and training. From a legal liability perspective, APRNs are liable separately for their medical acts. CAPRN advocates maintaining regulatory oversight and licensing under one entity. Currently, the Board of Nursing licenses registered nurses and, upon showing of enhanced education and holding proper certification, licenses APRNs.

The Study Committee heard further testimony on the prospect of APRNs practicing independently. CAPRN takes the position that if APRNs were to open their own business to provide independent care, there would be a referral process to physicians when appropriate. Part of APRN training is to refer patients properly as patient care and successful outcomes is the driving factor of their practice.

According to the National Governor's Association ("NGA"), surveys show that while patients prefer physicians for medical aspects of care, there were equal and in some cases higher rates of patient satisfaction for nurse practitioners when compared to physicians.¹¹ In terms of prescribing outcomes, data shows that in tracking second opinions on prescriptions for children, there was "no difference between the number of adjustments made to the prescriptions written by physicians and those written by [nurse practitioners]."¹² The NGA analysis concluded that most studies show comparable care to that provided by physicians and increased access.¹³

d. CRNAs Perspective

Georgia Association of Nurse Anesthetists indicated their presence at the meeting was to point out they are not PAs or APRNs, and they are content with the regulatory scheme governing their practice.

Meeting Two – September 17, 2019

The second meeting of the Study Committee was held in Augusta, Georgia at the Children's Hospital of Georgia. This meeting focused on the education and certification for APRNs, specifically the nurse practitioner subset, and PAs. To accomplish this review, the Chairman asked the following to testify:

- **Dr. Lucy Marion**, Dean of the College of Nursing at Augusta University ("AU");
- **Dr. DeWayne Hooks**, Executive Associate Dean of the AU College of Nursing;
- **Dr. Judith Stallings**, Department Chair of the AU College of Allied Health;
- **Dr. Doug Miller**, Vice Dean of the Medical College of Georgia at AU; and

Dean Marion's presentation showcased the education programs at AU as preparing APRNs for practice as well as their board certifications and licensing. AU is the flagship university for nursing education in Georgia, and serves as a model program. AU offers bachelors, masters, and doctorate degrees in nursing, and the masters program is ranked fourth in the nation. Dean Marion highlighted the growing demand and need for midlevel providers, especially APRNs, as

¹¹ NAT'L GOVERNORS ASS'N, THE ROLE OF NURSE PRACTITIONERS IN MEETING INCREASING DEMAND FOR PRIMARY CARE (2012).

¹² *Id.* at 5-6.

¹³ *Id.* at 8.

the rate of “baby boomers” turning age 65 grows. She also testified that workforce data on nursing in general is lacking.

She testified as to the significant health care education and workforce challenges for Georgia due to larger segments of the population reaching older ages. According to a Georgia Department of Labor study, health care and social assistance professions are expected to be highly sought-after and grow by nearly 100,000 jobs by 2026. Hospitals and nursing facilities are forecasted to have to fill nearly 33,000 jobs. Nurse practitioners are ranked as the tenth fastest growing occupation, and projected to grow 3.3 percent annually through 2026 in Georgia.¹⁴ AU hosts a three year accelerated bachelors program for nursing in order to meet the growing need.

Dr. Hooks is an APRN nurse practitioner in academia. He testified as to the accreditation of nursing education programs and expanding doctorate in nursing education programs at AU and other schools. The Study Committee heard that national organizations determine and guide rules for educational facilities—the American Association of Colleges of Nursing, National Organization of Nurse Practitioner Facilities, and the National Council of State Boards of Nursing. From these organizations, education facilities develop models for navigating nurses through APRN schooling based on licensure, accreditation, certification, and education (the “LACE” model). There are sixteen nurse practitioner education programs spread across Georgia.

As to education, AU’s bachelors program includes 60 credit hours of nursing-specific content and 765 hours in simulation and clinical hours. Doctorate degrees in nurse practitioner includes 77 credit hours and 1,156 clinical hours. Nationally, the minimum for doctorate programs is 1,000 clinical hours.

Dr. Stallings is a PA in academia. She described the roles a PA plays in the health care field: performing medical histories and examinations; ordering and interpreting lab tests; writing prescriptions; and assisting in surgical procedures. As for education, a bachelors degree is required for admission to PA school, along with minimum graduate exam testing scores. AU’s PA school admissions further require three letters of recommendation—two from PAs and one from a physician. Additionally, the school requires a minimum of 100 hours shadowing a physician or PA in a medical setting.

AU hosts a 27 month PA program with the first 15 months spent in classroom instruction and the following 12 months in supervised clinical practice settings covering pediatrics, OB/GYN, family medicine, or emergency medicine. Over the course of their education, PAs will earn 122 credit hours and 27 months of training. In regards to clinical rotations, over the 12 months in practice settings, PAs will undertake approximately 1920 hours of clinicals.

The National Commission on Certification of Physician Assistants certifies PAs nationally through examination. National certification lasts ten years with practitioners having to recertify every ten years thereafter. Once certified, a PA must seek licensure. In Georgia, GCMB allows temporary practice pending final board scores and licensure. A PA is not required under current law to be in the presence of the physician when providing services to patients.

Dr. Miller, a medical doctor (“MD”) working in academia, presented on the educational requirements for MDs. He pointed out that MDs are in competition with midlevel providers for

¹⁴ GEORGIA DEP’T OF LABOR, GEORGIA WORKFORCE TRENDS: AN ANALYSIS OF LONG-TERM EMPLOYMENT PROJECTIONS TO 2026. Available at: <https://explorer.gdol.ga.gov/vosnet/mis/Current/gaworkforcecurrent.pdf>.

clinical training spots, and that MDs in training work about 80 hours a week covering both clinical and book work.

The MD program requires two years in foundational sciences, two years of clinical sciences, and a four year concurrent program in ultrasound. Throughout their studies, students must take national exams. Four years of clinical training includes diagnosis and supervised patient care with exams each year, culminating in approximately 2,000 hours of clinical training. Licensing bodies require even further training before a physician is allowed to practice on their own.

The Senate Research Office was asked to provide objective testimony concerning South Carolina's recent PA practice law. The key comparisons between Georgia and South Carolina are:

1. South Carolina allows determination of the practice location of the PA to be made at the practice level between the PA and physician;
2. Georgia sets the physician supervision ratio to a maximum four PAs, two supervised at one time and maximum four APRNs, four supervised at one time, while South Carolina has adopted a six-to-one ratio for both, allowing physicians to mix PAs and APRNs up to six at one time;
3. South Carolina gives PAs limited prescribing authority for Schedule II controlled substances; and
4. South Carolina allows PAs to pronounce and certify death, and certify a handicap.¹⁵

Meeting Three – October 28, 2019

The third meeting of the Study Committee was held in Savannah, Georgia on Mercer University's Savannah Campus. This meeting focused on workforce challenges and whether current scope of practice laws hinder the provision of care in rural areas. The Chairman called the following to testify:

- **Jill Hendrix**, PA, Wellstar;
- **Charmaine Faucher**, PA, ex-officio member of the GCMB;
- **Tina Hood**, PA, rural health care;
- **Kay Argroves**, APRN;
- **Ngozi Orabueze**, APRN, private practice; and

Ms. Hendrix and Ms. Faucher, both PAs practicing in Georgia, testified that barriers exist hindering more expansive practice. Their testimony advocated for bringing PAs and APRNs under the same regulatory roof and to equalize the two professions. As for quality of care concerns, they discussed continued requirements for physician supervision but to loosen chart review requirements. As it stands now, PAs undergo a review of 50 percent of their patients monthly and APRNs are subject to a 10 percent review annually unless they prescribe, in which case they go through 100 percent review.

Ms. Hood is a PA practicing in rural Georgia. She provided key insight into rural health care, as well as testified to the ongoing challenges facing patients and providers in the delivery of services. Patients' continued overutilization of emergency rooms remains a challenge but, in some cases, it is unavoidable due to the restrictive nature of Georgia's PA practice. Patients will come to a rural ER with minor but painful injuries generally requiring a one-time or short term need for a Schedule II pain reliever. Midlevel providers such as PAs and APRNs covering the ER at the time are restricted from prescribing, and no physician may be readily available. The patient will be sent home unable to receive the level of care to fully relieve their pain, and have to return to the ER at another time. This is not only a cost and a duplication of services issue, but also a quality

¹⁵ See Appendix III, *South Carolina's "Physician Assistants Act of 2019,"* Senate Research Office.

of care problem for the patients. She advocated for at least some limited ability to prescribe Schedule II controlled substances. It was noted that studies on the effectiveness of pain relief shows there is little to no difference between some Schedule II and Schedule III controlled substances.

Additionally, Ms. Hood advocated for changes to the supervision ratios for midlevel providers. For PAs in particular, she explained that the maximum of four to one physician is not enough in rural health care settings. She testified further that PAs have the ability to order radiographic imaging tests at any time.

Ms. Orabueze, an APRN in private practice in the Atlanta area, testified as to the lower health outcomes present in restricted practice states. She specifically spoke to behavioral health needs and that PAs and APRNs may provide more efficient and effective care in community-based treatment settings. The Study Committee recognized the growing need for behavioral health workers and that the field for APRNs is expanding.

Additionally, Ms. Orabueze testified that some physicians charge exorbitant fees towards midlevel providers operating their own practice in order to act as the supervising physician. The Journal of Nursing Regulation surveyed 29 states including Georgia with APRN protocol/collaborative practice agreement requirements and found that 20.3 percent of respondents were charged a fee by a collaborating physician. In the surveyed states, these fees ranged from \$10.00 to \$50,000.00 to establish the collaboration, with fees to maintain the collaboration ranging from \$4.00 up to \$4,167.00 per month.¹⁶

Ms. Argroves, an APRN and current doctoral student, presented on the issues of infant and maternal mortality. She presented for herself and did not appear on behalf of any organization. Her testimony touched on important topics, and the Study Committee encouraged her to present at one of the committees or commissions the state hosts dedicated to the topics of infant and maternal mortality. She noted that expanding the scope of practice for PAs and APRNs will positively impact the provision of care to mothers and newborns.

The Senate Research Office was asked to provide objective testimony on recent changes to South Carolina's regulation of APRNs.¹⁷ That state overhauled its APRN practice with H.3821 in 2019 and S.345 in 2018. Among its many provisions, the bills:

1. Increased the number of APRNs a physician may supervise to six (as mentioned previously in the South Carolina PA reforms during meeting two, the overall cap on supervision of PAs and APRNs is six);
2. Eliminated the geographic limitation as to where an APRN may practice, provided that the physician must practice within the boundaries of the state;
3. Allowed APRNs to prescribe Schedule II controlled substances, differentiating between narcotic and nonnarcotic drugs; and
4. Allowed APRNs to certify an individual's manner and cause of death, and execute do not resuscitate orders.

Meeting Four – December 17, 2019

The fourth and final meeting of the Study Committee took place at the State Capitol. The Study Committee adopted a final report and recommendations.

¹⁶ Brendan Martin & Maryann Alexander, *The Economic Burden and Practice Restrictions Associated with Collaborative Practice Agreements: A National Survey of Advanced Practice Registered Nurses*, 9 J. of Nursing Reg., no. 4, 22-25.

¹⁷ See Appendix IV, *South Carolina APRN Legislation*, Senate Research Office.

RECOMMENDATIONS

1. The Study Committee recommends legislation to amend the current supervision ratios for PAs and APRNs to reflect six midlevel providers across both professions supervised by one physician. The recommended framework is one that is similar to recent changes made in the state of South Carolina. This change shall not impact anesthetist assistants and CRNAs. The Study Committee recommends consultation with the Georgia Composite Medical Board before passage of any legislation reflecting this change.
2. The Study Committee recommends legislation to amend and update the phrase “licensed to” in the context of a PA’s relationship to a supervising physician. This recommendation would be a language change strictly for the purpose of updating the phrase “licensed to” and have no substantive impact on the supervisory relationship a physician has with PAs. The Study Committee recommends consultation with the Georgia Composite Medical Board before passage of any legislation reflecting this change.
3. The Study Committee recommends legislation providing that the job description between a physician and PA be developed at the practice level. The Study Committee recognizes that the needs of practitioners are different across Georgia, and should reflect what is best for the needs of each community. The Study Committee recommends consultation with the Georgia Composite Medical Board before passage of any legislation reflecting this change.
4. The Study Committee recommends legislation to amend current law limiting an APRNs’ authority to order radiologic imaging so as to allow APRNs to order imaging on a regular basis. Currently, APRNs are only allowed to order imaging in the event of an emergency. The Study Committee was not unanimous in this recommendation as members expressed concern that there will be an over-ordering of imaging tests, and that imaging oftentimes requires skills for which an APRN is not trained—such as interpreting the results of imaging.
5. The Study Committee recommends legislation that would allow APRNs and PAs to prescribe Schedule II controlled substances in emergency situations only, and only in a limited supply. The Study Committee was not unanimous in this recommendation as members expressed concern that there will be overprescribing of opioids, and allowing more prescribers reflects poorly on the state’s commitment to ending the opioid epidemic.

Respectfully submitted,

**FINAL REPORT OF THE SENATE STUDY COMMITTEE ON
EVALUATING AND SIMPLIFYING PHYSICIAN OVERSIGHT OF
PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
REGISTERED NURSES**



**Senator Chuck Hufstetler
Chair
District 52**

APPENDICES

Appendix I - *Senate PA/APRN Presentation*, Senate Research Office.

Appendix II - *GAPA Presentation*, Georgia Association of Physician Assistants.

Appendix III - *South Carolina's "Physician Assistants Act of 2019,"* Senate Research Office.

Appendix IV - *South Carolina APRN Legislation*, Senate Research Office.



SENATE RESEARCH OFFICE
2019 Interim



SENATE PA/APRN PRESENTATION
**SENATE STUDY COMMITTEE ON EVALUATING AND SIMPLIFYING
PHYSICIAN OVERSIGHT OF PHYSICIAN ASSISTANTS AND
ADVANCED PRACTICE REGISTERED NURSES**

AUGUST 28, 2019

JAMES BEAL

Appendix I

Physician Assistant Regulation Basics



- Licensed by the Georgia Composite Medical Board
- 5,297 licensed PAs as of August 15, 2019
- Physician supervision is determined at practice level
 - Statute limits physician's supervision to four PAs maximum; two at any one time; with exceptions
- Prescriptive authority provided by statute allows PAs to order controlled substances III – V and dangerous drugs, as dictated by an approved job description
- PA's scope of practice is limited to approved scope of supervising physician's practice as dictated in an approved job description

Appendix I

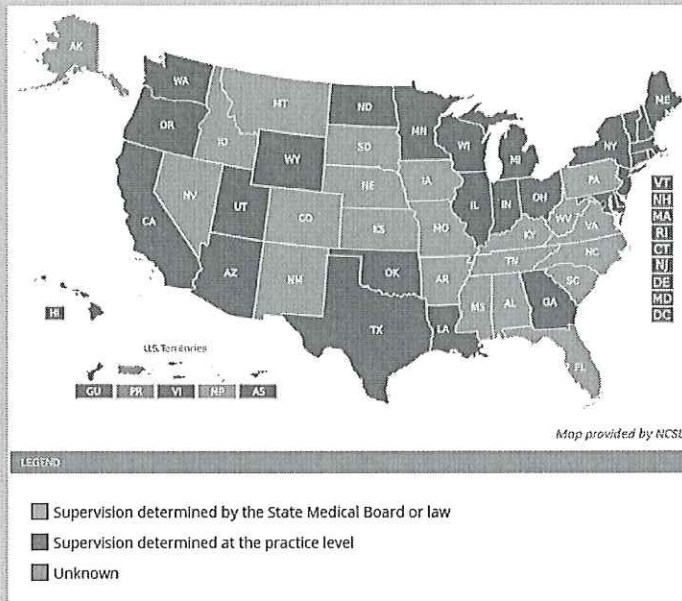
PA Supervision

Supervision determined by law/regulation

- State law or board rules provide supervision requirements

Supervision determined at practice level

- A written job description or collaborative agreement between physician and PA



PA Supervision Continued

- A primary supervising physician shall not have more than four PAs to supervise, and supervise not more than two at any one time, except:
 - A primary supervising physician may supervise up to four PAs at any one time in a group practice with other supervising physicians.
- An alternate supervising physician may also supervise up to four PAs in an institutional setting (eg. hospital or clinic), when on call for a primary supervising physician, or when otherwise approved by GCMB as an alternate.

PA Prescriptive Authority

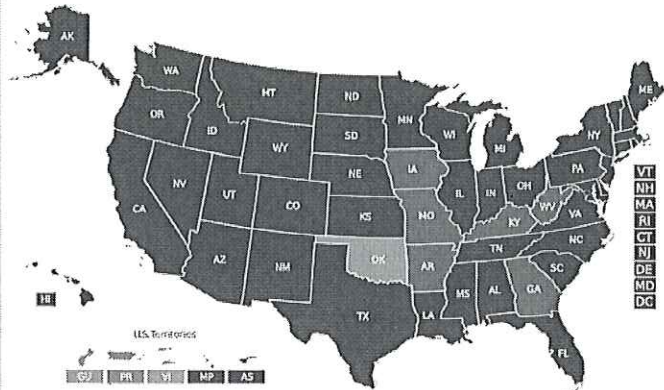
Georgia allows PAs to prescribe schedule III, IV, and V controlled substances.

44 states and D.C. allow PAs to prescribe schedule II, III, IV, and V controlled substances.

Prescriptive authority allowed for drugs only if a physician has delegated as provided in the PA's job description.

PA may order refills for up to 12 months. For scheduled drugs, refills up to six months.

▼ PRESCRIPTIVE AUTHORITY FOR PHYSICIAN ASSISTANTS



Map provided by NCSL

LEGEND

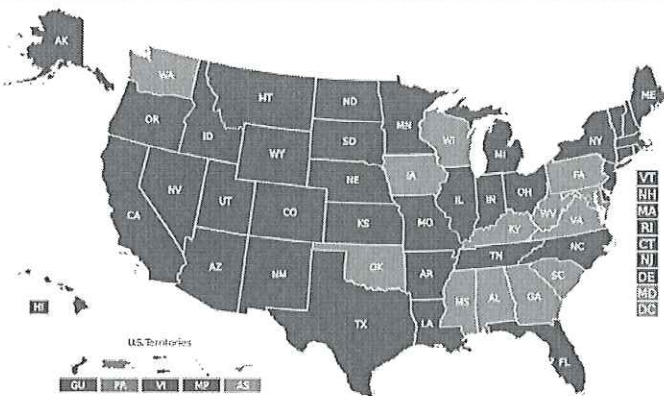
- Prescriptive authority determined by the State Medical Board or law
- Prescriptive authority excludes certain medications
- Prescriptive authority determined at the practice level
- Unknown

PA Scope of Practice

Georgia's scope of practice laws are based on the supervising physician's delegation, limited to only the physician's scope and must be approved by GCMB (same as South Carolina, Alabama, etc.).

States such as Florida, Louisiana, Texas, etc. do not require medical board/regulator approval.

▼ SCOPE OF PRACTICE DETERMINATION



Map provided by NCSL

LEGEND

- SOP determined by the State Medical Board or law
- SOP determined at the practice level
- Unknown

PA Education, License Requirements



- PA students attend formal physician assistant education programs approved by GCMB
- Usually six years of education – four years undergraduate/bachelors and two years in PA school
- Must pass the Physician Assistant National Certifying Exam (“PANCE”) administered by the National Commission on Certification of Physician Assistants
- Continuing education requirements
 - 40 hours biennially, 10 hours of which are in the physician’s specialty
 - 3 hours in pharmaceuticals for PAs with prescriptive authority
- Citizenship, legal permanent resident, or qualified alien status requirement
- Good moral character references by two physicians, may not be physician seeking to use the PA (Board regulation)

Advance Practice Registered Nurse Regulation Basics

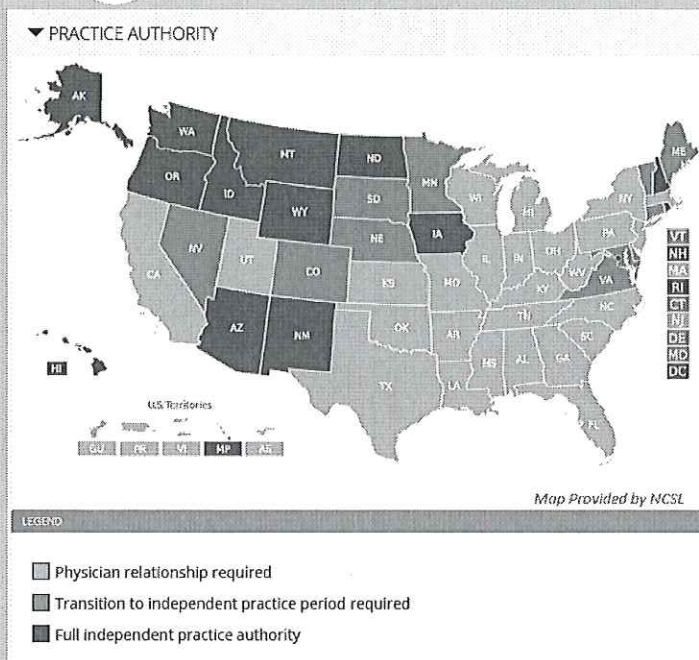


- Licensed by the Board of Nursing as a registered nurse, authorized as an APRN by the Board
- 15,422 authorized APRNs
 - Of these, 12,459 are nurse practitioners
- Georgia requires a written protocol between a supervising physician and APRN
 - Board of Nursing regulations limit physician’s supervision to four APRNs, with exceptions
- Prescribing authority is allowed pursuant to a written protocol and if authorized by the GCMB
- APRNs: Nurse-midwife; nurse practitioners; certified registered nurse anesthetist, clinical nurse specialist psychiatric/mental health; clinical nurse specialist

APRN Practice Authority

26 states require a physician relationship.

24 states allow APRN independent practice.



APRN Supervision

- A delegating physician may not enter into a nurse protocol agreement with more than four APRNs at any one time, except when the APRN is practicing in:
 - A licensed hospital;
 - A college or university;
 - DPH, county board of health, or CSBs;
 - A free health clinic, or birthing center;
 - A non-profit entity primarily serving uninsured or indigent Medicaid, Medicare patients;
 - FQHCs or other federally-authorized, -funded entity;
 - Local boards of education with school nurse programs;
 - Health maintenance organization; or
 - An EMS system, under local authority, with a full time physician medical director.

APRN Supervision Continued



- A supervising physician may not enter into a nurse protocol agreement with more than eight APRNs, and supervise no more than four at any one time, at locations which:
 - Maintain evidence-based clinical practice guidelines;
 - Accredited by a nationally recognized organization (eg. Joint Commission);
 - Require the physician maintain a record of review of at least 10 percent of the APRN's medical records;
 - Require physicians and APRNs to participate in and maintain quarterly clinical collaboration meetings; and
 - Require the delegating physician's contact information be provided to a patient's PCP.

O.C.G.A. § 43-34-25(g.1)

APRN Supervision Continued



- A supervising physician may not enter into a nurse protocol agreement with more than eight APRNs at any one time, or supervise more than four at any one time, in any EMS system operated by or on behalf of a local authority with a full-time medical director.

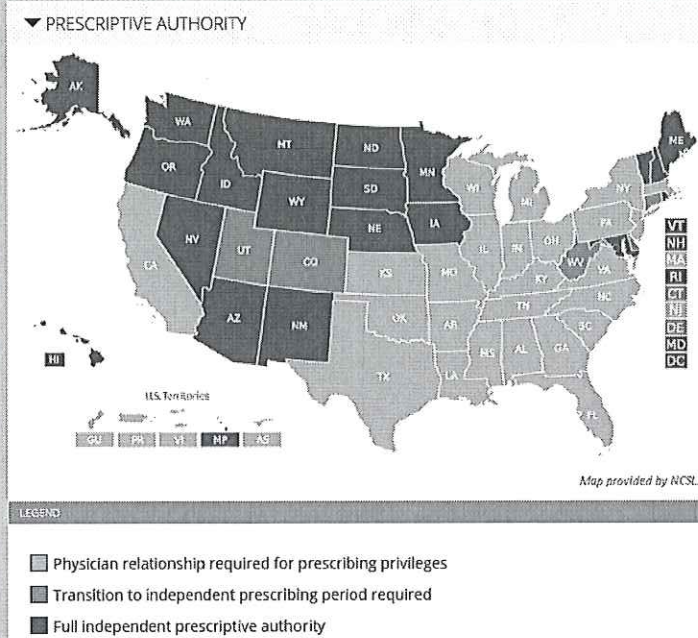
O.C.G.A. § 43-34-25(g.2)

APRN Prescriptive Authority

All states + D.C. allow APRNs to prescribe.

Georgia allows APRNs to prescribe schedule III, IV, and V controlled substances pursuant to a written protocol.

45 states allow APRNs to prescribe schedule II, III, IV, and V controlled substances.



APRN License, Education Requirements

- APRN students attend Board of Nursing-approved masters/graduate programs
- Usually six years of education – four years undergraduate/nursing program, two years in an approved advanced program
- Must be certified by a national board approved by the Board of Nursing
- Submit required documents as an RN, including passage of the NCLEX
- Required continuing education for renewal, but multiple options
 - Can be through continuing education classes, maintaining certification by a national board, completing a Board-recognized academic program, verification of competency from a facility with 500 hours practiced, or any other Board-approved methods.

2019 Georgia Legislation



- SB 168 – Allows APRNs working in an EMS system overseen by a physician medical director to order up to a 14 day supply of drugs in emergency situations, excluding schedule II substances and benzodiazepines; prohibits APRNs from ordering radiographic imaging, diagnostic studies, and medical devices; and requires referral of the patient to a physician, dentist, or FQHC (Passed – Effective April 25, 2019)
- HB 409 – Proposes to remove “life-threatening situation” as a prerequisite for APRNs ordering radiographic imaging tests; raises the number of APRNs a physician may supervise (In House Committee)
- SB 109 – Removes “life-threatening situation” as a prerequisite for APRNs licensed for at least five years to order radiographic imaging tests (Tabled)

GEORGIA LEGISLATIVE STUDY COMMITTEE ON EVALUATING AND SIMPLIFYING PHYSICIAN OVERSIGHT OF PAs AND APRNs

Tom Bauer,
Georgia Association of Physician Assistants

August 28, 2019



Appendix II

WHAT IS A PA?



Appendix II

WHAT CAN PAs DO?



Manage patients



Prescribe medication



Perform medical procedures



Order and interpret tests



Assist in surgery



Counsel on preventive care

Appendix II

HOW ARE PAs EDUCATED?



Educated at
MASTER'S DEGREE level



Programs are
27 MONTHS or **3 ACADEMIC YEARS**
(Bachelor's degree is required for acceptance)



2,000 hours
of clinical rotation

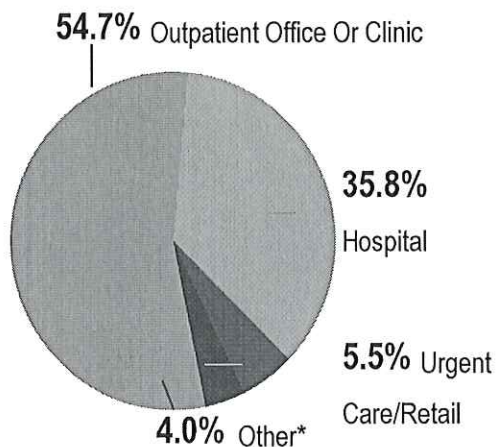


238 PA Programs
in the U.S.
ARC-PA, 2019

Appendix II

WHERE DO PAs WORK?

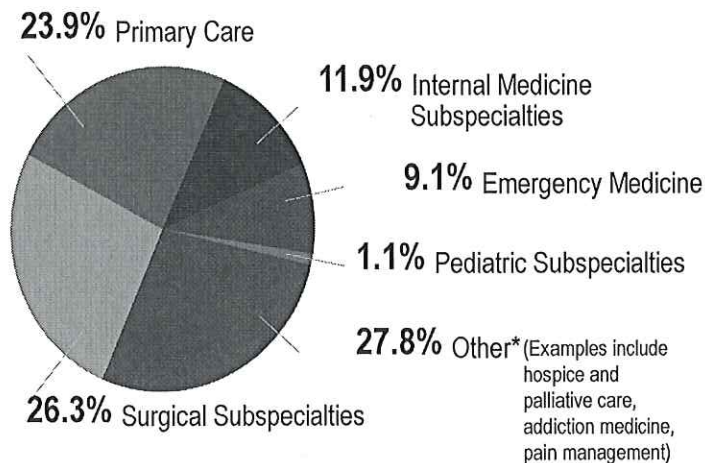
PAs practice in every work setting



2018 AAPA Salary Survey
All data based on clinically practicing PAs in the U.S.

*Other refers to a variety of work settings including but not limited to schools/universities, rehabilitation facilities, nursing homes and correctional facilities.

PAs practice medicines in all specialties



2018 AAPA Salary Survey
All data based on clinically practicing PAs in the U.S.

*Other refers to a variety of healthcare settings including but not limited to psychiatry, hospice and palliative care, obstetrics and gynecology, addiction medicine, pain management, public health and dermatology.

Appendix II

IS THERE A HIGH DEMAND FOR PAs?

Demand for PAs
has increased

300%

from
2011 to 2014.

*Merit Hawkins

PA Employment will
increase by

30%

between
2014 and 2024.

*U.S. Bureau of Labor Statistics

Multiple job offers
are received by

76%

of PAs upon
graduation.

*NCCPA 2015 Profile of P

Appendix II

HOW MUCH DO PAs MAKE?

\$105,000

MEDIAN BASE SALARY FROM PRIMARY EMPLOYER

*Data provided by the AAPA 2018 Salary Survey

\$105,000

Appendix II

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HISTORY OF GEORGIA PA ACT

- Original Georgia PA Act (1972)
- While containing the elements of a licensure bill, PAs were considered “certified”
- Envisioned extensive supervision with basic and detailed (long) job descriptions
- Anticipated the regulation of about 200 PAs
- First attempted major legislative change (allow remote site practice) was circa 1988
- Was not comprehensively updated until 2009

Appendix II

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PIECEMEAL AMENDMENTS (Before 2009)

- Delegation of Prescriptive Authority: 1995
- “Licensing” of PAs (was “Certified”): 1997
- Authorization for DEA Numbers: 1999
- Increase in PA to Physician Ratio: 2001-2002
- Authorization of the “Alternative Supervising Physician”: 2002
- Redefining the Nature of PA Job Description (Making it More General): 2004
- Request, Sign for Pharmaceutical Samples: 2004
- PA Assistance for Disaster Relief: 2006



Appendix II

Modernizing PA Laws and Regulations

**AAPA's
Six Key
Elements of a
Modern PA
Practice Act**

Full prescriptive authority

Adaptable collaboration requirements

“Licensure” as the regulatory term

Number of PAs a physician may practice with
determined at the practice level

Scope of practice determined at the practice level

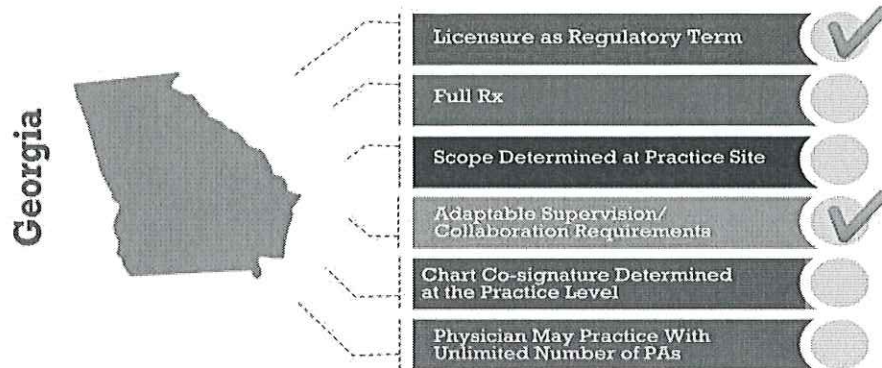
Cosignature requirements determined at the practice level



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Appendix II

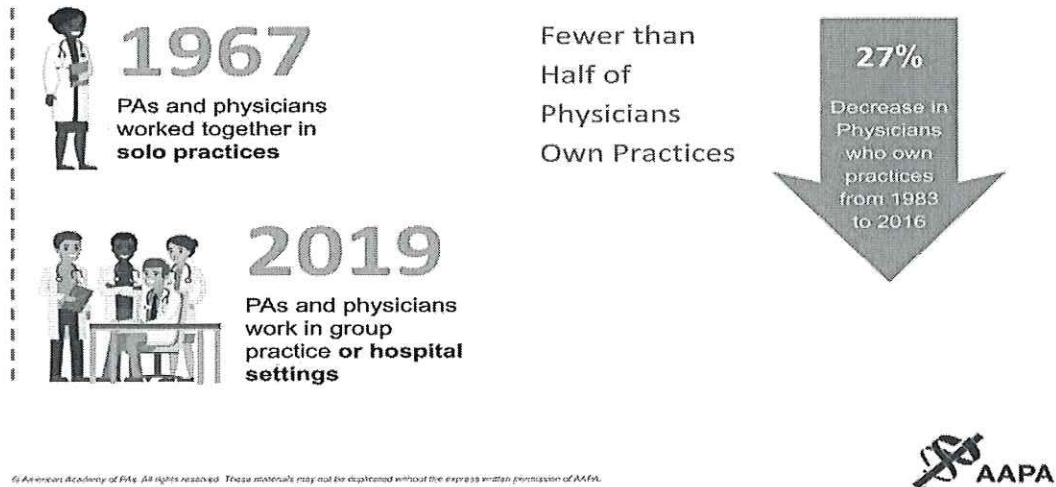
6 Key Elements in State PA Law



SIX ELEMENTS OF A MODERN PA ACT: Georgia/National Comparison

Element	Georgia	Total States
Licensure as a Regulatory Term	Yes	50
Full Prescriptive Authority (including Schedule II Drugs)	No	43 (Note: including every neighbor state) and D.C.
PA Scope of Practice at Practice Site	No	37 and D.C.
Adaptable Supervision Requirements (Distance, Physician Location)	Yes	30
Chart Co-Signature Requirements at Practice Level	No	33 and D.C.
No Ratio Restriction	No	14 (Note: 26 other states have ratios less restrictive than Georgia)

What's Driving the Need for Change?



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AREAS IN GEORGIA PA LAW TO EXAMINE

- Physician chart review of patients receiving a prescription from a PA
- Supervisory ratios
 - Number of PAs a physician can supervise at one time
 - Number of PAs with job description
 - Elimination of ratios
- Prescriptive authority
 - All Schedule II drugs
 - Hydrocodones



Appendix II

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AREAS IN GEORGIA PA LAW TO EXAMINE (Continued)

- Sites where PAs can practice (language on places where physician “regularly sees patient” needs to be eliminated)
- Arcane language in PA Act
- PA “licensed to” supervising physician
- Notification to patient of the right to see a physician prior to issuance of an prescription
- Inclusion of PAs in state statutes predating PA profession or where it was assumed that by including physicians, PAs were necessarily included



Appendix II

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AREAS IN GEORGIA PA LAW TO EXAMINE (Continued)

- Reimbursement issues
 - PAs are not eligible for direct payment from Medicare and nearly all commercial insurance payers
 - Can create problems:
 - PA marketability
 - Federal reimbursement of PA services in rural health clinics
- Designation of PAs as “Primary Health Care Providers” in all state programs



Appendix II

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FINAL NOTE

- Both Governor Deal's Rural Hospital Stabilization Committee and the House Rural Development Council have recommended the expansion of the scope of practice of physician assistants, among other health care professions.

QUESTIONS?





GEORGIA STATE SENATE SENATE RESEARCH OFFICE

204 Coverdell Legislative Office Building | 404.656.0015
18 Capitol Square SW
Atlanta, GA 30334

ELIZABETH HOLCOMB
DIRECTOR

MEMORANDUM

Date: September 17, 2019

To: SR 202 Study Committee

From: James Beal

Re: South Carolina's "Physician Assistants Act of 2019"

Effective August 11, 2019, South Carolina's Physician Assistants Act of 2019 (S132) overhauled the physician-to-PA relationship, as well as PAs' practice, in that state. The key features of the law are listed below:

1. Eliminates geographic limitations on PAs;
2. Allows a physician to enter into agreements with up to six PAs (but only six combined midlevel providers, Medical Board may make exceptions);
3. Signing as an alternate supervising physician will not go towards that alternate's six maximum, alternate can also be listed and not sign;
4. Eliminates six month on-site practice requirement and off-site practice approval by Medical Board, exception for PA with less than two years of continuous practice;
5. Eliminates ten percent physician chart review requirement for off-site PAs, requirement that a review pursuant to the scope of practice guidelines to ensure quality of care and patient safety instituted;
6. Allows a PA to begin supervised practice ten days after submitting scope of practice guidelines to the Medical Board instead of upon approval;
 - a. If disapproved by the Medical Board, the Medical Board must provide a written explanation and a suggested remedy where possible;
7. Allows PAs to carry out specific medical acts, unless the scope of practice guidelines state otherwise:
 - a. Certify a student is unable to attend school;
 - b. Refer a patient to PT;
 - c. Pronounce death, certify manner and cause of death, and sign death certificates;
 - d. Certify an individual is handicapped; and
 - e. Execute DNR orders;
8. Allows PAs to delegate limited tasks to unlicensed assistive personnel;
9. Eliminates requirement that a patient be seen by a physician prior to prescribing oral doses of Schedule II narcotic substances, PA must consult supervising physician after a five day initial dose prescription;
10. Requires the supervising physician approve of intravenous dosages of Schedule II narcotic substances beyond a one-time administration;

11. Eliminates the requirement that a PA and supervising physician periodically review documents concerning expanded prescriptive authority;
12. Requires education in pharmaceutical therapeutics, and four hours of continuing education in prescribing and monitoring controlled substances II through IV;
13. A hospital or provider group credentialing committee is authorized to begin credentialing a PA upon submittal of the scope of practice guidelines;
14. Exam on statutes governing PA practice eliminated ("jurisprudence exam");
15. Required Medical Board in-person interviews are eliminated and left to discretion of the Medical Board; and
16. Fees are eliminated for changing supervisors.

Comparing Georgia's Framework

1. Neither Georgia nor South Carolina now have geographic limitations; however, Georgia requires a PA practice "where the supervising physician...regularly sees patients..."¹
 - a. South Carolina leaves determination of location between the physician and PA;
2. Georgia has ratio limits for PAs separate from limits for other midlevel providers: maximum four PAs, two supervised at one time; maximum four APRNs, four supervised at one time;
3. Alternate supervising physicians may be listed for any number of PAs but are limited to supervise only four at any one time;
4. Georgia does not designate or have separate requirements for "off-site" PAs;
5. The only review requirement provided in Georgia statute is that a physician must review a PA's drug prescription orders and their corresponding charts every 30 days;
6. GCMB may grant a temporary permit to practice pending a PA applicant taking a test or GCMB granting approval;
 - a. In case of disapproval, there is no requirement to provide an explanation.
7. Georgia law expressly prohibits PAs signing death certificates and disability ratings documents²
 - a. PA may pronounce death;³
8. No express language concerning PA delegation of tasks to assistive personnel, in practice it may be that a physician can delegate the authority to a PA to delegate tasks;
9. Georgia has a blanket ban on Schedule II prescribing authority for PAs;
10. Georgia requires three hours in pharmaceuticals education every two years for PAs with prescribing authority;
11. No express language provides for credentialing PAs;
12. Georgia does not require an in-person interview;
13. GCMB charges a \$75.00 fee for changing supervisors.

¹ O.C.G.A. § 43-34-103(d).

² O.C.G.A. § 43-34-103(l) ("Except for death certificates and assigning a percentage of a disability rating, a physician assistant may be delegated the authority to sign...all documents relating to health care...within his or her scope of authorized practice").

³ O.C.G.A. § 43-34-103(j) ("A physician assistant shall be allowed to make a pronouncement of death pursuant to authority delegated by the supervising physician of the physician assistant and to certify such pronouncement in the same manner as a physician.").



GEORGIA STATE SENATE SENATE RESEARCH OFFICE

204 Coverdell Legislative Office Building | 404.656.0015
18 Capitol Square SW
Atlanta, GA 30334

ELIZABETH HOLCOMB
DIRECTOR

MEMORANDUM

Date: October 24, 2019

To: Senator Chuck Hufstetler

From: James Beal

Re: South Carolina APRN Legislation

You requested information concerning recent legislative changes to South Carolina's advanced practice registered nurse ("APRN") profession. In 2018, South Carolina enacted S.345, amending the state's framework for APRN practice, supervision, and prescriptive authority.

Additionally, the South Carolina legislature made minor amendments to the law in 2019 with H.3821. These changes are briefly described as noted below.

S.345

Effective July 1, 2018, South Carolina's APRN practice¹ underwent reforms and adopted the framework set forth under S.345², which:

1. Replaces "written protocol" between physician and APRN(s) with "Practice Agreement." The statute requires that the Practice Agreement contain:
 - a. Physician and APRN identifying information,
 - b. Nature of practice and practice locations,
 - c. How consultation with physician and backup physician is provided,
 - d. Physician's quality of care and patient safety mechanisms,
 - e. Prescriptive authority, and
 - f. Any restrictions on an APRN's ability to practice statutorily-provided medical acts.
2. Provides that APRNs may perform medical acts pursuant to the Practice Agreement, subject to the scope and standards of practice established by Board-approved credentialing in the APRN's specialty area of practice. Additionally, the following acts may be performed unless stated otherwise in the Practice Agreement:
 - a. Provide noncontrolled prescription drugs at an entity that provides free medical care for indigent patients;
 - b. Certify that a student is unable to attend school but may benefit from receiving instruction given in his home or hospital;
 - c. Refer a patient to physical therapy for treatment;
 - d. Pronounce death and sign death certificates;

¹ Nurse Practice Act, S.C. Code Ann. § 40-33-5, *et seq.*

² As passed S.345 here: https://www.scstatehouse.gov/sess122_2017-2018/prever/345_20180508.htm.

- e. Issue an order for a patient to receive appropriate services from a licensed hospice; and
 - f. Certify an individual is handicapped and declare a temporary or permanent handicap for purposes of an individual receiving a placard.
- 3. Allows practice to begin without the Practice Agreement first being approved by state regulators³;
- 4. Requires the State Board of Nursing to conduct audits of Practice Agreements every two years;
- 5. Authorizes the State Board of Medical Examiners to conduct audits at its discretion;
- 6. Requires physicians and APRNs to produce Practice Agreements within 72 hours of an audit request;
- 7. Adds the following grounds for misconduct:
 - a. Failure to produce Practice Agreement upon board request within 72 hours,
 - b. Failure of the Practice Agreement to reflect statutory requirements, and
 - c. Failure of either physician or APRN to comply with Practice Agreement terms.
- 8. Medical acts or functions performed by the APRN must be within the physician's usual practice, training, or experience;
- 9. Increased the number of APRNs a physician may supervise to six (South Carolina caps the number of all midlevel providers a single physician may supervise at six total);
- 10. Geographic limitation as to where an APRN may practice is eliminated and law provides that the physician must practice within the boundaries of the state;
- 11. Physician must be "readily available"⁴ to the APRN;
- 12. Allows APRNs to prescribe Schedule II controlled substances:
 - a. Nonnarcotic Schedule II – each prescription shall not exceed a 30 day supply;
 - b. Narcotic Schedule II – a five day supply may be prescribed by the APRN, but subsequent prescriptions must be agreed to by the physician; and
 - c. In hospice and palliative care settings, an APRN may supply narcotic Schedule II up to a 30 day supply.
- 13. APRNs with prescriptive authority must register with the state's health department; and
- 14. APRNs may perform medical acts provided in the Practice Agreement via telemedicine.

H.3821

Effective July 23, 2019, South Carolina's APRN practice was further amended by H.3821.⁵ This bill expanded APRN authority to perform the following:

- 1. Certify an individual's manner and cause of death; and
- 2. Execute a do not resuscitate order.

Additionally, H.3821 amended provisions governing Schedule II controlled substances prescriptive authority by allowing APRNs to prescribe narcotic Schedule II in long-term care facilities for up to a 30 day supply.

³ This is not a change in S.345. South Carolina previously allowed practice without state approval.

⁴ "Readily available" means the physician can be contacted either in person or by telecommunication or other electronic means to provide consultation and advice. S.C. Code Ann. § 40-33-20(52).

⁵ As passed H.3821 here: https://www.scstatehouse.gov/sess123_2019-2020/prever/3821_20190521.htm.