PERSPECTIVES ON ADVANCED PRACTICE REGISTERED NURSING IN GEORGIA

GEORGIA WATCH™

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HEALTH ACCESS PROGRAM

Perspectives on Advanced Practice Registered Nursing in Georgia

By Beth Stephens, JD

Director, Health Access Program

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EXECUTIVE SUMMARY

APRNs serve important roles in the provision of pediatric care, acute care, adult primary care, maternity care, mental health treatment, and chronic disease management. APRNs are registered nurses that have additional education, training and certification in a specific area of practice. In 2010 there were slightly over 7,000 APRNs licensed in Georgia. In four years, that number has grown to more than 9,500. This reflects recent national trends of enormous growth in the profession.

Georgia's APRN practice laws are some of most restrictive in the nation. Georgia law requires that APRNs have a protocol agreement with a supervising physician and mandates additional supervision requirements. APRNs in Georgia cannot write prescriptions for Schedule II medications, and their ability to order diagnostic tests is also limited. Georgia could enable APRNs to better serve patients and potentially lower healthcare costs for consumers by granting APRNs the authority to practice to the full extent of their education and training.

Georgia is facing a serious physician shortage, and APRNs have the training and expertise to fill the gaps in our healthcare system, particularly in primary care. Georgia currently ranks 49th in the number of primary care doctors per capita, down from 44th in 2007. Over 80% of Georgia's counties contain substantial populations without a consistent source for primary care. Additionally, there are 63 counties without a single pediatrician, 79 without an OB/GYN, and 78 without a psychiatrist. Georgia's outdated and restrictive APRN practice regulations do not align with national trends and inhibit the state's ability to meet the needs of a growing patient population.

The provider demographic is changing, and along with it, patient expectations for provider choice. As more Georgians obtain insurance coverage as a result of the Patient Protection and Affordable Care Act, it is important that they have the option to elect APRNs as their healthcare providers. As one of the lowest scoring states in terms of overall health, Georgia needs to encourage the ability of non-physician providers, like APRNs, to practice more autonomously, particularly in rural parts of the state, in order to ensure that Georgians have an adequate system of care.

Georgia Watch urges state policymakers to consider adopting the following four recommendations to better position the state to address current and future healthcare needs:

- **Grant APRNs full practice authority, which includes Schedule II prescriptive authority and the ability to order radiographic imaging tests, like MRIs and CT scans, in non-emergency situations.**
- **Ensure fair and impartial regulatory board oversight of APRNs.**
- **Improve access to care by mandating third-party coverage of APRN care and enabling patient choice in providers.**
- **Support the healthcare workforce pipeline by enabling more graduate level education and clinical training opportunities for nurses.**

INTRODUCTION

This paper explores the practice environment for advanced practice registered nurses (APRNs) in Georgia and makes policy recommendations based on the regulatory frameworks that exist in a majority of other states.[i] This research project was funded by a generous grant from the Georgia Health Foundation. Georgia Watch is a nonprofit, nonpartisan 501(c)(3) organization advocating for consumers and patients in our state. Our mission is to empower and protect Georgia consumers on matters that impact their wallets and quality of life through education, advocacy and policy development. Georgia Watch's Health Access Program (HAP) seeks to ensure access to safe, quality and affordable healthcare for all Georgians. Improving healthcare workforce capacity is critically important to ensuring access to care, and this paper discusses ways to make the best use of Georgia's existing non-physician provider resources.

APRNs can be found almost everywhere in Georgia's healthcare industry. They are in the operating room, emergency room, labor and delivery, private practice offices, nursing homes, federally qualified health centers, and charitable care clinics. They serve important roles in the provision of pediatric care, acute care, adult primary care, maternity care, mental health treatment, and chronic disease management. APRNs are registered nurses that have additional education, training and certification in a specific area of practice.

Most states, including Georgia, require APRNs to have a graduate nursing degree. APRNs may have a Master of Science or Doctorate in Nursing. Individuals wishing to become APRNs must complete a four-year undergraduate degree in a nursing-related field before they can apply to a graduate program. Master's level nursing programs typically last two years and include both classroom and clinical experiences. Many APRNs were registered nurses for a number of years before they chose to enter graduate school. In fact, APRNs have at least 6 years of formal education and may have many more years of practical experience.

The Georgia Board of Nursing reports that 9,551 APRNs are currently licensed in the State of Georgia in five categories recognized by statute[1]:

APRN Category	Licensed (January 2015)
Certified Nurse Practitioner (NP)	6,793
Certified Registered Nurse Anesthetist (CRNA)	1,865
Certified Nurse-Midwife (CNM)	494
Clinical Nurse Specialist (CNS)	116
Clinical Nurse Specialist / Psychiatric Mental Health (CNS-PMH)	283

[i] This paper focuses largely on nurse practitioners and nurse midwives only because those are the APRN groups for which Georgia Watch found the most widely available data and information.

Certified Nurse Practitioners (NPs) comprise the largest group of APRNs with 6,793 active licensees. NPs are educated and trained to treat patients in a wide variety of populations, including pediatrics, neonatology, acute care, gerontology, women's health, psychiatric mental health and adult primary care. The Georgia Board of Nursing began requiring that nurses practicing in APRN roles certify with the state in the 1980s.

To read more about APRN education, training and licensing, see Appendix A.

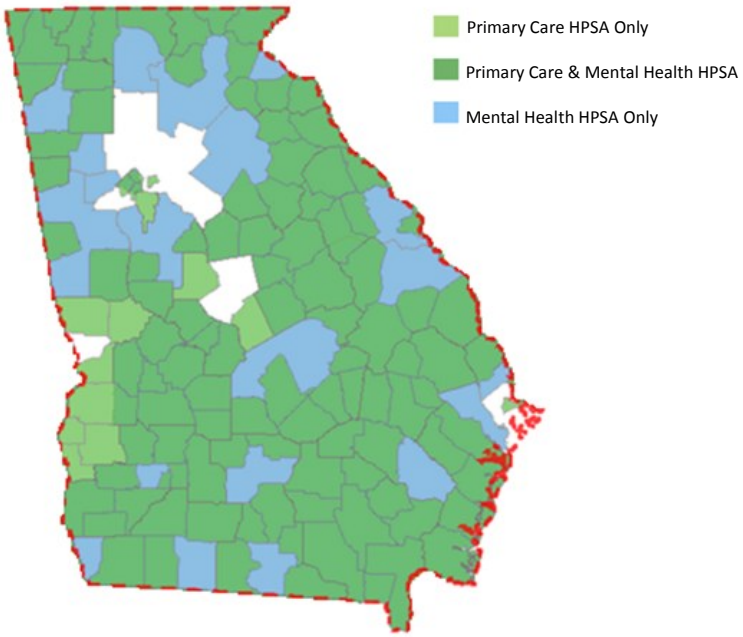
GROWTH OF APRN PRACTICE IN THE U.S. AND GEORGIA

The number of APRNs practicing nationwide is growing rapidly. This growth is also occurring in Georgia where APRNs have treated patients since the inception of the role nearly fifty years ago. In 2010 there were slightly over 7,000 APRNs licensed in Georgia.[2] In four years, that number has grown to more than 9,500. This reflects recent national trends of enormous growth in the profession. The American Association of Nurse Practitioners estimates there were around 63,000 nurse practitioners practicing across the United States in 1999. In 2014, that number has grown to over 192,000, with about three out of four practicing in at least one primary care setting.[3]

GEORGIA'S PHYSICIAN SHORTAGE

Reports of a looming national physician shortage have been circulating since well before the passage of the Affordable Care & Patient Protection Act, and Georgia is projected to fare worse than most other states.[4,5] By the year 2020, the United States is projected to have a deficit of around 91,000 physicians.[6] Georgia currently ranks 39th in the number of physicians per capita, with almost half of that shortfall being in primary care.[7] Georgia is expected to rank last in total number of physicians by the year 2020.[8] With approximately 10 million residents, Georgia is the 9th most populous state. However, it currently ranks 49th in the number of primary care doctors per capita, down from 44th in 2007.[9,10]

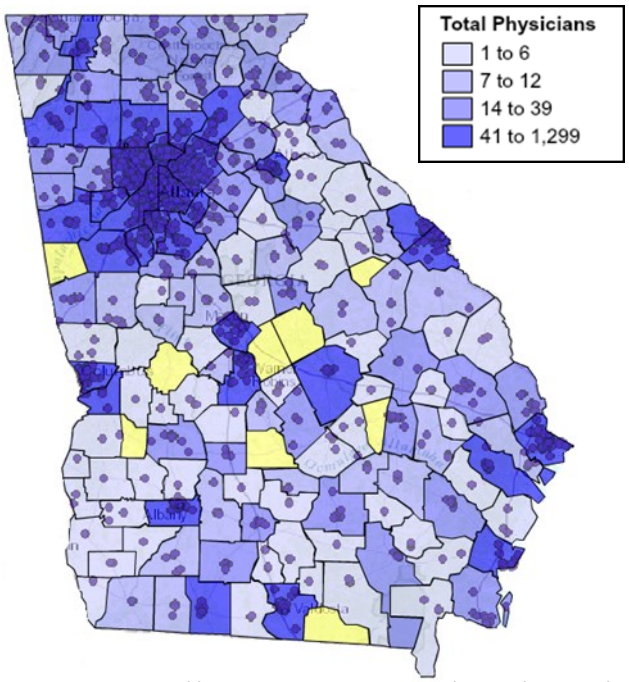
Primary Care and Mental Health Professional Shortage Areas (2014)



Source: HRSA Data Warehouse Map Tool (2014), available at http://datawarehouse.hrsa.gov/tools/MapTool.aspx#

Georgia has already seen the effects of inadequate primary healthcare access, particularly in rural parts of the state.[11,12] Physician distribution exacerbates the problem. Over 25% (1,885) of the state's primary care physicians are located in Fulton and DeKalb counties. In rural Georgia, several counties have no primary care physician, and another 13 have only one primary care physician serving the entire county.[13] A total of 129 out of Georgia's 159 counties contain federally designated primary care health professional shortage areas (HPSA).[14] This means over 80% of Georgia's counties contain substantial populations without a consistent source for primary care. The supply of other essential medical providers, namely OB/GYNs, pediatricians and psychiatrists, is equally dismal. There are 63 counties without a single pediatrician, 79 without an OB/GYN, and 78 without a psychiatrist. In addition, nearly 96% of Georgia's counties contain designated mental health HPSAs.[15]

Total Primary Care Physicians (2010:) ***Includes Family Medicine, General Practice, Internal Medicine and Pediatrics***



Source: http://www.graham-center.org/online/graham/home/tools-resources/npi.html

As the physician workforce ages and an increasing number of medical students choose to enter medical specialties instead of primary care, Georgia will be unable to provide enough physicians to care for a rapidly growing and aging population requiring more frequent and routine care.[16] Despite recent efforts to expand medical school enrollment and the availability of Georgia residencies, there will still be a significant gap between the demand and availability of primary care physicians. High primary care physician to population ratios are associated with improved health outcomes and overall reductions in mortality.[17] As one of the lowest scoring states in terms of overall health, our state needs to encourage the ability of non-physician providers, like APRNs, to practice independently, particularly in rural parts of the state, in order to ensure that Georgians have an adequate system of care.[18]

APRNs have the training and expertise to fill the gaps in our healthcare system, particularly in primary care. Over the last several decades, healthcare education and practice have evolved to a point that many health professions share overlapping knowledge, skill and expertise. States that have adjusted licensure laws to reflect educational developments are in a better position to meet the primary care needs of their residents and have the flexibility to adopt new models of care delivery that make effective use of existing state resources. Unfortunately, the dated licensure structure in Georgia does not reflect the professional abilities of the APRN workforce and exacerbates the state's physician shortage problem.

To read more about APRN practice regulation and legislative history in Georgia, see Appendix B.

PRACTICE REGULATION

APRN practice is governed by national professional standards of practice, state practice acts, and state regulatory board rules and regulations. Georgia is one of the more restrictive states in the nation when it comes to permitting APRNs to practice to the full extent of their training. The AANP lists Georgia as one of 12 states with the most restrictive practice environments for nurse practitioners.[19] Although laws governing APRN practice vary from state to state, more restrictive state laws have some commonalities, such as: medical board regulation of APRN practice, physician supervision requirements and restrictions on the ability of APRNs to perform certain medical acts, like writing prescriptions.

Physician Supervision Requirements

In more restrictive states, including Georgia, APRNs are legally constrained from providing patient care unless the APRN is supervised by a physician who "delegates" or grants to the APRN the authority to perform certain medical acts, which can include diagnosing patients, ordering tests and writing prescriptions. All APRNs in Georgia must be supervised by a licensed physician with whom they are required to have a protocol agreement. The protocol agreement is a written document by which the physician delegates to the APRN the authority to perform designated medical acts. More restrictive states also require supervising physicians to review a certain percentage of APRNs' charts and/or see their patients on a periodic basis. APRNs in Georgia who prescribe drugs are subject to chart reviews, and delegating physicians must see their patients on a quarterly basis.

In more restrictive states, delegating physicians may also be restricted in the number of APRNs they are allowed to supervise. In Georgia, if a physician delegates prescriptive authority to an APRN, he or she cannot have a protocol agreement with more than 4 APRNs. This limits the number of APRNs who can write prescriptions in our state. Physician supervision policies and procedures specific to certain practice settings and institutions also exist. These guidelines may be even more restrictive than existing state laws and policies. For example, in some Georgia practices, supervising physicians review 100% of all APRN charts, even when the APRN does not prescribe medicine. This is not required by Georgia law.

In many states, a supervisory relationship between an APRN and a physician is not required. Some states legally require APRNs to have a collaborative arrangement with a physician. In a growing number of states, APRNs are licensed to practice independent of the legal requirement of a formal relationship with a physician as a condition of advanced practice nursing. Some of these

state laws specify that the APRN is responsible to consult a physician or other healthcare provider when specialized knowledge is needed. For many APRNs, particularly nurse midwives, collaboration is a hallmark of their patient care model, regardless of statutory requirements.

Prescriptive Authority Restrictions

Forty-nine states and the District of Columbia authorize APRNs to prescribe controlled substances under state law. The most restrictive states only permit APRNs to prescribe drugs that are classified as Schedules III-V by the Drug Enforcement Agency. Schedule II prescription drugs are more highly regulated due to their addictive nature and potential for abuse. Many of these are commonly prescribed pain management drugs, like hydrocodone, and mental and behavioral health medications, like Adderall and Ritalin. Only physicians may write prescriptions for Schedule II drugs in Georgia. APRNs in Georgia may independently write prescriptions for Schedules III, IV and V drugs, but only if their protocol agreement allows.

In 2006, the Georgia legislature gave prescriptive authority to APRNs for the first time. It was one of the last states to do so. Florida is the only state where APRNs cannot write prescriptions at all. Georgia is one of 9 states where APRNs do not have Schedule II prescribing authority,[20] and many APRNs in Georgia choose not to have the authority to write prescriptions because of the burdensome supervision requirements involved. Among other limitations, a delegating physician must see an APRN's patients quarterly when that APRN writes prescriptions and must review all of those patients' charts.

Georgia statute also limits the situations in which APRNs can order radiographic imaging tests, such as MRIs, PET or CT scans, without a physician's authorization. APRNs who have been delegated this authority can only independently order such tests in life-threatening situations. These imaging tests are reported to the physician (the APRN is copied), and they must be interpreted by a physician. The exception is an ultrasound exam, which APRNs may order without the need for a physician's signature.

Physician Boards Have Authority

In more restrictive states, boards of medicine often have the ability to dictate rules that impact APRN practice. Boards of medicine, composed largely of physicians, have financial incentives to limit APRNs' practice autonomy and maintain control of the patient care market for physicians.[21] In Georgia, the Georgia Board of Nursing (GBN) and the Georgia Composite Medical Board (GCMB) have the statutory authority to promulgate rules that define the professional requirements and limitations of APRN practice. Georgia's current regulatory structure gives great authority to the GCMB, and this contributes to the restrictive nature of Georgia's APRN practice environment.

All nursing licensure, discipline and APRN authorization is regulated by the GBN. The GCMB is sanctioned by law to define the supervisory requirements for physicians who delegate prescriptive authority to APRNs, and they go further than the law requires in doing so.

According to the GCMB, a delegating physician must review:

- 100% of patient records for patients receiving prescriptions for controlled substances,
- 100% of patient records in which an adverse outcome has occurred, and
- 10% of all other patient records.

Physicians who delegate prescriptive authority to APRNs must submit their protocol agreements to the GCMB for initial review. The GCMB charges physicians a fee of $150.00 for each protocol agreement it reviews.[22]

At least 17 U.S. states allow nurse practitioners full practice autonomy, and that number could be as high as 19, depending on statutory interpretation.[23] Physician groups such as the American Medical Association and its local counterpart, the Medical Association of Georgia, actively oppose legislation that provides more legal autonomy and authority to APRNs. They cite concerns about patient safety because APRNs with master's degrees have spent less time receiving formal education, typically six years (a four-year undergraduate program and a two-year master's program) compared to physicians who usually receive somewhere from nine to twelve (four years in undergraduate education, four years in medical school, and a residency). However, research demonstrates that doctors' groups have little reason for concern.

Studies show that primary care provided by APRNs is as safe and effective as care provided by physicians. An influential 2010 Institute of Medicine (IOM) report entitled *The Future of Nursing* points to fifty years of evidence supporting this idea.[24] In October 2012, the respected journal *Health Affairs* published an article wherein the author conducted a "systematic review of 26 studies published since 2000" and found that "health status, treatment practices and prescribing behavior were consistent between nurse practitioners and physicians." The author also stated that patients of nurse practitioners were found to have greater satisfaction with their care. "Studies found that nurse practitioners do better than physicians on measures related to patient follow up; time spent in consultations; and provision of screening, assessment, and counseling services."[25]

For a number of reasons, Georgia's restrictive practice environment is unnecessary and overly burdensome on our healthcare economy. Physician supervision requirements in Georgia result in the expenditure of valuable provider time and costs that ultimately get passed on to consumers. In its 2010 report, the IOM urged the Federal Trade Commission (FTC) to investigate the role of nurse practitioners as primary care providers as well as state laws that create barriers to healthcare access and consumer choice.[26] Following its investigation, in March 2014, the FTC "urged state legislators and policymakers to consider" several principles when evaluating proposed changes to nurse practitioners' scope of practice.[27] These factors included the importance of consumer access to safe and effective healthcare and the consumer benefits that arise from increased competition among healthcare providers, especially in areas where there are primary care shortages and medically underserved populations. The FTC advocated nurse collaboration with other health care practitioners but stressed that this collaboration "does not

always require direct physician supervision."[28] The report proposes that allowing extensions to nurses' legal practice capabilities will increase competition and drive medical costs down.

METHODOLOGY

In addition to conducting an extensive review of existing literature and research, Georgia Watch interviewed APRNs, physicians, physician assistants, policymakers and professors from a variety of geographic areas and practice settings, including charitable care clinics, hospitals, private practices and retail health clinics. Georgia Watch greatly appreciated the cooperation of the Coalition for Advanced Practice Registered Nurses and the Medical Association of Georgia who communicated our request for interviews with their organizations' membership and contacts. Georgia Watch staff conducted extensive interviews with 10 APRNs, 5 physicians, 4 coalition or professional organization leaders, 1 legislator, 4 nursing professors, and 3 charitable care clinic representatives. Respondents represented both rural and metropolitan regions of the state, creating a diverse sampling of both perspective and practical experience. Respondents practiced in Atlanta, Warner Robins, Douglas, Vidalia, Gainesville, Millen, Macon, Sylvania, Jasper, Statesboro, Marietta and Austell. The views expressed by these key informant groups provided a more in-depth understanding of the field of practice and current challenges faced by APRNs and other providers in ensuring healthcare delivery to the state's residents.

KEY THEMES AND FINDINGS

We found that physicians and APRNs enjoyed working together in a collaborative environment. 100% of providers interviewed expressed appreciation for the atmosphere of teamwork and shared knowledge that collaboration requires. A Certified Nurse Midwife (CNM) that we spoke to said, "[without a doubt, I think it is best to work as a team." One physician acknowledged that Georgia's supervision requirements may be too restrictive but went on to applaud the existing structure because it "forces a degree of collaboration between the groups."

Opinions differed about whether Georgia's APRN practice environment is too restrictive. Two out of five physicians interviewed thought that Georgia's laws were sufficiently permissive. However, all APRNs felt that mandated supervision requirements, such as chart reviews, were unnecessary. Most APRNs felt that required supervision gives the impression that they are somehow beneath the physician or less qualified to provide care. This offends APRNs who may have been practicing in an area for many more years than their supervising physician. One APRN told us, "I find it offensive when they call me a mid-level provider. I am an APRN. I find it offensive when physicians are called my supervisor. There are many issues that I have with this because I have far more knowledge in some areas. We like the term 'collaborating physician' more."

When asked whether practice restrictions requiring APRNs to obtain a physician's signature on orders or prescriptions created additional wait times for patients and slowed down the provision of

care, all APRNs interviewed answered affirmatively. Some APRNs expressed difficulty locating delegating physicians when their signatures are needed. We found that physicians frequently sign orders and prescriptions without seeing the patient or making a detailed inquiry about the purpose. APRNs that we interviewed felt trusted to make decisions about diagnosis and treatment by their supervising physicians. "My role is to know my limits," said one of our APRN interviewees. "The notion that APRNs will not use the expert knowledge of other providers unless legally required to do so is silly."

In terms of chart reviews, we found that, in most cases, physicians are thoughtfully reviewing APRN patient charts for the appropriateness of the treatment based on the diagnosis. However, this review is typically conducted long after the patient has left the office. The obstetricians we interviewed expressed the importance of chart reviews to avoid malpractice liability. In hospitals, retail health clinics and other settings, we found that quality control mechanisms often exist that make physician oversight and chart reviews obsolete.

In terms of protocol agreements, we found that many practices simply use a template nurse protocol agreement with little additional thought in defining the parameters of the agreement. This template may be from a larger parent company, an educational institution or an organization like the GCMB. The GCMB provides an example nurse protocol agreement for family practice settings on its website, and it seems that many practices use this example agreement. We found that sometimes busy physicians ask the APRNs in their practices to draft their own agreements. However, in other offices, the initial drafting of the protocol agreement seems to be a thoughtful, collaborative process. Institutional settings, like hospitals, typically have internal protocol agreements that allow for little flexibility on the part of the entering parties.

POLICY RECOMMENDATIONS

APRNs in Georgia make safe and accurate decisions about patient diagnosis and treatment on a daily basis. Georgia Watch found that, despite legal requirements that exist on paper, physician supervision practices and internal policies vary widely. Georgia's existing regulatory framework for APRNs no longer reflects the realities of practice and is constraining the state's ability to make better use of healthcare workforce resources. Georgia Watch urges state policymakers to consider adopting the following four recommendations to better position the state to address current and future healthcare needs.

- **Grant APRNs full practice authority, which includes Schedule II prescriptive authority and the ability to order radiographic imaging tests, like MRIs and CT scans, in non-emergency situations.**
- **Ensure fair and impartial regulatory board oversight of APRNs.**
- **Improve access to care by mandating third-party coverage of APRN care and enabling patient choice in providers.**
- **Support the healthcare workforce pipeline by enabling more graduate level education and clinical training opportunities for nurses.**

Grant APRNs Full Practice Authority

Georgia could enable APRNs to better serve patients and potentially lower healthcare costs for consumers by granting APRNs the authority to practice to the full extent of their education and training. Georgia's physician supervision requirements cost money and time without any significant benefit for the consumer. The most important part of the medical decision-making, the in-person assessment of a patient's condition and diagnosis, is typically done by the APRN without a physician present. APRNs are also making determinations about appropriate medication and dosage, even if a physician's name ultimately ends up on the prescriptions. Physician names on patient prescriptions where APRNs are, in reality, making the treatment decisions misleads consumers and makes it difficult to trace back to the origin of the treatment decision. With the advent of the electronic medical record and email communication, physician authorization of APRN prescriptions and orders without thought or inquiry has become even easier and more common.

Thoughtful physician review of APRN decisions, if it is done at all, is usually done after the fact and not in real time, further supporting the general consensus that APRNs have sufficient ability and training to diagnose patients and determine appropriate treatment. If an APRN needs to consult with a physician or colleague in real time to determine the appropriate treatment or diagnosis for a patient they do so, not because a protocol agreement mandates it, but because their training and professional responsibility demand it. Physicians do not make good use of their valuable time when

they have to forward test results to the APRNs who actually ordered them, put their signature on prescriptions that have already been written, and review APRN charts out of obligation rather than necessity or interest. As the FTC points out, "[e]ach transaction to secure an agreement imposes costs on both the APRN and the physician."[29] Georgia Watch recommends that the state grant APRNs Schedule II prescriptive authority, legally sanction them to use their own professional judgment when ordering radiographic imaging tests, and eliminate unnecessary physician chart review and other supervision requirements.

Ensure Fair & Impartial Regulatory Board Oversight

The National Council of State Boards of Nursing (NCSBN) recommends that state boards of nursing alone have complete authority over nursing programs.[30] When boards of nursing or independent boards comprised of a variety of providers dictate practice requirements for APRNs, collaboration is encouraged and APRN practice is typically less restricted. Pennsylvania uses collaborative agreements for its nurse practitioners, which are approved through the Board of Nursing. In New York, collaborative agreements are supervised by the State Education Department.[31] By using boards that are not primarily comprised of physicians, these states present models for nurse collaboration that provide less incentives for restricting the practice of nurses.

In addition to outdated licensure limitations, Georgia's patchwork of practice authorization and dual regulatory board oversight has created a duplicative and costly system that lacks meaningful benefit for consumers or the healthcare delivery system. Georgia's current regulatory structure gives great authority to the GCMB, and this contributes to the restrictive nature of Georgia's APRN practice environment. Georgia Watch urges policymakers to ensure fair and impartial regulatory board oversight of advanced nursing practice in Georgia by granting the GBN complete authority over APRN practice in the state.

Increase Competition and Ensure Fair Reimbursements for APRN Services

The provider demographic is changing, and along with it, patient expectations for provider choice. As more Georgians obtain insurance coverage as a result of the Patient Protection and Affordable Care Act, it is important that they have the option to elect APRNs as their providers and have those services covered by their insurance. In Georgia, no statute mandates the third-party reimbursement of APRN services. Reimbursement rates for APRN services vary from state to state and insurer to insurer. Some insurance companies will not recognize, or "credential," APRNs as primary care providers and reimburse them accordingly for their services. Some states have laws requiring insurers to recognize APRNs as providers and reimburse them independently of physicians. In Georgia, some private insurers reimburse for APRN services.[32] Others require that nurse practitioners bill "incident to" an on-site delegating physician. Incident billing has its own set of rules and restrictions; one being that the physician has to see the patient at the first visit. This is burdensome and time-consuming for providers. Additionally, when an APRN must

bill incident to a physician, the service gets reimbursed at the physician rate, and the practice or facility can collect more for that visit. This ultimately increases costs for insurance companies and patients.

Expanding the use of APRNs and allowing them greater practice authority has the potential to save consumers and the government money by lowering the cost of care. In addition to increasing competition in the healthcare marketplace, APRN providers are routinely paid less than physicians when their services are independently reimbursed. Medicare reimburses APRN services at 85 percent of the physician fee schedule amount for the same primary care services, even though the Medicare Payment Advisory Commission found that there was "no specific analytical foundation" for this discrepancy.[33,34] Family NPs, Pediatric NPs, OB/GYN NPs, CNMs and CRNAs are eligible for Medicaid reimbursement from the Department of Community Health in Georgia, but the reimbursement rates vary. NPs and CRNAs are reimbursed at 90% of a physician's rate, and CNMs are reimbursed at 100% (a recent increase from 95%) of a physician's payment.

Georgia Watch does not advocate that APRNs should receive less pay for equal services. Instead, Georgia Watch believes that consumers should have the option to select a nurse practitioner as their provider and that third-party payers should be required to reimburse for that care fairly. Such policies would increase competition and incentivize APRNs to practice in Georgia. Georgia Watch urges policymakers to require third-party insurers to credential APRNs as primary care providers and reimburse them fairly for their services.

Ensure Graduate Nursing Opportunities

Georgia is facing a serious shortage of healthcare professionals that threatens the quality and availability of healthcare in our state, and our restrictive regulations are not attracting graduate nursing students to study and practice here.[35] Georgia has the 8th largest number of APRNs in the nation, but due to the vast size of the state, only ranks 38th in the number of nurse practitioners relative to the population.[36] There are 50 nurse practitioners per 100,000 Georgians, but there is potential to improve that ratio in the near term through improved licensure laws and investments in graduate nursing programs and clinical training opportunities.[37] In 2010, 15 master's level nursing programs and 7 doctorate programs (with more in development) existed in Georgia.[38] Georgia schools graduated 362 master's level nurses and 36 doctoral level students in the 2007-2008 academic year.[39] Despite the recent growth of graduate nursing programs, more work is needed to encourage Georgia nurses to obtain graduate degrees so that they can practice as APRNs and teach in graduate level programs in our state. Georgia Watch encourages policymakers to support graduate nursing education by funding nursing faculty development, APRN scholarship, service-based loan repayment programs and community clinical site investments.

CONCLUSION

APRNs serve a wide array of patient populations in all types of healthcare settings. To further support the policy recommendations included in this paper, Georgia Watch suggests additional research specifically focused on how APRNs are meeting the needs of underserved patient populations in Georgia and how this element of the healthcare workforce can be used to expand access to healthcare in rural parts of the state. As more Georgians obtain insurance coverage as a result of the Patient Protection and Affordable Care Act, it is important that they have the option to elect APRNs as their providers. Georgia Watch urges state policymakers to consider adopting the following four recommendations to better position the state to address current and future healthcare needs.

POLICY RECOMMENDATIONS

- Grant APRNs full practice authority, which includes Schedule II prescriptive authority and the ability to order radiographic imaging tests, like MRIs and CT scans, in non-emergency situations.
- Ensure fair and impartial regulatory board oversight of APRNs.
- Improve access to care by mandating third-party coverage of APRN care and enabling patient choice in providers.
- Support the healthcare workforce pipeline by enabling more graduate level education and clinical training opportunities for nurses.

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APPENDIX A

APRN LICENSING & EDUCATION

Georgia authorizes as APRNs those who meet the Georgia Board of Nursing's (GBN) criteria. That authorization must be renewed every 2 years, at the same time a Registered Nursing (RN) license is renewed. Applicants wishing to possess an APRN authorization from the State of Georgia must: hold an active Georgia RN license, hold a master's or other graduate degree approved by the GBN (unless they were recognized as an APRN by the GBN prior to June 30, 2006), submit employment verification documenting 3 months (500 hours) of APRN practice (or proof of graduation from an approved nursing program within 4 years immediately preceding the date of application) and provide verification of active national certification in an area of specialty.[1] The GBN recognizes the following national certification bodies: The American Midwifery Certification Board; American Academy of Nurse Practitioners; National Certification Corporation; Pediatric Nursing Certification Board; National Board on Certification and Recertification of Nurse Anesthetists; American Nurses Credentialing Center; and the American Association of Critical-Care Nurses Certification Corporation.[2]

CERTIFIED NURSE PRACTITIONERS, or NPs, are the largest group of APRNs in Georgia with **6,793** active licensees. NPs practice in primary and acute care pediatrics, acute care adult health and gerontology, primary care adult health and gerontology, and psychiatric and mental health. NP programs provide very specialized training in many areas of medical science, including professional leadership. NPs must maintain their Georgia RN license with NP authorization and certification in their area of specialty. Recertification through a national certifying body typically must be done every five years and requires the completion of minimum practice hours and continuing education classes. NPs in Georgia are essential to the non-physician primary care provider workforce.

CERTIFIED REGISTERED NURSE ANESTHETISTS, or CRNAs, are the second largest group of APRNs with **1,865** active licenses. CRNAs administer anesthesia under the direction and responsibility of a duly licensed physician.[3] CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms, hospitals, ambulatory surgical centers, and the offices of dentists, podiatrists, ophthalmologists, plastic surgeons and pain management specialists.[4] CRNAs provide anesthesia services and related care in four general categories: preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; perianesthetic and clinical support; and postanesthesia care.[5] CRNAs in Georgia must have an advanced nursing degree, unless they graduated from an approved nurse anesthetist educational program prior to January 1, 1999, and be certified by The Council on Certification of Nurse Anesthetists. CRNAs are governed by a different statute than other APRNs and do not have prescriptive authority in

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CERTIFIED NURSE MIDWIVES, or CNMs, provide a full range of women's health services, including prenatal and labor and delivery care. CNMs often work as part of a team with obstetricians who can be consulted when necessary. Many women choose to receive their prenatal care from a midwife because they prefer a provider with a more holistic approach to the birthing process. Research shows that births attended by midwives usually have fewer interventions, such as labor induction, epidurals, cesarean sections, episiotomies and the use of forceps and vacuums.[7] CNMs must graduate from a program that is accredited by the Accreditation Commission for Midwifery Education (ACME). To maintain the designation of CNM, midwives must be recertified every 5 years by the American Midwifery Certification Board (AMCB). There are **494** licensed CNMs in Georgia. Emory University's Nell Hodgson Woodruff School of Nursing has the only ACME accredited midwifery program at an educational institution in Georgia.

CLINICAL NURSE SPECIALISTS, or CNSs, specialize in a wide variety of clinical areas, but are trained with a particular focus on influencing patient outcomes through health systems improvement. Although CNSs do provide direct patient care, they primarily serve in a patient education, consultative, or management function. CNSs typically practice in a hospital setting and are often engaged in programs to increase patient safety or the cost-effectiveness of care.[8] There are only **116** licensed CNSs in Georgia. CNSs do not have prescriptive authority in Georgia. CNSs must graduate from a program that is accredited by the Commission on Collegiate Nursing Education or the Accreditation Commission for Education in Nursing, but beginning January 2016, the American Nurse Credentialing Center will no longer recognize any CNS accredited specialties.

CLINICAL NURSE SPECIALIST/PSYCHIATRIC MENTAL HEALTH, or CNS-PMH, is a mental health provider with prescriptive authority in Georgia. These providers are skilled in therapeutic interventions, diagnosis and managing medications. Beginning January 2016, the American Nurse Credentialing Center will no longer recognize CNS-PMH as an accredited specialty. It is being replaced with the Psychiatric Mental Health Nurse Practitioner. This change in APRN education and credentialing is due to a recognition that APRNs treating patients for mental health diagnoses often need to perform physical exams and manage other chronic conditions. Only 2 Georgia schools have Psychiatric Mental Health Nurse Practitioner programs: Georgia State University and Valdosta State University. Georgia Regents University offers a post-master's certificate program. There are currently only **283** licensed CNS-PMH APRNs in Georgia.

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APPENDIX B

STATUTORY FRAMEWORK & LEGISLATIVE HISTORY[1]

APRNs in Georgia must be supervised by a physician who "delegates" or grants an APRN the authority to perform certain medical acts, which can include diagnosing patients, ordering tests and writing prescriptions. All APRNs in Georgia must be supervised by a licensed physician with whom they are required to have a protocol agreement. The protocol agreement is a written document detailing the delegated practice of the APRN and responsibilities of the physician who are parties to that agreement. The boundaries of that protocol agreement are determined by statute.

Physicians may delegate the authority to perform certain medical acts to APRNs under one of two Georgia statutes within the Medical Practice Act of the State of Georgia (Medical Practice Act): O.C.G.A. § 43-34-23 and O.C.G.A. § 43-34-25. APRNs practicing under either statute must have a protocol agreement with a supervising physician. However, only physicians who delegate authority to APRNs under O.C.G.A. § 43-34-25 must submit their protocol agreements to the Georgia Composite Medical Board (GCMB) for approval.

O.C.G.A. § 43-34-23, often referred to as the "**old nurse protocol statute**," was enacted in 1989 as part of the Medical Practice Act.[2] It allows physicians to delegate certain acts, such as ordering controlled substances, medical treatments and diagnostic studies, to APRNs in accordance with a written nurse protocol agreement. It empowers the GCMB to promulgate rules and regulations governing physicians who delegate authority under nurse protocols.[3] It does not allow physicians to delegate to APRNs the authority to issue written prescriptions. Under this statute, nurses can call in orders for tests and medications under a physician's name but cannot independently write prescriptions.

O.C.G.A. § 43-34-25, often referred to as the **"prescriptive authority statute"** was enacted in 2006 as part of the Medical Practice Act. This statute allows physicians to delegate the authority to independently write prescriptions for medications and some controlled substances to APRNs. Although it specifically allows for the delegation of prescriptive authority, this statute prohibits APRNs practicing under it from ordering radiographic imaging tests outside of life-threatening situations. It also creates more rules for nurse protocol agreements and requires that nurse protocols under this statute be submitted to the GCMB for review and approval.

Many APRNs continue to practice under the earlier 1989 protocol statute, O.C.G.A. § 43-34-23, and simply call in orders under a physician's name without prescriptive authority because the protocol statute from 2006 contains burdensome and difficult supervisory requirements for physicians and APRNs.

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APRNs practice under one of two Georgia statutes:	
Old Nurse Protocol Statute O.C.G.A.§ 43-34-23	**Prescriptive Authority Statute** O.C.G.A. § 43-34-25
• Enacted in 1989 • APRNs cannot write prescriptions • APRNs practicing under this statute call in orders under a physician's name • No GCMB review of nurse protocol agreement with supervising physician • No required physician review of APRN charts	• Enacted in 2006 • APRNs can write prescriptions for Schedule III, IV and V drugs • APRNs can order radiographic imaging tests, such as MRIs and CT scans, but only in life-threatening situations • Nurse protocol agreements must be submitted to the GCMB for review • Supervising physicians must periodically review APRN patient charts • Supervising physicians must see APRN patients quarterly if controlled substances are prescribed

RECENT LEGISLATIVE HISTORY

SENATE BILL 480

In 2006, the Georgia Legislature passed Senate Bill 480 despite opposition from the Medical Association of Georgia and other physician groups. Senate Bill 480 is probably most significant for granting prescriptive authority to APRNs.[4] Georgia was one of the last states in the U.S. to give prescriptive authority to APRNs, 34 years after the first state to do so, Idaho. A similar bill had been introduced in the Georgia Legislature each year since at least 1994.[5] Senate Bill 480 created O.C.G.A. § 43-34-25 but did not repeal the old protocol statute, O.C.G.A. § 43-34-23. Thus, APRNs in Georgia may practice under one of two statutes.

In addition to granting prescriptive authority to APRNs, Senate Bill 480 included language requiring APRNs to have a master's or other graduate degree and created additional restrictions and requirements for physicians delegating authority to APRNs in nurse protocol agreements. As is common during the legislative process, the APRN language in this bill was added as an amendment after all other APRN prescriptive authority bills had been defeated. The bill ultimately passed with overwhelming majority in both Senate and the House of Representatives.

While the bill gave APRNs the ability to register with the federal Drug Enforcement Administration for a prescribing license, it specifically excluded Schedule I and II controlled substances and abortion inducing agents from APRNs' prescriptive authority. Although the bill was a victory for APRNs because it granted at least some prescriptive authority, it also included

some language that was problematic. It amended the Medical Practice Act and not the Nurse Practice Act and required that protocol agreements written under this statutory authority be submitted to the GCMB annually for review and approval. Thus, the GCMB gained some indirect authority over APRN practice by dictating the requirements of nurse protocol agreements submitted under this statute by a delegating physician.

The bill also restricted APRNs' ability to order radiographic imaging tests outside of life-threatening situations. Orders for CT, MRI, PET and nuclear medicine under this statute require a physician's signature, unless the need for the test is urgent because the patient's situation is life-threatening. Other key provisions of the bill regarding delegation of physician authority and nurse protocol agreements require that:

- the protocol agreement "be between an APRN who is in a comparable specialty area or field as that of the delegating physician;"[6]
- the delegating physician's primary practice be in Georgia or within 50 miles of where the APRN is practicing;
- the protocol agreement contain a provision for immediate consultation and provide for an alternative physician to consult if the delegating physician is unavailable;
- a patient who receives a prescription drug order pursuant to a nurse protocol agreement be evaluated or examined by the delegating physician at least quarterly;
- the protocol agreement include a schedule for periodic review by the delegating physician of patient records.

The bill also restricts a physician from being an employee of an APRN if the physician is responsible for supervising that APRN. This restricts APRNs from running practices and employing physicians to supervise their work. It also limits the ratio of supervising physicians to nurse practitioners to 4 to 1 (with exceptions for some settings including hospitals, free health clinics and universities).

In Senate Bill 480, the definition of "advanced practice registered nurse" was modified to include the requirement of a "master's degree or other graduate degree."[7] Those recognized as an APRN by the Board prior to June 30, 2006, were grandfathered in. The following year, in 2007, CRNAs who graduated from an approved nurse anesthetist program prior to January 1, 1999 were also grandfathered in.

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HOUSE BILL 303

In 2011, APRNs achieved a legislative victory with House Bill 303.[9] This bill passed both houses with overwhelming support from physician groups and APRNs. It amended the Medical Practice Act to give APRNs and physician assistants the authority to sign certain patient forms without the need for a physician's stamp or co-signature, examples include sports physicals, Department of Motor Vehicles disability tag applications and verification and evaluation forms for various State boards and departments.[10] There is an exception for death certificates and the assignment of a percentage of disability for workman's compensation claims.[11] It also simplified the previously onerous process for advanced practice providers to distribute medication samples to patients.[12]

MOST RECENT EFFORTS

Recent legislative efforts to give APRNs the ability to order radiographic imaging tests in non life-threatening situations have been unsuccessful. Senate Bill 386 was introduced during the 2011-2012 legislative session. It passed the Senate in 2012 over objections from the Georgia Radiological Society and the Medical Association of Georgia (MAG). It stalled in the House Health and Human Services Committee. It was reintroduced as Senate Bill 94 during the 2013-2014 legislative session with additional sponsors. The bill again passed the Senate and stalled in the House Health and Human Services Committee.

REGULATING BOARDS

GEORGIA BOARD OF NURSING (GBN)

The laws governing nursing practice are contained in the Georgia Registered Professional Nurse Practice Act (Nurse Practice Act). The Nurse Practice Act gives the Georgia Board of Nursing (GBN) the authority to license APRNs who have obtained the requisite education, practical experience and certifications in their areas of expertise.[13] All nursing licensure, discipline and APRN authorization is regulated by the GBN. The GBN promulgates rules and regulations for APRN practice and has authority over nurse protocol agreements falling under the old nurse protocol statute, O.C.G.A. § 43-34-23.

The GBN is made up of thirteen Governor-appointed members including "two registered nursing educators, one practical nursing educator, two registered nurses employed in nursing service administration, one registered nurse employed in nursing home administration or nursing service administration, two advanced practice registered nurses, one additional registered nurse, three licensed practical nurses, and one consumer member.[14]

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This membership falls within the recommendations set forth by the National Council of State Boards of Nursing ("NCSBN").[15]

On July 1, 2014, HB 315, the General Appropriations Act, took effect. This act calls for the Office of the Secretary of State to "ensure the quality of the nursing profession by requiring nurses, hospitals and other employers of nurses to report if there is reasonable cause to believe a nurse is in violation of their license."[16] This act expands the GBN by nine new positions, which include two nursing consultants, four complaint/compliance officers, and three investigators. The Secretary of State has also reallocated two existing staff members that now exclusively serve the Nursing program to assist with renewals and registrations of licenses.[17] This act was a welcome and much-needed expansion of the GBN's capacity.

GEORGIA COMPOSITE MEDICAL BOARD (GCMB)

The GCMB licenses physicians, physician assistants, resident physicians, respiratory care professionals, perfusionists, orthotists, prosthetists, acupuncurists and pain management clinics. The GCMB also dictates the requirements for nurse protocol agreements utilized by physicians wishing to delegate prescriptive authority to APRNs. The GCMB is comprised of sixteen members appointed by the Governor and confirmed by the State Senate. By statute, two members are consumer members, one is a physician assistant (and is an ex-officio member), two are physicians with Doctor of Osteopathy degrees, and eleven are physicians with Doctor of Medicine degrees.[18]

The GCMB reviews nurse protocol agreements that grant prescriptive authority and fall under O.C.G.A. § 43-34-25. These protocol agreements must be approved by the GCMB and reviewed annually by their physician and nurse practitioner parties.[19] The 2006 prescriptive authority statute generally requires periodic review of patient records, but the GCMB rules go further in defining that obligation. According to the GCMB, the supervising physician must review:

- 100% of patient records for patients receiving prescriptions for controlled substances,
- 100% of patient records in which an adverse outcome has occurred, and
- 10% of all other patient records.

The GCMB charges physicians a fee of $150.00 for each protocol agreement it reviews.[20] Although the requirement exists that these protocol agreements be reviewed and, if necessary, updated annually, parties need not submit updated protocols to the GCMB. Providers must simply make them available to the GCMB upon request.

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Georgia Watch
55 Marietta Street, NW, Suite 903
Atlanta, GA 30303

www.georgiawatch.org