South Carolina Coalition for Access to Healthcare Representing over 2000 SC NPs and CNMS

SUPPORT Senate Bill 553 NOW

THE HEALTH CARE PROBLEM:

- South Carolina ranks 41st in the nation in the United Health Foundation's health report card for 2022 [1].
- BUT as one influencing factor after the scope of practice for NPs and CNMs was changed in 2018, access to primary care improved from 41 to 37 [1].
- The March of Dimes has awarded SC a grade of "F" indicating the state of maternal health is worsening [2].
- SC has the 8th highest rate of maternal deaths among all 50 US states. Maternal death rates for women of color in SC are twice those of white women [3].
- SC has the 4th highest rate of preterm births among all 50 US states. The average first year of medical costs for one preterm birth is $49,140 compared with one birth at term ($13,024) [4].
- AHEC Data Workforce indicate that NPs are maintaining primary care in non-metropolitan areas [10].
- South Carolina is in crisis as we face a continued critical shortage of primary health care physicians.
- Parts or all of 46 counties in South Carolina are designated as medically underserved by the South Carolina Department of Health and Human Services and DHEC.
- The American Association of Medical Colleges Center for Workforce Studies predicts that there will be a shortage of about 63,000 physicians by 130,600 by 2025. SC Ranks 43th in nation in primary care physicians supply. [7]

APRN AND ACCESS TO CARE:

- Workforce studies predict severe physician shortages within the next few years particularly in primary care.
- 70-80% of all Advanced Practice Registered Nurses (APRNs) provide primary care in SC. [2]
- Enrollment in nurse practitioner programs is growing each year in South Carolina. Currently there are over 400 Advanced Practice Registered Nurses (APRNs) enrolled in our state's educational programs.
- The Veterans Administration will enact full practice authority for APRNs January 9, 2017 in order to increase access to care for veterans [11].
- 100% of Nurse Practitioners and Certified Nurse-Midwives are providing care to underserved populations (LLR, Board of Nursing). [12]

APRN EFFECTIVENESS AND SAFETY:

- Numerous studies in the last decade have been published documenting the critical role APRNs play in providing cost-effective, safe, and high quality care. The most recent meta-analysis in 2011, documented quality patient outcomes related to APRN care. [3]
- There is an increased satisfaction with APRN care and lower costs associated with educating APRNs. [4]
- On average, NPs and CNMs who receive their master's degree have spent 4-5 years in clinical training by the time they are awarded their degree. NPs and CNMs who are enrolled in a Doctor of Nursing Practice (DNP) program often have 6-7 years of clinical training by the time they finish their formal education and remain life-long learners through continuing education, credentialing, and relicensure.
- Community birth centers have demonstrated excellent outcomes for women with low-risk pregnancies using the midwifery model of care resulting in shorter labors, fewer cesarean births, fewer costly interventions, newborns with high Apgar scores, and high rates of patient satisfaction. [13]

NATIONAL RECOMMENDATIONS AND FINDINGS:

- The Macy Foundation, the National Health Policy Forum, AARP, and most notably, the Institute of Medicine (IOM) have recommended that nurses should practice to the full extent of their education and training.
- The IOM's most recent report, *The Future of Nursing: Leading Change, Advancing Health*, issues a key message to policy makers and the public that "nurses should practice to the full extent of their education and training." The first recommendation under this key message is that "scope of practice barriers should be removed." [5]
- The National Governors Association (NGA) recently released a paper titled *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care.* The NGA a "bipartisan organization of the nation's governors— concluded that "NPs may be able to mitigate projected shortages of primary care services. Expanded utilization of NPs has the potential to

increase access to health care, particularly in historically underserved areas." [6, p. 11]

- Two recent rulings by the Federal Trade Commission (FTC) call for state legislatures to adopt less restrictive regulatory models that permit APRNs to practice without unnecessary physician supervision.
- The FTC ruled that "The IOM noted state twenty states and the District of Columbia allow APRNs to practice and prescribe independently, and there were no differences in safety and quality between states with restrictive scope of practice laws and regulations, and those that allow APRNs to practice independently, including prescribing medications without an agreement with a physician." [8] [9]
- In states where practice barriers have been removed, approximately 50 percent of nurse practitioners choose to work in rural areas or with underserved populations.
- In those states where practice barriers have been removed, physicians' incomes have not been decreased or compromised by allowing nurses full scope of practice. [10]

SOUTH CAROLINA APRN BARRIERS THAT IMPOSE A BURDEN TO PRACTICE AND IMPEDE ACCESS:

- Restricting APRN scope of practice in South Carolina by requiring physician collaboration is in direct conflict with the educational system and Federal Trade Commission that state NPs should practice independently to conduct patient evaluations, diagnose, order and interpret diagnostic tests, initiate and monitor treatments, as well as write prescriptions.
- In South Carolina APRNs must practice in collaboration with physicians. In 2018, the scope of practice was changed to removed supervision and as a result, NPs and CNMS are maintaining primary care in non-metropolitan areas. But we can do more to improve access to care and outcomes by removing this last barrier to require that APRNs must practice in collaboration with physicians. 26 states have full practice authority with NO physician collaboration or supervision.

WHAT NEEDS TO BE DONE:

1. **Legislative action must remove barriers to advanced practice nursing in order to increase access and reduce health care costs. Remove barriers NOW and institute Full Practice Authority, which impedes APRNs' ability to provide care to all people in the state.**

Authorizing APRNs to practice to the fullest extent is right thing to do for increasing access to care and reducing costs.
NOW is the right time for change.

References:

[1] United Health Foundation. allstatesummaries-ahr22.pdf (americashealthrankings.org).

[2] March of Dimes Report Card. https://www.marchofdimes.org/report-card

[3] South Carolina Maternal Morbidity and Mortality Review Committee. https://scdhec.gov/sites/default/files/media/document/2021SCMMMRCLe

[4] March of Dimes Peristats – Preterm Birth. https://www.marchofdimes.org/peristats/data?reg=99&top=3&stop=362&lev=1&slev=1&obj=1

[2] Naylor, MD, Kurtzman, ET. (2010)The Role of Nurse Practitioners In Reinventing Primary Care. Health Affairs 29. 5 (May 2010): 893-9.

[3] Newhouse RP et al., (2011). Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review. *Nursing* Economics 29(5).

[4] Safriet, BJ. (1992). "Health Care Dollars & Regulatory Sense: The Role of Advanced Practice Nursing," Yale Journal on Regulation, 426-40.

[5] IOM report (2010). http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

[6] National Governors Association. (2012). The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care. Washington, DC. accessed from, http://www.nga.org/cms/home/nga.

[7] Leveraging Graduate Medical Education to Increase Primary Care and Rural Physician Capacity in SC. GME Advisory Group Report in response to Proviso 33.34E, 2014.

[8] Federal Trade Commission, 2014. Competition and Regulation of Advanced Practice Nurses.

[9] Supreme Court of the US. NC State Board of Dental Examiners versus Federal Trade Commission. Feb 2015, #13-534.

[10] Federal Trade Commission issues an advisory opinion that says House Bill 3078 will expand access. House Bill 3508 impedes access and is restraint of trade (November 2015).

[11] Veterans Full Practice Authority for APRNs ruling. https://federalregister.gov/d/2016-29950.

[12] AHEC Data Workforce 2022.

[13] Sonenberg A. Maternity care deserts in the US. *JAMA Health Forum*. 2023; 4(1):e225541.

APRN Liability Insurance

NPs, CNMs and CNS can purchase liability insurance (occurrence) either through SC Medical Malpractice Association (formerly the JUA) or Marsh.

Cost is $1400-$2362 per year, depending on part time or full time and specialty focus area of practice (family, women's health, pediatrics for example).

https://www.proliability.com/

https://scmma.net/

NOTE: Physicians increase their exposure for vicarious liability when assuming full accountability in team care. That is why it is important for all professionals to be independently licensed, even though health professionals work together in teams.

Changing the Nurse Practice Act: What does it mean? And Why Change the Nurse Practice Act?

Senate Bill 553 for APRN (NP, CNM, CNS) Proposed Changes. New language is underlined and old language is ~~stricken~~ through	Rationale
"Advanced Practice Registered Nurse" or "APRN" means a registered nurse who is prepared for an advanced practice registered nursing role by virtue of additional knowledge and skills gained through an advanced formal education program of nursing in a specialty area that is approved by the board. The categories of APRN are nurse practitioner, certified nurse-midwife, clinical nurse specialist, and certified registered nurse anesthetist. An advanced practice registered nurse shall hold a doctorate, a post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing. APRNs must achieve national certification within two years post-graduation. An APRN ~~may perform~~ who holds a valid, full practice license may practice within the full scope of practice as defined in this section, including but not limited to, those activities considered to be the practice of registered nursing or advanced practice consisting of nonmedical acts, such as population health management; quality improvement or research projects within a health care system; ~~and~~ analysis of data and corresponding system recommendations, revisions, developments, or informatics; and other specified medical acts, including but not limited to, those provided in 40-33-34 and those allowed pursuant to federal law. ~~. An APRN also may perform specified medical acts pursuant to a practice agreement as defined in item (45).~~	**APRNs as defined by the National Council of State Boards of Nursing (NCSBN) are fully licensed and practice within their scope of practice and include federal laws that authorize acts such as ordering home health, diabetic shoes, durable medical equipment, etc. This language brings the Nurse Practice Act in alignment with National Council State Boards of Nursing that regulate APRNs,** **NP = Nurse Practitioner** **CNM = Certified Nurse Midwife** **CNS = Clinical Nurse Specialist** **https://www.ncsbn.org/** **https://www.nursingworld.org/certification/aprn-consensus-model/** **Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives. ACNM Board of Directors, December 2021.** **http://www.midwife.org/default.aspx?bid=59&cat=2&button=Search** **The National Council of State Boards of Nursing fully endorse Full Practice Authority for NPs, CNMs, and CNSs.** **2012_APRN_Model_and_Rules.pdf (NCSBN)**
~~6) "Agreed to jointly" means the agreement by the Board of Nursing and Board of Medical Examiners on medical acts that nurses perform and that must be defined in a practice agreement pursuant to item (45)~~	**National Council State Boards of Nursing (NCSBN) supports that Nursing regulate Nursing. No need for Board of Medicine to regulate or agree to APRNs scope of practice. This means that all providers and staff work together as a team, but professionals are licensed independently of each other based on credentials and education.** **This language brings the SC Nurse Practice Act in alignment with the National Council of State Boards of Nursing proposed rules and regulations.**

	https://www.ncsbn.org/ **https://www.nursingworld.org/certification/aprn-consensus-model/** **2012_APRN_Model_and_Rules.pdf (NCSBN)**
(11) "Authorized licensed provider" means a provider of health care services who is authorized to practice by a licensing board in this State where the scope of practice includes authority to order and prescribe drugs or therapy in treating patients.	**Therapy means interventions such as respiratory treatments (cystic fibrosis treatments), physical therapy, occupational therapy, counseling for domestic violence, abuse, or molestation, etc.**
(18) "Certified Nurse-Midwife" or "CNM" means an advanced practice registered nurse who holds a ~~master's~~ graduate degree in the specialty area, maintains an American Midwifery Certification Board certificate, and is trained and competent to provide management of women's health care from adolescence beyond menopause, focusing on gynecologic and family planning services, preconception care, pregnancy, childbirth, postpartum, care of the normal newborn during the first twenty-eight days of life, and the notification and treatment of partners for sexually transmitted infections. A CNM shall have full practice authority once he obtains a valid, active South Carolina license as an advanced practice registered nurse according to the provisions of this chapter.	**Added graduate degree to clarify that CNMs must graduate with a masters and/or doctoral degree. Added full practice authority to be consistent with National Council State Boards of Nursing definitions scope of practice for CNMs. The National Council of State Boards of Nursing fully endorse Full Practice Authority for CNMs.** **https://www.ncsbn.org/** **https://www.nursingworld.org/certification/aprn-consensus-model/** Midwifery as practiced by certified nurse-midwives (CNMs) encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. **http://www.midwife.org/default.aspx?bid=59&cat=2&button=Search** Midwifery care includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. These services are provided in partnership with individuals and families in diverse settings such as ambulatory care clinics, private offices, telehealth and other methods of remote care delivery, community and public health systems, homes, hospitals, and birth centers. **http://www.midwife.org/default.aspx?bid=59&cat=2&button=Search**

	Although ACNM endorses a minimum of a master's degree as basic preparation for midwifery practice, it recognizes the need to develop competencies for midwifery education at the doctoral level and supports a variety of doctoral degree options for midwives. Doctoral education competencies include leadership, population health, health systems, policy and data analysis, information technology, and scholarship and dissemination.**http://www.midwife.org/default.aspx?bid=59&cat=2&button=Search** ACOG respects a pregnant person's right to make a medically informed decision about their birth attendant and place of delivery and believes hospitals and licensed, accredited birth centers are the safest setting for birth. ACOG supports the standards used by the American Midwifery Certification Board (AMCB) which credentials certified nurse-midwives (CNM). ACOG's Joint Statement of Policy with the American College of Nurse-Midwives supports CNMs practicing to the full extent of their credential, training, and experience. **The American College of Obstetricians and Gynecologists, affirmed, 2018**
(20) "Clinical Nurse Specialist" or "CNS" means an advanced practice registered nurse who is a clinician with a high degree of knowledge, skill, and competence in a practice discipline of nursing. This nurse shall hold a ~~master's~~ graduate degree in nursing, with an emphasis in clinical nursing. These nurses are directly available to the public through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. ~~A CNS who performs medical acts is required to have physician support and to practice pursuant to a practice agreement as defined in item (45). A CNS who does not perform medical acts is not required to have physician support or to practice pursuant to a practice agreement as provided in Section 40-33-34.~~A CNS shall have full practice authority once he obtains a valid, active South Carolina license as an advanced practice registered nurse according to the provisions of this chapter.	**Added graduate degree to clarify that CNSs must graduate with a masters and/or doctoral degree. Added full practice authority to be consistent with National Council State Board of Nursing definitions scope of practice for CNSs.** **The National Council of State Boards of Nursing fully endorse Full Practice Authority for CNSs.** **https://www.ncsbn.org/** **https://www.nursingworld.org/certification/aprn-consensus-model/** **2012_APRN_Model_and_Rules.pdf (NCSBN)**
(40) "Nurse Practitioner" or "NP" means a registered nurse who has completed an advanced formal graduate education program at the master's level or doctoral level acceptable to the board, and who demonstrates advanced knowledge and skill in assessment and	**Added graduate degree to clarify that NPs must graduate with a masters and/or doctoral degree. Added full practice authority to be consistent with National Council State Board of Nursing definitions scope of practice for NPs.**

management of physical and psychosocial health, illness status of persons, families, and groups. ~~Nurse practitioners who perform medical acts must do so pursuant to a practice agreement as defined in item (45).~~ A NP shall have full practice authority once he obtains a valid, active South Carolina license as an advanced practice registered nurse according to the provisions of this chapter.	**Need to add back in:** A NP shall have full practice authority once he obtains a valid, active South Carolina license as an advanced practice registered nurse according to the provisions of this chapter. **The National Council of State Boards of Nursing fully endorse Full Practice Authority for NPs.** **https://www.ncsbn.org/** **https://www.nursingworld.org/certification/aprn-consensus-model/** **2012_APRN_Model_and_Rules.pdf (NCSBN)** Doctoral education competencies include leadership, population health, health systems, policy and data analysis, information technology, and scholarship and dissemination.
(68) "Full practice authority" means a NP, CNM, or CNS who is also licensed as an APRN by the South Carolina Board of Nursing to practice within the full scope of practice including ordering and interpreting diagnostic procedures; conducting an advanced assessment; providing a diagnosis; prescribing, ordering, administering, and dispensing therapeutic measures and pharmacological agents, including over-the-counter, legend, and controlled substances medications; delegating and assigning therapeutic measures to assisting personnel.	**Added full practice authority to be consistent with National Council State Board of Nursing definitions for full practice authority and scope of practice for NPs, CNS, and CNMs. This means that all providers and staff work together as a team, but professionals are licensed independently of each other based on credentials and education.** **This language brings the SC Nurse Practice Act in alignment with the National Council State Boards of Nursing rules and regulations.** **https://www.ncsbn.org/** **2012_APRN_Model_and_Rules.pdf (NCSBN)** **https://www.ncsbn.org/public-files/presentations/2020AM-APRN.pdf** **https://www.nursingworld.org/certification/aprn-consensus-model/** **https://www.midwife.org/full-practice-authority-stad**

	Currently, the Veterans Administration and across the country and 27 states have Full Practice Authority (FPA) for NPs, CNMs, and CNS: Alaska, Arizona, Colorado, Connecticut, Delaware, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Vermont, Washington, and Wyoming are full practice authority states. **The VA in SC has Full Practice Authority!!** **ACOG supports the standards used by the American Midwifery Certification Board (AMCB) which credentials certified nurse-midwives (CNM). ACOG's Joint Statement of Policy with the American College of Nurse-Midwives supports CNMs practicing to the full extent of their credential, training, and experience.** **The American College of Obstetricians and Gynecologists, affirmed 2022. Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse-Midwives, affirmed 2022.** **The Department of Veterans Affairs (VA) has passed a rule allowing three types of advanced practice registered nurses (APRNs)—certified NPs, clinical nurse specialists, and certified nurse midwives (CNMs)—to practice to "the full extent of their education, training, and certification" without physician supervision. The rule applies throughout the VA's national network of medical centers, and takes precedence over individual state laws regulating the scope of APRN practice.** **Sofer, D. AJN, American Journal of Nursing 117(3):p 14, March 2017. | DOI: 10.1097/01.NAJ.0000513271.43979.37** **According to AHEC Data Workforce, the Nurse practitioner (NP) workforce is maintain and "saving" access to primary care in SC, especially in rural areas, underserved areas, and non-metropolitan areas. According to the 2021 SC Health Professions Data Book* 2019, there were:** ○ 22 counties with fewer than 3 active family practice physicians per 10,000 population. ○ 14 counties with Zero (NONE) active Ob-Gyn physicians. ○ 10 counties with fewer than 3 active OB-GYN physicians per 10,000 women ages 15-44. ○ 10 counties with Zero (NONE) active pediatrics physicians per 10,000 population ages 0-17.

	○ 7 counties with fewer than 3 active pediatrics physicians per 10,000 population ages 0-17. ○ 17 counties with Zero (NONE) active general psychiatry physicians. ○ 27 counties with fewer than 3 active general psychiatry physicians per 10,000 population. **https://www.scahec.net/scohw/reports**
(C)(1) A licensed nurse practitioner, certified nurse-midwife, or clinical nurse specialist ~~must provide evidence of a practice agreement, as provided in this section. A licensed NP, CNM, or CNS~~ must spend a portion of his time practicing in an underserved or rural area or serving an underserved population as defined in Section **40-33-20**. ~~A licensed NP, CNM, or CNS performing medical acts must do so pursuant to a practice agreement with a physician who must be readily available for consultation.~~ To the extent permitted by federal law, the Centers for Medicare or Medicaid, notwithstanding any provisions of law, and Chapter 47, an APRN may perform the following medical acts, including but not limited to: ~~(D)(1) Medical acts performed by a nurse practitioner or clinical nurse specialist must be performed pursuant to a practice agreement between the nurse and the physician or medical staff. The practice agreement must include, but is not limited to:~~ ~~(a) the following general information:~~ ~~(i) name, address, and South Carolina license number of the nurse;~~ ~~(ii) name, address, and South Carolina license number of the physician;~~ ~~(iii) nature of practice and practice locations of the nurse and physician;~~ ~~(iv) date the practice agreement was entered into and dates the practice agreement was reviewed and amended; and~~ ~~(v) description of how consultation with the physician is provided and provision for backup consultation if the physician is unavailable; and~~ ~~(b) the following information for medical acts:~~ ~~(i) medical conditions for which therapies may be initiated, continued, or modified;~~	**The proposed changes continue to support NPs, CNMs, and CNS who must work in rural or with underserved populations, no changes in that language.** **Wider availability of evidence-based show that Nurse Practitioner and Certified Nurse Midwife care for rural, underserved, patients with chronic disease management and low-risk women can prevent and rectify maternity care deserts, lower costs and improve health outcomes. See attached for mini-literature sources.** CNMs are often the initial contact for persons seeking health care and frequently provide services to rural and other underserved populations. **Phillippi JC, Barger MK. *J Midwifery Womens Health*. 2015;60(3):250-257. doi:10.1111/jmwh.12295** **Proposed language for deleting practice agreements throughout the Practice Act. Evidence supports in numerous studies, SC, and other states that practice agreements are cost prohibitive because physicians charge a fee for entering into collaborative agreements with NPs, CNMs, and CNS (see attached evidence sources).** **Also, if the physician terminates (for example the physician relocates or becomes employed by an organization) the practice agreement with the NP, CNM, or CNS, then the NP, CNM, or CNS must also close until another physician has agreed to enter into a new practice agreement, impeding access to care and services.** **During COVID, Governor McMaster issued a public health emergency suspending all practice agreements. Evidence shows that disciplinary cases against NPs, CNMs, and CNS were negligible during this time frame (< 0.3 %). Clearly, NPs, CNMs, CNS adhered to safe quality practice in serving their patients without practice agreements.**

~~(ii) treatments that may be initiated, continued, or modified;~~ ~~(iii) drug therapies that may be prescribed; and~~ ~~(iv) situations that require direct evaluation by or referral to the physician.~~ ~~(2) Notwithstanding any provisions of state law other than this chapter and Chapter 47, and to the extent permitted by federal law, an APRN may perform the following medical acts unless otherwise provided 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, certify the manner and cause of death, and sign death certificates pursuant to the provisions of Chapter 63, Title 44 and Chapter 8, Title 32; (e) issue an order for a patient to receive appropriate services from a licensed hospice as defined in Chapter 71, Title 44; (f) certify that an individual is handicapped and declare that the handicap is temporary or permanent for purposes of the individual's application for a placard; (g) execute a do not resuscitate order and post an order pursuant to the provisions of Chapter 78, Title 44; ~~and~~ (h) issue an order for home health services pursuant to the provisions of Chapter 69, Title 44~~.~~; (i) delegate certain tasks to certified medical assistants pursuant to the provisions of Section 40-47-106; (j) commit a patient to a psychiatric facility if the patient is unable to consent and the APRN deems that the patient is a danger to himself or others;	**An average total of 4000 APRNs (NP, CNMs, CNS, CRNA) are actively licensed in South Carolina per year.** **APRNs (4000) represent less than 7% of the total RN active licensees (56689) per year.** **98 APRN Discipline Cases since 1999. 98/92000 (4000 APRNs x 23 years) = .0001 or 0.01`% of all APRNs disciplined since 1999.** **Average percent of APRNs disciplined per year/per total APRNs licensed in SC: 1-13 Cases per year/4000 total APRNs per year = 0.02% - 0.3%** **https://verify.llronline.com/LicLookup/LookupMain.aspx** **https://llr.sc.gov/nurse/** **For medical acts, added language to include that APRNs can commit a patient to psychiatric facility. Currently, the law requires 2 physicians. However, in primary care settings, jail settings, or SC DOC facilities, physicians are not always available on site to sign those commitment papers. For the safety of the individual or others, involuntary commitment is necessary in extenuating circumstances. NPs, CNMs, or**

(k) hold admitting privileges within an acute care facility or a licensed birth center; and (l) engage in ionizing fluoroscopy pursuant to applicable regulations and the Medical Radiation Health and Safety Act.	**CNS need the law changed to commit in emergency cases when the patient is a danger to themselves or others.** **Additionally, added that CNMs need the capability to admit to acute care facilities or birthing centers for the safety of their patients. For NPs or CNS, facilities can determine admitting privileges based on facility policy.** **Additionally, need to clarify with the DHEC language that NPs, CNMs, and CNS can continue to engage in fluoroscopy in primary care and acute care settings (Chest Xray, CT scans for example).** **CMS (Centers for Medicaid and Medicare) supports full scope of practice because their target population is considered underserved with equity disparities; studies showing improved access to care and health outcomes when care is delivered by NPs. For example, effective March 1, 2020, Section 3708 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136) amended sections 1814(a) and 1835(a) of the Social Security Act to allow Nurse Practitioners (NPs), certified Clinical Nurse Specialists (CNSs) to certify beneficiaries for eligibility under the Medicare home health benefit and oversee their plan of care. This is a permanent change that will continue after the Public Health Emergency.** **https://www.cms.gov/** **https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-05-07-mlnc** **https://llr.sc.gov/nurse/** **Health care systems should develop hospital privileging and credentialing mechanisms for midwives that are consistent with the profession's standards, recognize midwifery as distinct from other health care professions, . . . (Executive summary recommendations on Regulation and Credentialing, p. iii)** **Guidance from *Charting A Course for the 21st Century: The Future of Midwifery*, a joint report from the Pew Health Professions Commission and the University of California, San Francisco Center for the Health Professions (1999).**

	Nationally, nearly 1 in 10 births is attended by a certified nurse midwife (9.4 percent). March of Dimes encourages states to ensure that their laws foster access to midwifery care and also supports efforts to further integrate their model of care, with full autonomy, into maternity care in all states. **March of Dimes, 2021 Report Card** **Lack of access to birth facilities and maternity care providers has contributed to rising US maternal mortality and morbidity rates, especially among women in rural areas. Policy recommendations based on survey results include (a) support for midwifery education and workforce development, (b) removal of hospital-level restrictions for privileges of midwives, and (c) consideration for public payment models that promote expansion of midwifery practices.** **Smith, D. et al. Policy, Politics & Nursing Practice. 2023; doi:10.1177/15271544221147301**
~~(3) The original practice agreement and any amendments to it must be reviewed at least annually, dated and signed by the nurse and physician, and made available to the board for review within seventy-two hours of request. Failure to produce a practice agreement upon request of the board is considered misconduct and subjects the licensee to disciplinary action. A random audit of a practice agreement must be conducted by the board at least biennially.~~	**Proposed language for deleting practice agreements. Evidence supports in numerous studies, SC, and other states, that practice agreements are cost prohibitive because physicians charge a fee for entering into collaborative agreements with NPs, CNMs, and CNS and burdens government with unnecessary regulations).** **Also, if the physician terminates (for example the physician relocates or becomes employed by an organization) the practice agreement with the NP, CNM, or CNS, then the NP, CNM, or CNS must also close until another physician has agreed to enter into a new practice agreement, impeding access to care and services.** **During COVID for 2 years, Governor McMaster issued a public health emergency suspending all practice agreements. Evidence shows that disciplinary cases against NPs, CNMs, and CNS were negligible (.03%) during this time frame, and these APRNs adhered to safe quality practice in serving their patients without practice agreements.** **Finally, physicians are charging NPs and CNMs for practice agreements, $1000-$3000 per month!!!!!!!** **https://www.ftc.gov/** **https://llr.sc.gov/nurse/**

(F)(1) Authorized prescriptions or institutional facility orders by a nurse practitioner, certified nurse-midwife, or clinical nurse specialist with prescriptive authority: (a) must comply with all applicable state and federal laws and executive orders; (b) is limited to drugs, therapies, and devices utilized to treat medical problems within the specialty field of the nurse practitioner, certified nurse midwife, or clinical nurse specialist ~~as prescribed in the practice agreement~~; (c) may include Schedules III through V controlled substances ~~if listed in the practice agreement and as authorized by Section 44-53-300;~~ (d) may include Schedule II nonnarcotic substances ~~if listed in the practice agreement and~~ as authorized by Section **44-53-300**, provided, however, that each such prescription must not exceed a thirty-day supply; (e) may include Schedule II narcotic substances ~~if listed in the practice agreement~~ and as authorized by Section **44-53-300**, provided, however, that the prescription must not exceed a five-day supply and another prescription must not be written ~~without the written agreement of the physician with whom the nurse practitioner, certified nurse-midwife, or clinical nurse specialist has entered into a practice agreement, unless the prescription is written for patients in hospice or palliative care or for patients residing in long-term care facilities~~ unless the patient is post operative or a patient of a chronic pain practice; (f) may include Schedule II narcotic substances for patients in hospice or palliative care, or for patients in long-term care facilities, ~~if listed in the practice agreement~~ as authorized by Section **44-53-300**, provided, however, that each such prescription must not exceed a thirty-day supply; (g) may include ordering Schedules II-V narcotic substances in acute care facilities or licensed birthing centers; (h) a CNM may dispense, prescribe, and administer Schedule II controlled substances in licensed birth centers;	**No changes in prescribing controlled and non-controlled substances. Added language to include ordering therapies (for example: respiratory treatments (cystic fibrosis treatments), physical therapy, occupational therapy, counseling for abuse or molestation).** NPs, CNS, and CNMs have been granted the authority to prescribe con- trolled substances in all 50 states and the District of Columbia. **Osborne, K. Journal of Midwifery & Women's Health, 2017. 62(3). doi:10.1111/jmwh.12615** Certified Nurse-Midwives need full prescribing authority, including schedule II substances, to order and administer to patients in the acute care inpatient and community birth settings for the management of labor, postpartum, and gynecologic pain. **Need to clarify that CNMs can order controlled substances in acute care and birthing centers for labor, postpartum, and gynecological care.** **Need to add that APRNs can prescribe a 30 day supply of narcotic substances for patients in chronic pain or post-operative care.** **Need to add back in that APRNs can prescribe schedule 2-5 narcotics for 30 days for patients in hospice and palliative or for patients in long term care facilities. This language CURRENTLY exists in the Nurse Practice Act.** **Deleted language to require that hard copy prescriptions need to include the name of the physician. Some pharmacies in the upstate SC have taken it one step further and refused to fill ERX prescriptions unless the physician's name is on the ERX, which is NOT required by state law. Moreover, some software EMRs don't have the capability to list 2 providers on ERXs, thus, impeding access to care for patients when prescriptions are NOT filled in a timely manner.**

(i) a CNM may order, administer, and monitor effects of Schedule II-V substances in the care of the inpatient persons in labor, postpartum, and gynecological care in accordance with federal state laws and institutional policies; ~~(g)~~(j) must be signed or electronically submitted by the NP, CNM, or CNS with the prescriber's identification number assigned by the board and all prescribing numbers required by law. Written prescription forms must include the name, address, and phone number of the NP, CNM, or CNS ~~and physician~~. Electronic prescription forms must include the name, address, and phone number of the NP, CNM, or CNS ~~and, if possible, the physician through the electronic system~~. All prescriptions must comply with the provisions of Section **39-24-40**. A prescription must designate a specific number of refills and may not include a nonspecific refill indication; and ~~(h)~~(k) must be documented in the patient record of the practice and must be available for review and audit purposes. (2) An NP, CNM, or CNS who holds prescriptive authority may request, receive, and sign for professional samples, including controlled substances, and may distribute professional samples to patients ~~as listed in the practice agreement~~, subject to federal and state regulations. (G) Prescriptive authorization may be terminated by the board if an NP, CNM, or CNS with prescriptive authority has: (1) not maintained certification in the specialty field; (2) failed to meet the education requirements for pharmacotherapeutics; ~~(3) prescribed outside the scope of the practice agreement;~~ (~~4~~3) violated a provision of Section **40-33-110**; or (~~5~~4) violated any state or federal law or regulations applicable to prescriptions.	

WHY DO WE NEED TO CHANGE THE NURSE PRACTICE ACT for FULL PRACTICE AUTHORITY?

1. **Decrease in the number of payments made by physician for malpractice.**
   - McMichael, B., Safriet, B., Buerhaus, P. (2017). The extra-regulatory effect of nurse practitioner scope-of-practice laws on physician malpractice rates. *Medical Care Research and Review*. https://doi.org/10.1177/1077558716686889
2. **Lower rate of increase in ED use in states with expanded authority following the Affordable Care Acts' Medicaid expansion.**
   - McMichael, B., Spetz, J., Buerhaus, P. The association of nurse practitioner scope of practice laws with emergency department use: Evidence from Medicaid expansion. Medical Care. 57(5):362-368, May 2019
3. **Decrease cesarian rates with full practice authority for CNMs**
   - McMichael, Benjamin (2020) "Healthcare Licensing and Liability," Indiana Law Journal: Vol. 95 : Iss. 3 , Article 5.
   - **Sonenberg, A. JAMA Health Forum. 2023;4(1):e225541. doi:10.1001/jamahealthforum.2022.5541**
4. **Increased access to care for rural and vulnerable populations, including dual eligibles, with full practice authority for NPs.**
   - Xu, W., Retchin, S., Buerhaus, P. Dual-eligible beneficiaries and inadequate access to primary care providers. *American Journal of Managed Care*. 2021;27(5)
   - DesRoches, CM, Clarke, S., Perloff, J., O'Reilly-Jacob, M, Buerhaus P. (2017). The quality of primary care provided by nurse practitioners to vulnerable Medicare beneficiaries. *Nursing Outlook* (2017), doi:10.1016/j.outlook.2017.06.007.
   - DesRoches, C, Gaudet, J, Perloff, J, Donelan, K., Iezonni, L. Buerhaus, P. (2013). Using Medicare Data to Assess Nurse Practitioner Provided Care. *Nursing Outlook*. 61(6):400-407.
   - **https://www.scahec.net/scohw/reports**
5. **Increased access to care for rural and vulnerable populations, including dual eligibles, with full practice authority for NPs.**
   - Barnes, H, Richards, M, McHugh, M., & Martsolf, G. Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners, *Health Affairs* 37, no. 6 (June 2018): 908–14, https://www.ncbi.nlm.nih.gov/pubmed/29863933.
   - Ying, X, Smith, J, & Spetz, J. Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. The *Journal of the American Medical Association* January 1/8, 2019 Volume 321, Number 1, pp 102-105
   - Xu, W., Retchin, S., Buerhaus, P. (2001). Dual-eligible beneficiaries and inadequate access to primary care providers. *American Journal of Managed Care*. 2021;27(5)
   - DesRoches, CM, Clarke, S., Perloff, J., O'Reilly-Jacob, M, Buerhaus P. (2017). The quality of primary care provided by nurse practitioners to vulnerable Medicare beneficiaries. *Nursing Outlook* (2017), doi:10.1016/j.outlook.2017.06.007.
   - DesRoches, C, Gaudet, J, Perloff, J, Donelan, K., Iezonni, L. Buerhaus, P. (2013). Using Medicare Data to Assess Nurse Practitioner Provided Care. *Nursing Outlook*. 61(6):400-407.
6. **Lower costs by NPs who lowered use of services, less expensive services (controlling for severity).**
   - Razavi, M., O'Reilly-Jacob, M., Perloff, J., Buerhaus, P. 2020. Drivers of cost differences between nurse practitioner and physician-attributed Medicare beneficiaries. *Medical Care* Feb 2021 59(2):177-184.
7. **Improvement in mental health, mental health related mortality, including suicide.**
   - Alexander, D. & Schnell, M. Just what the nurse practitioner ordered: Independent prescriptive authority and population mental health. Revised January 9, 2019. WP2017-08 Federal Reserved Bank of Chicago.
8. **ZIP CODE 29203 has a 20 times higher than the US rate of amputee in the NATION!** ***The State,*** **March 2022.**

COVID and SCOPE OF PRACTICE?

Due to the COVID-19 pandemic, APRNs were granted the ability to practice at the top of their license with the use of federal and state Public Health Emergency (PHE) waivers. APRNs were and continue to be essential in providing quality patient care during a time of great demand. Governor McMaster declared the same Public Health Emergency in SC, suspending all scope of practice barriers, including practice agreements.

APRNS have practiced safely and competently during this state of emergency with the use of waivers and flexibilities from the Centers for Medicare and Medicaid Services. Telehealth is an important example of how APRNs communicated and provided care during the pandemic utilizing technology to diagnose and treat patients, including prescribing medication to patients. Telehealth is still widely used for vulnerable individuals and to bridge the gap in mental health services.

Reports from the National Provider Data Bank (NPDB) indicate that APRNs have very low rates of action taken against them. For years 1990 through 2022, the total number of "Unique Providers" in South Carolina with medical malpractice payments and/or certain adverse actions made against them was 9587. Looking at provider type, specifically physicians and APRNs for this time-period, the number of actions taken is as follows:

- Physicians (MD): 2872
- APRNs: 131
- Physicians (DO): 117

For years 2020 – 2022 during the pandemic:

- Physicians (MD): 394
- APRNs: 39
- Physicians (DO): 19

Removing unnecessary barriers to practice is consistent and well documented by organizations such as the Institute of Medicine, National Academy of Medicine, the Brookings Institute, the Bipartisan Policy Center, the World Health Organization, and the Federal Trade Commission.

Removing physician "supervision," collaborative agreement, and granting admitting privileges for APRNs is needed for both timely access and continuum of care. For critical access hospitals, rural health clinics, federally qualified health centers, removing constraints provide workforce flexibility in rural and underserved communities where provider shortages have increased the most in recent years. Additionally, a lack of physicians has made finding a collaborating provider increasingly more difficult. Regulations in place cap how many APRNs can be "supervised" or can hold a practice agreement with each physician. Additionally, some physicians require payment for collaborative services which can be cost prohibitive for the advanced practice nurse leading to nurse practitioners and certified nurse midwives leaving their practices or moving out of the state.

Lower health care costs and focusing on preventative care rather than "just in time" care is the goal of removing limitations on APRN practice. Dr. Ruth Kleinpell noted that a study conducted by UnitedHealth indicated that if APRNs were able to work to the full scope of their education and certification, that there would be a 70% reduction in the primary care shortage (Kleinpell, 2022).

Kleinpell, R., Likes, W., Schorn, M. N., (2022). Breaking down institutional barriers to advanced practice registered nurse practice. *Nursing Administration Quarterly 46*(2). 137-143.

Definitions of MSPA and HPSA: HRSA

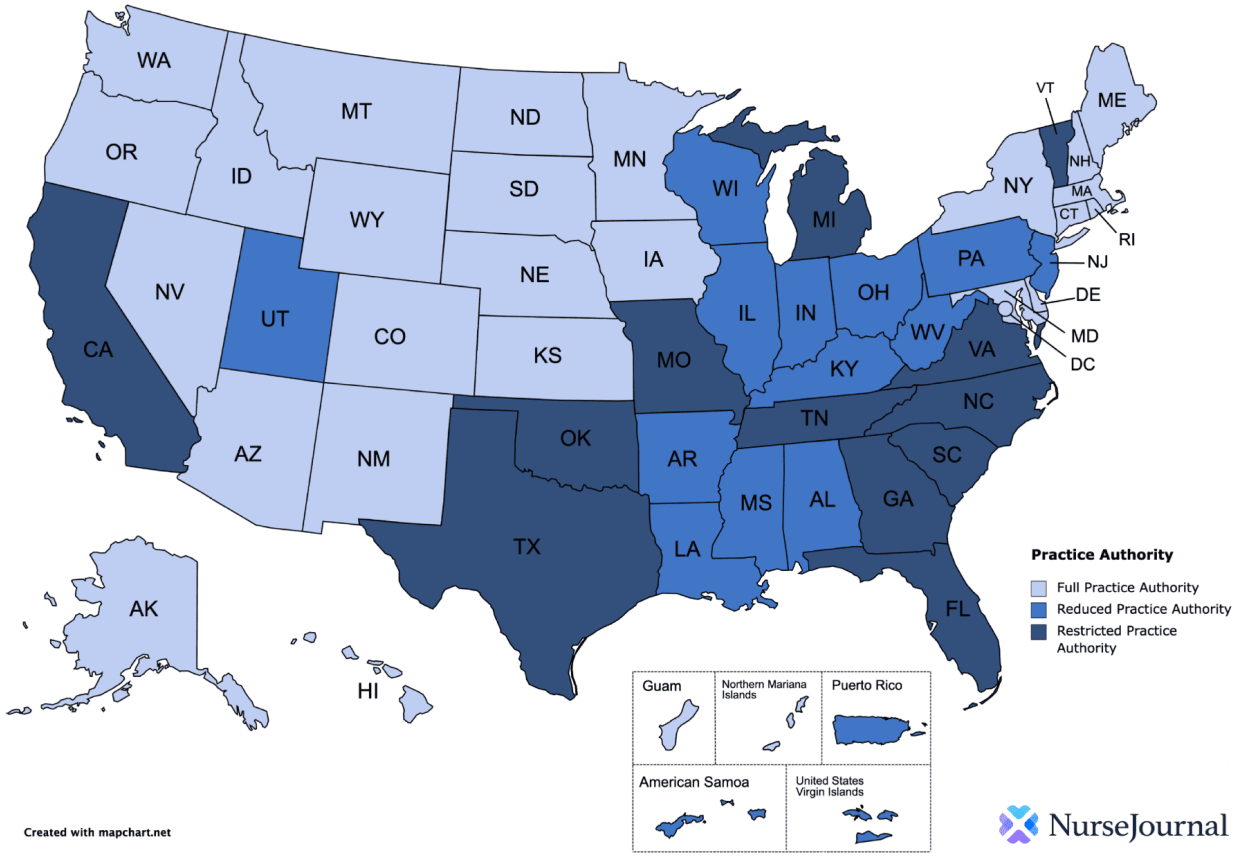
Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g. low income or Medicaid eligible) or facilities (e.g. federally qualified health center or other state or federal prisons).

https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx

Full Practice Authority

Currently, the Veterans Administration across the country and 25 states have Full Practice Authority (FPA): Alaska, Arizona, Colorado, Connecticut, Delaware, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Vermont, Washington, and Wyoming are full practice authority states.



https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/

Oct 2022

Distinguishing Tardive Dyskinesia (TD) from other Acute Dopamine Receptor Blocking Agents (DRBA) – Induced Movement Disorders

Kelli Lozano, MSN, AGPCNP-BC

Clinical Practice Liaison

NEUROCRINE® BIOSCIENCES

March 23, 2023

6:00pm

(Presentation to start promptly at 6:30)

Augusta Grill
1818 Augusta Street, Greenville, South Carolina

To RSVP:

864-749-5553

klozano@neurocrine.com

This educational event is sponsored by Neurocrine Biosciences, Inc., and is not intended or eligible for CME credit. The speakers are employees of Neurocrine Biosciences, Inc.

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Need NPs and CNMs Now!

The SC Stats on Providers in SC

- Data from the AHEC Data Workforce indicate that the number of primary care NPs increased by 108.2% between 2010-2018 in nonmetropolitan counties while the number of primary care physicians decreased by 13.5% between 2009-2019 in nonmetropolitan counties.
- According to AHEC Data Workforce, the Nurse practitioner (NP) workforce is maintaining and "saving" access to primary care in SC, especially in rural areas, underserved areas, and non-metropolitan areas.
- According to the 2021 SC Health Professions Data Book*, in 2019, there were:
    - 22 counties with fewer than 3 active family practice physicians per 10,000 population.
    - 14 counties with Zero (NONE) active Ob-Gyn physicians.
    - 10 counties with fewer than 3 active OB-GYN physicians per 10,000 women ages 15-44.
    - 10 counties with Zero (NONE) active pediatrics physicians per 10,000 population ages 0-17.
    - 7 counties with fewer than 3 active pediatrics physicians per 10,000 population ages 0-17.
    - 17 counties with Zero (NONE) active general psychiatry physicians.
    - 27 counties with fewer than 3 active general psychiatry physicians per 10,000 population.
- According to the 2021 SC Health Professions Data Book*, in 2020, there were.
    - 40 counties are served by 5 or more active NPs per 10,000 population.
    - 4 counties had fewer than 3 active NPs per 10,000 population.

https://www.scahec.net/scohw/reports

REMOVE SCOPE OF PRACTICE BARRIERS NOW!!

SOAR into Improved Health

Save money, increase access, improve outcomes, remove regulations that impede care

Why remove barriers to practice?

Save money by keeping people out of the ER for primary care problems. SC DHHS Data 2014-2017 indicate that the top 15 reasons Medicaid beneficiaries sought the ER for care were for primary care complaints costing the state over $150, 000,000 dollars! **Data retrieved from SC DHSS report from Dr. Tan Platt and Dr. Marion Burton 2017.** Data pending 2018 to present.

Improve outcomes by timely care that is quality. Team based care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care." (Core Principles and Values of Effective Team-Based Health Care, National Academy of Medicine). It is not a construct for licensure of other professionals. **https://nam.edu/perspectives-2012-core-principles-values-of-effective-team-based-health-care/, 2023.** Although a few studies show that NPs cost the system money in ordering more diagnostic testing, overwhelmingly, the literature demonstrates that NPs and CNMs provide high quality care that is cost-effective and patient centered (CMS, 2022). One study during the pandemic demonstrated that NPs working in urgent care increased cost to the hospital by ordering more diagnostic tests, but mortality or co-morbidity data was not reported in the study. **Barnes, H., Richards, M. R., McHugh, M. D., & Martsolf, G. (2018). Rural and nonrural primary care physician practices increasingly rely on nurse practitioners. *Health Affairs*, *37*(6), 908–914. https://doi.org/10.1377/hlthaff.2017.1158.**
Medicare Payment Advisory Commission, 2022, Report to the Congress: Medicare Payment Policy. Washington, DC: MedPAC, 2022.

Increase access to care. United health foundation reports that SC Access to Primary Care improved from 2018 to 2022. Although SC health rankings overall remain poor, access to care improved from 41 to 37, after NP Scope of practice changed in 2018 to allow greater access to care and IT WORKED! **ahr_2022annualreport.pdf (americashealthrankings.org), 2022. allstatesummaries-ahr22.pdf (americashealthrankings.org).**

Remove barriers that impede care and access. The Federal Trade Commission deems it inappropriate for one profession to regulate another. Removing statute and regulatory barriers increases access and decreases cost. **Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses (ftc.gov), 2022.**

Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists as Compared to Physicians' Education and Clinical Training

	Nurse Practitioners/Certified Nurse Midwives/Clinical Nurse Specialisits **Advanced Practice Nursing**	**Physicians**
What is the Basic Education for APRNs (NP, CNM, CNS) and MD?	Must have bachelor's degree in nursing to enter Master's and Doctoral NP Program. National average is at least 10,000 hours of direct patient care as a RN. Must be licensed as RN with a BSN to apply for APRN (MSN or Doctoral) program.	Must complete 4 years of college courses in basic and behavioral sciences as prerequisites. Complete 4 years of Medical School, then enter into a specialty area of practice with 1-3 years of residency. No requirement to have a BS in health professions to enter into Medical School. No requirement to have direct patient care or licensure to enter Medical School.
What is the Advanced Practice or MD Degree Provided?	Must obtain Master's Degree in Advanced Practice Nursing but the requirement to a mandated Doctoral Degree in Advanced Practice Nursing is within the next 5 years.	Both are considered professional degrees.
Total Post High School Education?	6-9 years plus additional training depending on the doctoral program.	8 years of college plus 1-3 years of residency, depending on the specialty area of physician practice training.
Experience before Applying to Program?	Must have experience as RN before or during the program	Experience NOT required for any direct patient care as a licensed as health professional to enter Medical School.
Curriculum	• Advanced Pathophysiology across the lifespan based on previous extensive anatomy and physiology courses • Advanced Pharmacology • Advanced Clinical Assessment and Reasoning across the lifespan • Advanced Diagnostics • Multiple Advanced Care Management (Didactic/clinical courses) I , II, III in role and population foci, acute or primary care • Scientific underpinnings for practice • Evidence Based Practice, Quality and Safety • Graduate Project: Doctoral defense, presentation and publication • Informatics • Advanced Health Policy and Advocacy • Epidemiology and Biostatistics • Organizational theory and Health Care systems • Applied Health Care Economics and Finance • Role Practicums (Internship) • Residency I, II, III • Frameworks for Leadership and interprofessional practice	• Advanced Anatomy and Physiology courses • Advanced Pathophysiology courses • Advanced Pharmacology courses • Physical Dx and Clinical Application • Bioethics and Behavioral science • Didactic and clinical courses, fundamentals of medicine I, II, III • Clinical problem solving courses • Community and primary care courses, geriatric, surgical, emergency medicine, pediatric, etc. • Post graduate medical school residency for clinical application of chosen area of specialty.
Is National Board Certification Required After Graduation?	Yes	Yes
Is Re-Certification Required?	Yes	Yes

	Nurse Practitioners/Certified Nurse Midwives/Clinical Nurse Specialisits **Advanced Practice Nursing**	**Physicians**
What is the Specialty Focus?	Specialty is based on the education training (family, pediatric, adult/gero, psych mental health, neonatal, acute care, midwifery).	Specialty is based on the residency training of the physician.
Licensure	Practice in collaboration with physician, who is available for consultation and advice. Licensed by the Board of Nursing as APRN (NP/CNM/CNS).	Full Practice as a physician. Licensed by the Board of Medicine as a physician.
Scope of Practice	Scope of Practice is determined by national standards and guidelines and Board of Nursing.	Scope of Practice is determined by the specialty training area of residency completed by the physician and is recognized by the Board of Medicine.
Hospital Privileges	Yes. Can admit under APRN if allowed by the hospital.	Yes.
Responsibility	Collaboration is required with a physician for consultation and advice. 25 states authorize NPs to practice independently. 17 states authorize collaborative practice (agreements) between the NP and physician. SC has 20+ NP practices. VA recognizes full practice authority, including SC> . Over 50% of SC NPs do not work on site with a physician. No requirement for a physician to be on site with the NP or CNM.	Physician is directly responsible for his/her patient care and outcomes.
Types of job responsibilities	A Nurse Practitioner's or CNM's job profile may allow one to work in collaboration with a physician but no law requires a physician to be on site. They exercise autonomy and initiative in clinical decision-making. The duties include but are not be limited to: conducting physical examination, obtaining medical histories, physical therapy, performing diagnostic tests and procedures, prescribing drugs, providing prenatal care, counseling and educating patients, diagnosing, treating, and managing diseases, performing procedures and minor surgeries (biopsies/LP's). Providing coordination of care, making referrals, patient education and counseling. Contribute to care coordination/population management initiatives for the entire practice. The institutions that can employ NPs include community clinics and health centers, prisons, nursing homes, private and public schools, hospitals, physicians' and NP practices, and more such at academics. They can fill hospitalist positions, round, and take call.	Physicians are medical professionals, and their scope of practice is determined by their specialty area of training. They perform tasks such as collecting medical information from patients, performing examinations and test and interpret, diagnosing illnesses, prescribing medications, referring patients to specialists, counseling and performing surgery.
Prescriptive Authority	Yes. Authorized to prescribe medications in all 50 states and 49 states authorize controlled medications as well with DEA.	Yes. Recognized to prescribe in all states.

Information on Board of Nursing Disciplinary Cases against APRNs

Table of South Carolina Discipline Data for APRNs 1999-2023

An average total of 4000 APRNs (NP, CNM. CNS, CRNA) actively licensed in South Carolina per year.

APRNs (4000) represent less than 7% of the total RN active licensees (56689) per year.

98 APRN Discipline Cases since 1999. 98/92000 (4000 APRNs x 23 years) = .0001 or 0.01`% of all APRNs disciplined since 1999.

Average percent of APRNs disciplined per year: 1-13 Cases per year/4000 total APRNs per year = 0.02% - 0.3%

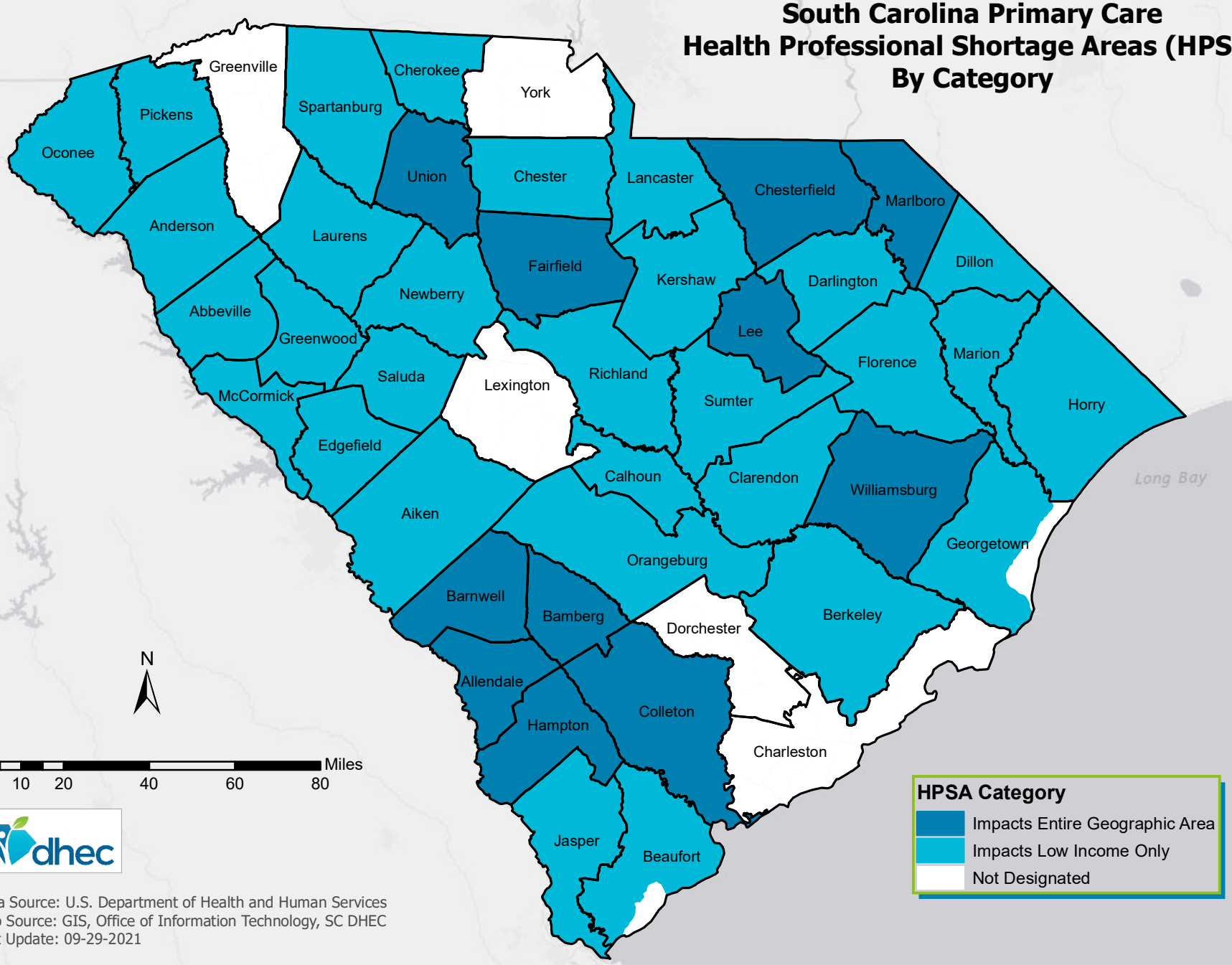
https://verify.llronline.com/LicLookup/LookupMain.aspx

https://llr.sc.gov/nurse/

Year and Types of infractions	Year and # of APRNs disciplined
1999: One case involved a failure to provide evidence of National Certification. 2004: One case involved a failure to obtain annual protocol. 2005: One case involved inappropriate delegation. Two cases involved substance abuse/drug diversion and were ordered to enter RPP. 2006: Three cases involved substance abuse/diversion and were ordered to enter RPP. One case involved a medication error. 2007: Three cases involved substance abuse/diversion and were ordered to enter RPP. 2008: One case involved a failure to renew APRN license on time. One case involved a failure to identify patient scheduled for surgery. 2009: Eight cases involving substance abuse and were ordered to enter RPP. One case involved obtaining medications for a physician planning a mission trip. 2010: One case involved a medication error. One case involved inappropriate delegation. Eight cases involved substance abuse/diversion and were ordered to enter RPP.	1999 1 2000 None 2001 None 2002 None 2003 None 2004 1 2005 3 2006 4 2007 3 2008 2 2009 9 2010 10 2011 4 2012 3 2013 2 2014 3 2015 0 2016 1 2017 5 2018 10 2019 9 2020 9 2021 5 2022 13 2023 1

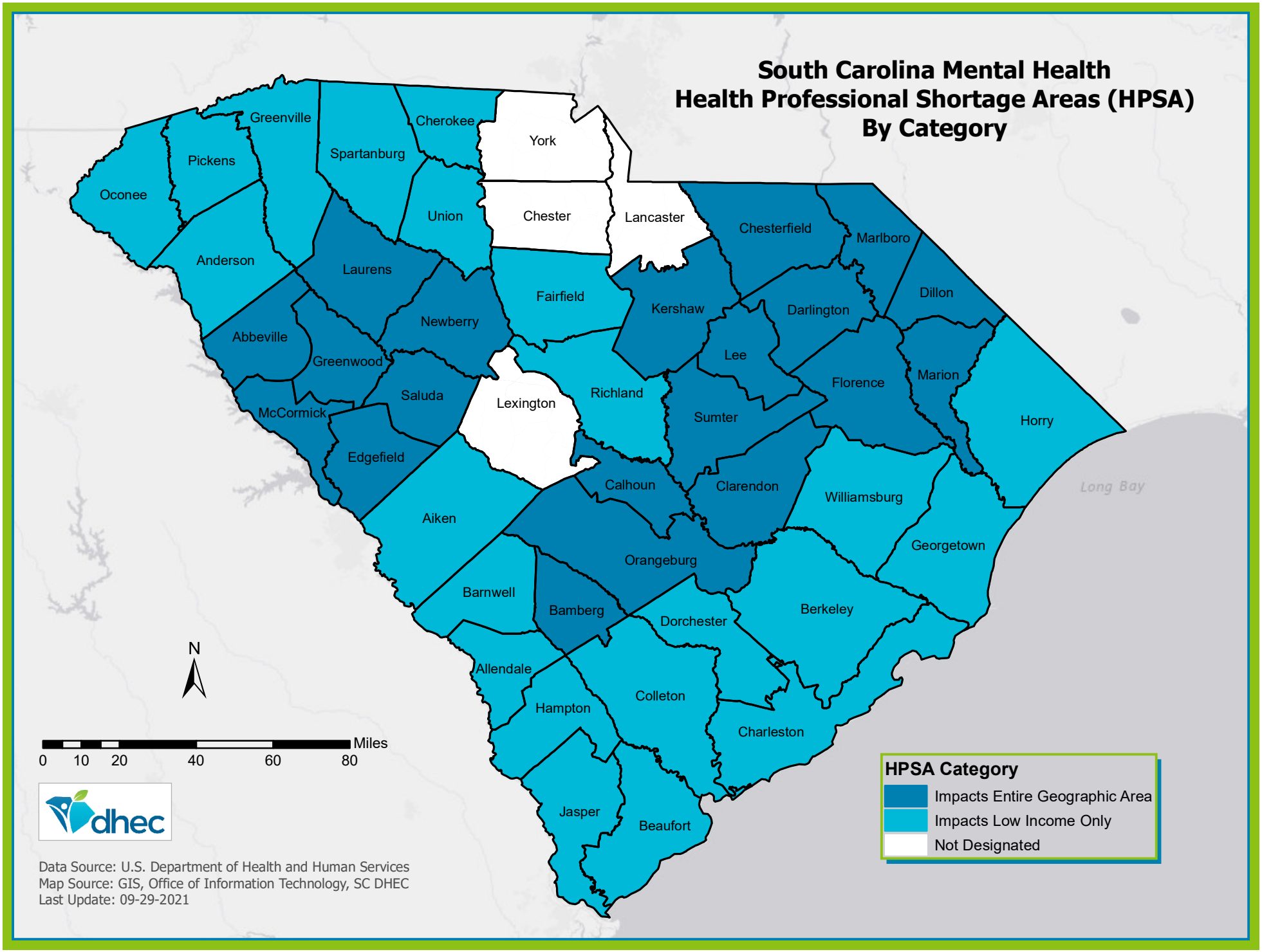
2011: One case involved entering into a person and financial relationship with a patient. Three cases involved substance abuse. One case involved writing prescriptions for non-patients. 2012: Two cases involved substance abuse. One involved poor documentation 2013: Two cases involved substance abuse. 2014: Three cases involved substance abuse and writing prescriptions for non-patients. 2016: One case of Diversion, licensed relinquished 2017: One case for diversion. One case for writing prescriptions for non-patients, One case without having collaborating MD. One case of impairment at work, One case for assaulting co-worker and DUI. Licenses suspended or place on restriction. 2018: 2 Cases forged prescriptions. 2 cases for SUD, entered RPP program. 2 cases writing prescriptions for non-patients. One case for forging documentation on a home visit. One case for below standard of care. One case for prescribing out of scope of practice. One case unprofessional conduct. Licenses suspended, placed on probation, or public reprimand. 2019: One case forged prescriptions. One case of diversion. 2 cases for writing prescriptions for non-patients. One case for possible criminal charges out of state. 2 Cases APRN relinquished license. One case of Medicaid Fraud, license suspended in another state. One case unprofessional conduct towards co-worker (sexual). Licenses suspended, placed on probation, revoked, or public reprimand. 2020: One case falsified APRN license information. 3 cases diversion. 3 cases writing prescriptions for non-patients. One case of SUD, in RPP. One case forged prescription. Licenses suspended, placed on probation, or public reprimand. 2021: Three cases surrendered license. One case unprofessional conduct towards patient (sexual). One case writing prescriptions for non-patients. Licenses suspended, placed on probation, revoked, or public reprimand. 2022: One case of Diversion. Two cases of substandard care. One case unprofessional conduct towards patient (sexual). 2 cases without a Collaborative Agreement. 4 cases diversion (one was out of state). 2 cases relinquished license. One case SUD and entered into RPP. Licenses suspended, placed on probation, revoked, or public reprimand. 2023: One case without a collaborative agreement.	

South Carolina Primary Care Health Professional Shortage Areas (HPSA) By Category



Data Source: U.S. Department of Health and Human Services
Map Source: GIS, Office of Information Technology, SC DHEC
Last Update: 09-29-2021

South Carolina Mental Health Health Professional Shortage Areas (HPSA) By Category



Data Source: U.S. Department of Health and Human Services
Map Source: GIS, Office of Information Technology, SC DHEC
Last Update: 09-29-2021

REMOVE BARRIERS TO PRACTICE

COMMON SENSE APPROACH TO MANAGING HEALTHCARE

HOW DOES SOUTH CAROLINA BENEFIT?

Support Nurse Practitioners and Nurse Midwives: "SC SOARS" into Improvement: HOW?????
Save money
Improve patient care outcomes
Increase access
Remove barriers to care
Safe care

SAVE MONEY

By keeping patients out of the ER for primary and psychiatric care, this reduces costs to BC/BS and tax payers. The average ER visit nationwide is about $1233. Nationwide, there is a 20% increase in ER visits; 65% of ER visits in 2014-2015 were for non-emergent issues. In SC 2014-2017 (data 2018-2022 pending from SCDHHS), the top 15 reasons Medicaid beneficiaries sought the ER were for primary care complaints costing the state over 140 million dollars! Spending $1233 for a UTI, STD, or upper respiratory infection is not an efficient way to manage health care, especially when a more affordable option is available for $60 per visit by seeing a Nurse Practitioner or Certified Nurse Midwife.

IMPROVE PATIENT OUTCOMES

Studies show that Nurse Practitioners have excellent outcomes with chronic disease management and Certified Nurse Midwives reduce C-section rates.

INCREASE ACCESS TO CARE

Removing barriers enhances hospital systems, physicians, and Nurse Practitioners/Certified Nurse Midwives to enhance capabilities to increase access to health care, especially primary care, prenatal care, and mental health care. Psychiatric providers are scarce in SC. Seventeen (17) SC counties have NO mental health psychiatrists Removing barriers to practice will allow psychiatric Nurse Practitioners to establish practices, manage patients in outpatient settings, and reduce Emergency Visits for mental health care.

REMOVE BARRIERS TO CARE

25 States recognize full practice authority for Nurse Practitioners and Certified Nurse Midwives.

SAFE CARE

Studies show that NPs and CNMs are safe providers. There have been no patient safety issues with the elimination of the supervision. Physician groups contend that supervision ensures that APRNs make a correct diagnosis. However, a government study found that physicians misdiagnose 20% of the time.

TEAM BASED CARE WITH INDEPENENT LICENSED PROVIDERS

Team based care, while licensing health professionals as independent providers, improves patient outcomes and ensures that each provider brings their unique contribution to the table, is accountable for their own practice, and removes liability from other professionals. Each provider is independent.

Who supports: Nurse Practitioners, Certified Nurse Midwives, Coalition for Access to Healthcare, SC Society for Pain Management, AARP, SC House Calls, Agape Primary Care, Free Medical Clinics, Physicians Across the SC, South Carolina Nurses Association, American College of Gynecologists, Designated Legislators, SC

Who Opposes: South Carolina Medical Association, SC Academy of Family Practice

REFERENCES

National Council of State Boards of Nursing. (2014). [Graph illustration of overview of each state's consensus model implementation status]. *NCSBN's APRN Campaign for Consensus: State Progress toward Uniformity.* Retrieved from https://www.ncsbn.org/5397.htm

National Governors Association Center for Best Practices. (2012). *The role of nurse practitioners in meeting increasing demand for primary care.* Washington, DC: Authors. Retrieved from http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf

Nurse Practitioner Roundtable. (2014). *Nurse practitioner perspective on education and post-graduate training.* Washington, DC: Authors. Retrieved from http://www.aanp.org/images/documents/policy-toolbox/nproundtablestatementmay6th.pdf

Weinberg, M. & Kellerman, P. (2014). Full practice authority for nurse practitioners increases access and controls cost. San Francisco, CA: Authors. Retrieved from http://www.bayareaeconomy.org/media/files/pdf/BACEI_NPs_CA_Final.pdf
http://www.consumerhealthratings.com/index.php?action=showSubCats&cat_id=107

SC Office of Research and Statistics, Licensure Data. (2004-15). South Carolina Budget and Control Board. *Office of Research and Statistics*.

Bergeson, J., Cash, R., Boulger, J., & Bergeron, D. (1997). The attitudes of rural Minnesota family physicians toward nurse practitioners and physician assistants. *Journal of Rural Health, 13*(3), 196-205.

Burgess, S.E., Pruitt, R.H., Maybee, P., Metz, A.E., & Leuner, J. (2003). SC Rural and urban physicians' perceptions regarding the role and practice of the nurse practitioner, physician assistant, and certified nurse midwife. *Journal of Rural Health*, *19*(S), 321-328.

Conway-Welch, C. (1991). Issues surrounding the distribution and utilization of nurse non-physician providers in rural America. *The Journal of Rural Health, 7*, 388-403.

Drozda, P. (1992). Physician extenders increase health care access. *Health Progress, May,* 46-74.

Ford, V. & Kish, C. (1998). Family physician perceptions of nurse practitioners and physician assistants in a rural practice setting. *Journal of American Academy of Nurse Practitioners, 10*(4), 183-171.

Glaser, V. (1994). Does your practice need a midlevel provider*? Family Practice Management, September,* 43-52.

Krein, S. (1997). The employment and use of nurse practitioner and physician assistants by rural hospitals. *The Journal of Rural Health, 13*(1), 45-58.

Louis, M. & Sabo, C. (1994). Nurse practitioners: Need for and willingness to hire as viewed by nurse administrators, nurse practitioners, and physicians*. Journal of American Academy of Nurse Practitioners, 6(*3), 113-119.

Office of Technology Assessment (1990). Health care in rural America. Washington, D.C.: U.S. Government Printing Office. *U.S. Government.*

Prescott, P. (1994). Cost-effective primary care providers: An important component of the health care reform. *International Journal of Technology Assessment in Health Care, 10*(2), 249-257.

Safriet, B. (1994). Impediments to progress in health care workforce policy: License and practice laws. *Inquiry, 31*, 310-317.

Samuels, M. & Shi, L. (1992). Survey of community and migrant health centers regarding the utilization of nurse practitioners. , physician assistants, and certified nurse midwives. *Rural Health.* Kansas City, Missouri: National Rural Health Association.

Sardell, A. (1988). The U.S. experiment in improving medicine: The community health center program and the use of NP, 1965-1986. Pittsburgh, Pennsylvania: University of Pittsburgh Press.

Shi, L., Samuels, M., Konrad, T., Rickets, T., Stoskopf, C., & Richter, D. (1993). The determinants of utilization of non-physician providers in rural community and migrant health centers*. Journal of Rural Health, 9*(1), 27-39.
Sox, H. (2000). Independent primary care practice by Nurse Practitioners. *JAMA, 283*(1), 106-108.

Strickland, W., Strickland, D. & Garretson, C. (1998). Rural and urban non-physician providers in Georgia. *Journal of Rural Health, 14*(2), 109-120.

Styles, M. (1990). Nurse practitioners creating new horizons for the 1990s. *The Nurse Practitioner, 15*(2), 48-57.

Sullivan, J., Dachelet, M., Sultz., H., Henry, M., & Carroll, H. (1978). Overcoming barriers to the employment and utilization of the nurse practitioner. *American Journal of Public Health, 68*(11), 1097-1103.

Sullivan-Marx, E. & Maislin, G. (2000). Comparison of nurse practitioner and family physician work values. *Image: Journal of Nurse Scholarship, 32*(1), 71-76.

Aquilino, M., Damiano, P., Willard, J., Momany, E., & Levy, B. (1999). Primary care physician perceptions of the nurse practitioner in the 1990s. *Archives of Family Medicine, 8*, 224-227.

Birkholz, G. & Viens, D. (1999). Medicaid claims data comparisons for nurse practitioners, physician assistants, and primary care physicians in New Mexico. *Journal of American Academy of Nurse Practitioners, 11*(1), 3-10.

Brody, S., Cole, L., Storey, P., & Wink, N. (1976). The geriatric nurse practitioner. A new medical resource in the skilled nursing home. *Journal of Chronic Diseases, 29*(8), 537-543.

Brown, S. & Grimes, D. (1993). A meta-analysis of process of care, clinical outcomes, and cost-effectiveness of nurses in primary care: Nurse practitioners, and certified nurse midwives. Washington, D.C.: American Nurses Association.

Garrard, J., Kane, R., Radeosevick, D., Skay, C., Arnold, S., Kepferle, L., McDermott, S., & Buchanan, J. (1990). Impact of geriatric nurse practitioners in nursing home residents' functional status, satisfaction, and discharge outcome. Medical Care, 28, 271-283.

McGrath, S. (1990). The cost-effectiveness of nurse practitioners. *The Nurse Practitioner, 15,* 40-42.

Mundinger, M., Kane, R, Lenz, E., Totten, A., Wei-Yann, T., Cleary, P., Friedewald, W., Siu, A., & Shelanski, A. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. *JAMA, 283*(1), 59-68.

Office of Technology Assessment. (1986, December). Nurse Practitioners, Physician Assistants, and Certified Nurse-mid wives: A policy analysis health technology case study 37 (2 0510-8025). Washington, DC: U.S. Government Printing Office.

Schmittdiel, J., Selby, J., Grumbach, K., & Quesenberry, C. (1999). Women's provider preferences for basic gynecology care in a large health maintenance organizations. *Journal of Women's Health Gender Based Medicine, 8*(6), 825-833.

Shi, L**. & Samuels, M. (1997). Practice environment and the employment of nurse practitioners, physician assistants, and certified nurse midwives in community health centers. *Journal of Allied Health, 26*(3), 105-109.**

Abdellah, F. (1982). The nurse practitioner 17 years later: Present and emerging issues. *Inquiry, 19*(1), 105-106.

South Carolina Laws that Govern Nursing, 2002-2015.

South Carolina Laws that Govern Nursing, 2004.

American Nurses Association Credentialing Center. (2006). *Credentialing Catalogue for APRNs, 2006-2016.* Washington: American Nurse Publishing.

US Census. (2000, 2010). http://www.census.gov/

University South Carolina. (2012, 2016). http://www.sc.edu/facultystaff/

South Carolina Department of Mental Health. (2012). http://www.state.sc.us/dmh/

Office of Rural Health. (2006-2015). http://www.scorh.net/

Columbia College. (2006). www.colacollege.edu

Centers for Medicare and Medicaid. (2015). www.cms.org

Institute of Medicine Report (IOM). (2010). The Future of Nursing: Leading change, advancing health. Washington, DC: National Academies Press. Retrieved December 10, 2010. http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=12956

Avorn, J., Everitt, D., & Baker, M. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurse practitioners. *Archives of internal Medicine, 15*(4), 694-698.

Bakerjan, D. (2008). Cost of nursing home residents by advanced practice nurses: A review of the literature. *Journal of Gerontological Nursing, 1*(3), 177-185.

Running, A., Kipp, C., & Mercer, V. (2009). Prescriptive patterns of nurse practitioners and physicians. *Journal of American Academy of Nurse Practitioner, 18*, 228-233.

Cooper, M., Lindsay, G., Kinn, S., & Swann, J. (2012). Evaluating emergency care by nurse practitioners: A randomized control trial. *Journal of Advanced Nursing Science, 40*(6), 771-730.

Brown, S. & Grimes, D. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. *Nursing Research, 44*(6), 332-339.

Ettner, S., Kotlerman, J., Abdelomonem, A. Vazirani, S. Hays, R., & Shapiro, M. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary physician-nurse practitioner model. *Medical Decision Making, 26*, 9-17.

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care provide equivalent care to physicians. *British Medical Journal, 324*, 819-823.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of physicians by nurse practitioners in primary care. *Cochrane Data Base of Systematic Reviews, 2006*, Issue 1.

South Carolina Board of Nursing. List of Credentialing Organizations Approved by Board. Retrieved November 30, 2010, and again 2016. http://www.llr.state.sc.us/POL/Nursing/index.asp?file=advpraccertorg.htm

Lenz, E. Mundinger, M., Kane, R., Hopkins, S., & Lin, S. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two Year follow-up. *Medical Care Research and Review, 61*(3), 332-351.

Lin, S., Hooker, Lens, E., Hopkins, S. (2002). Nurse Practitioners and physician's assistants in hospital outpatient departments, 1997-1999. *Economics, 20*(4), 174-179.

Ohman,-Strickland, P., Orzano, A., Hudson, S., Solberg, L., DiCiccio-Bloom, B., & O'Malley, D. (2008). Quality of care in family medicine practices: Influence of nurse practitioners and physician's assistants. *Annals of Family Medicine, 6*(1), 14-22.

Prescott, P. (1994). Cost-effective primary care providers: An important component of the health care reform. *International Journal of Technology Assessment in Health Care, 10*(2), 249-257.

Roblin, D., Becker, R., Adams, E., Howard, D., Roberts, M. (2004). Patient satisfaction with primary care: Does the type of practitioner care matter? *Medical Care, 42*(6), 606-623.

Sacket, D., Spitzer, W., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. *Annals of Internal Medicine, 80*(2), 137-142.

Safriet, B. (1992). Health care dollars and regulatory sense: The role of the advanced practice nursing. *Yale Journal on Regulation, 9*(2).

Spitzer, W., Saket, D., Sibley, J., Roberts, M., Gent, M., Kergin, D., Hacket, B., & Olynick, A. (1974). The Burlington randomized trial of the nurse practitioner. *The New England Journal of Medicine, 290*(3), 252-256.

American Association of Colleges of Nursing (2000). Nurse Practitioners: The growing solution in health care delivery. Retrieved December 1, 2010 http://www.aacn.nche.edu/Media/factSheets/npfact.htm

American Academy of Nurse Practitioners (2010). Documentation of Quality of Nurse Practitioner Care. Retrieved December 15, 2010 and again September 2016. www.aanp.org

American Medical Group Association. (2009). 2009 Physician Compensation Survey. Retrieved September 22, 2009. http://www.cehkasearch.com/compensation/amga

Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses. A review of the literature. Research in Gerontological Nursing, 1(3), 177-185.

Boling, P. (2000). Care transitions and home health care. *Clinical Geriatric Medicine, 25,* 135-146.

Burl, J., Bonner, A., Rao, M., & Khan, A. (1998). Geriatric nurse practitioners in long term care: A demonstration of effectiveness in managed care. *Journal of Geriatrics Care Society, 46*(7), 506-510.

Burl, J., Bonner, A., & Rao, M. (1994). Demonstration of the cost-effectiveness of a nurse practitioner team in primary care teams. *Journal of HMO Practice, 8*(4), 156-157.

Chen, C., McNeese-Smith, D., Cowan, M., Upenieks, V., & Afifi, A., (2009). Evaluation of nurse practitioner led care management model in reducing inpatient drug utilization and costs. *Nursing Economics, 27*(3), 160-168.

Chenoweth, D. Martin, N., Pankowski, J., & Raymond, L. (2005). A benefit cost analysis of a worksite nurse practitioner program: First impressions. *Journal of Occupational and Environmental Medicine, 47*(11), 1110-1116.

Doddington, J. & Sands, L. (2008). Cost of health care and quality of care at nurse-managed clinics. *Nurse Economics, 26*(2), 75-94.

Cowan, M., Shapiro, M., Hays, R., Afifi, A., Vazirani, S., & Ward, C. (2006). The effect of the multidisciplinary hospitalist physician and advanced practice nurse collaboration on hospital costs. *The Journal of Hospital Administration, 36*(2), 79-85.

Hummel, J. & Pirzada, S. (1994). Estimating the cost of using non-physician providers in an HMP. Where would the savings begin? *Journal of HMO Practice, 8*(4), 162-164.

Hunter, J., Ventura, M., & Kearns, P. (1999). Cost analysis of a nursing center for the homeless. *Nursing Economics, 17*(1), 20-28.

Intrator, O., Zinn, J., & Mor, V. (2004). Nursing home characteristics and potentially preventable hospitalization of long stay residents. *Journal of American Geriatrics Society, 52*, 1730-1736.

Jenkins, M & Torrisi, D. (1995). NPs, community nursing centers, and contracting for managed care. *Journal of American Academy of Nurse Practitioners, 7*(3), 119-123.

Larkin, H. (2003). The case and cost of Nurse Practitioners. *Hospitals and Health Networks,* August, 54-59.

Office of Technology Assessment. (1981). *The Cost and Effectiveness of Nurse Practitioners.* Washington, DC: US Government Printing Office.

Paez, K. & Allen, J. (2006). Cost effectiveness of nurse practitioner management of hypercholesterolemia following coronary revascularization. *Journal of American Academy of Nurse Practitioner, 18*(9), 436-444.

Roblin, O., Howard, D., Becker, E., Adams, E., & Roberts, M. (2004). Use of midlevel practitioners to achieve labor costs savings in the primary care practice of a MCO. *Health Services Research, 39*, 607-626.

Searhs, J., Wickizer, T., Franklin, G., Cheadie, A., & Berkowitz, B. (2007). Expanding the role of nurse practitioners: Effects on rural access to care for injured workers. *Journal of rural Health, 24*(2), 171-178.

Spitzer, R. (1997). The Vanderbilt experience. *Nursing Management, 28*(3), 38-40.

United Health Group. (2009). Federal health care cost containment. How in practice can it be done? Options with a real world track record of success. Retrieved December 3, 2010 http://www.unitedhealthgruop.com/hrm/UNH_WorkingPaper1.pdf

American Association of Colleges of Nursing. Retrieved December 22, 2010. http://www.aacn.nche.edu/ and http://www.aacn.nche.edu/Accreditation/pdf/standards09.pdf

National Organization of Nurse Practitioner Faculties. Retrieved December 22, 2010. http://www.nonpf.com/

National Task Force on Quality Nurse Practitioner Education. (2008). *Criteria for the Evaluation of Nurse Practitioner Programs.* Washington, DC: Author.

American Association of Colleges of Nursing. Consensus Model for Licensure, Accreditation, Credentialing, and Education. Retrieved December 22, 2010. http://www.aacn.nche.edu/education/pdf/APRNReport.pdf

American Nurses Association. Retrieved December 22, 2010 http://nursingworld.org/EspeciallyForYou/AdvancedPracticeNurses/ANABoardEndorsesStandardsforAPRNRegs.aspx

South Carolina Laws that Govern Nursing. Retrieved December 22, 2010. http://www.llr.state.sc.us/POL/Nursing/index.asp?file=laws.htm

South Carolina Department of Labor, Licensing, and Regulation. Retrieved December 22, 2010. https://verify.llronline.com/LicLookup/Nurse/Nurse.aspx?div=17

APRN model act/rules and regulations. Chicago: National Council of State Boards of Nursing, 2008. Retrieved December 12, 2010. (http://www.ncsbn.org/APRN_leg_language_approved_8_08.pdf.)

Fariman, J., Rowe, J., Hassmiller, S., & Shalala, D. (2010). Broadening the scope of practice for nurse practitioners. *New England Journal of Medicine*. Retrieved December 22, 2010. http://www.nejm.org/doi/pdf/10.1056/NEJMp1012121

Eibner C., Hussey P., Ridgely M., & McGlynn E. Controlling health care spending in Massachusetts: an analysis of options. Retrieved August 2009. (http://www.rand.org/pubs/technical_reports/2009/RAND_TR733.pdf.)

University Specialty Clinics Matrix of Credentialing Organizations. Retrieved December 22, 2010. http://specialtyclinics.med.sc.edu/index.asp

Pearson, L. (2015). Annual update of how each state stands on legislative issues affecting advanced nursing practice. *The Nurse Practitioner.*

Starck, P. The cost of doing business in nursing education. *Journal of Professional Education, 21*, 183-190.

American Medical Association. (2009). *Nurse Practitioners.* Retrieved December 22, 2010. http://www.acnpweb.org/files/public/080424_SOP_Nurse_Revised_10_09.pdf

Affordable Health Care Act for America (2009). Retrieved 8-1-2010. http://energycommerce.house.gov/Press_111/health_care/hr3962_SUMMARY.pdf

Bauer, J. (2010). Nurse Practitioners as an underutilized resource for health care reform: Evidence based demonstrations of cost-effectiveness. *Journal of American Academy of Nurse Practitioners, 22*, 228-231.

Fitzpatrick, A., Powe, N., Cooper, L., Ives, D., & Robbins, J. (2004). Barriers to health care access among the elderly and who perceives them. *American Journal of Public Health, 94*(10, 1788-1794.

Latter. S., Maben, J., Myall, M., &Young, A. (2007). Evaluating the clinically appropriateness of nurses' prescribing practice: method development and findings from an expert panel analysis. *Quality and Safety in Health Care,* 16(6), 415-421.

Running, A., Hoffman, L. & Mercer, V. (2008). Physician perceptions of nurse practitioners: a replication study. *Journal of the American Academy of Nurse Practitioners*, 20, 429-433.

Bennett, K., Probst, J., Moore, C., & Shinogle, J. (2003). Emergency department use by medically indigent rural residents [Draft]. *South Carolina Rural Health Research Center.* Arnold School of Public Health, July, 2003. Retrieved January 23, 2010, from http://rhr.sph.sc.edu/report/SCRHRC%20ED_Exec%20sum.pdf.

National Rural Health Association. (2009). *About the NRHA*. Retrieved December, 18, 2010 from http://www.ruralhealthweb.org/go/top/about-the-nhra/

South Carolina Campaign to Prevent Teen Pregnancy. (2006). 15 years of commitment: 2010 Teen pregnancy report. Retrieved November 12, 2009 from http://www.teenpregnancysc.org/documents/Map.pdf.

South Carolina Cancer Profiles. (n.d.). Cancer profiles by county. Retrieved November 17, 2010 from http://statecancerprofiles.gov.

South Carolina Department of Health and Environmental Control. Best Chance Network. Retrieved November 17, 2010 from http://www.scdhec.gov/health/chcdp/cancer/bcn.htm.

South Carolina Department of Health and Environmental Control. Bureau of Health. Retrieved on November 10, 2010 from http://www.scdhec.gov/health/disease/immunization/docs/contacts.pdf**.**

South Carolina Department of Health and Environmental Control: Bureau of

Community Health and Chronic Disease Prevention. (n.d.). *County Chronic Disease Fact Sheet, September 2009*. Retrieved November 17, 2010 from http://www.scdhec.gov/hs/epidata/county reports and http://www.scdhec.gov/health/epidata/docs/chronic/Richland.pdf.

South Carolina Department of Health and Environmental: Bureau of Community Health and Chronic Disease Prevention. (n.d.). Annual Report on Reportable Conditions. Retrieved November 10, 2010 http://www.scdhec.gov/health/disease/docs/Annual_Report_on_Reportable_Conditions.pdf.

South Carolina Department of Health and Environmental Control. (n.d.). *Healthy people living in healthy communities 2008.* Retrieved on November 17, 2010 from http://www.scdhec.gov/administration/library/ML-006048.pdf.

South Carolina Department of Health and Environmental Control. *Making the Grade on Women's Health: Women 18-64, non-institutionalized civilian population*. Retrieved November 17, 2010 from http://www.scdhec.gov/health/chcdp/cancer/facts.htm.

South Carolina Department of Health and Environmental Control: Office of Public Health Statistics and Information Services, Division of Biostatistics 2009. (n.d.). Retrieved November 10, 2010 from http://www.scdhec.gov/co/phsis/biostatistics/an_pubs/IMR2007highlights.pdf.

South Carolina Department of Health and Environmental Control: Office of Public Health Statistics and Information Services, 2010. Division of Biostatistics. *The SC Teen Pregnancy Handbook.* Retrieved on November 10, 2010. http://www.scdhec.gov/co/phsis/biostatistics/an_pubs/Teen_Pregnancy_2007.pdf.

South Carolina Department of Juvenile Justice. (n.d.). 2008 Report Card. Retrieved November 18, 2010 from http://www.state.sc.us/djj/pdfs/2008-Report-Card.pdf.

South Carolina Department of Social Services. (2004) *Child and Family Services Review: Statewide Assessment.* 2004;200:1-124.

Needleman, J., & Minnick, A.F. (2008). Anesthesia provider model, hospital resources, and maternal outcomes. *Health Services Research, 44*, 464-482.

Pine, M., Holt, K.D., & Lou, Y-B. (2003). Surgical mortality and type of anesthesia provider. *AANA Journal, 71*(2), 109-116.

Simonson, D.C., Ahern, M.M., & Hendryx, M.S. (2007). Anesthesia staffing and anesthetic complications during cesarean delivery: A retrospective analysis. *Nursing Research, 56*(1), 9-17.

Smith, A.F., Kane, M., & Milne, R. (2004). Comparative effectiveness and safety of physician and nurse anesthetists: A narrative systematic review. *British Journal of Anesthesia, 93*(4), 540- 545. doi: 10.1093/bja/aeh240.

Abenstein, J.P., Long, K.H., McGlinch, B.P., & Dietz, N.M. (2004). Is physician anesthesia cost-effective? *Anesthesia & Analgesia, 98*(3), 750-757.

Martin-Sheridan, D., & Wing, P. (1996). Anesthesia providers, patient outcomes, and costs: A critique. *AANA Journal, 64*(6), 528-534.

Merritt Hawkins & Associates. (2008). *2008 Review of physician and CRNA recruiting initiatives*. Retrieved December 2010 from http://www.merritthawkins.com/com pensation-surveys.aspx

Donnelly, E.F., & Buechner, J.S. (2001). Complications of anesthesia. Rhode Island Department of Health. *Health by Numbers, 3*(10). Retrieved from http://www.health.ri.gov/publications/healthbynumbers/0110.pdf

Health Cost and Utilization Project. (2007). *Nationwide inpatient sample*. Retrieved from http://www.hcupus.ahrq.gov/nisoverview.jsp

South Carolina Office of Rural Health. *About SCORH.* Retrieved November 22, 2010 from http://www.scorh.net/view.php?pid=3

U.S. Census Bureau. (n.d.). *South Carolina State and County Quick Facts*. Retrieved November 17, 2009 from http://quickfacts.census.gov/qfd/states/45/45079.html.

US Census data. (n.d.). South Carolina State Census Data for Census Tract 29204. Retrieved November 17, 2009 from http://quickfacts.census.gov/qfd/states/45000.html.

U.S. Department of Health and Human Services DHHS, Administration for Children & Families. (n.d.*). The AFCARS Report: Preliminary FY 2005 Estimates as of September 2006*. Retrieved October 31, 2009 from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report13.htm.

U.S. Department of Health and Human Services DHHS. Healthy People 2010. Retrieved on November 25, 2009 from http://www.hhs.gov/.

Dullise, B. & Cromwell, J. (2010). No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians. *Health Affairs*, 29, no.8 (2010):1469-1475. Retrieved January 20, 2011 from http://content.healthaffairs.org/content/29/8/1469.full.html

Hogan, P., Seifert, R., Moore, C., & Simonson, B. (2010). Cost of Effectiveness Analysis of Anesthesia Providers. *Nursing Economics,* 3(28), 159.

SC APRN Licensure Data 2008. Retrieved on January 25, 2011-2015 from https://dwhcubes.state.sc.us/panorama/panorama_public_nursing.htm

Fairman, J., Rowe, J., Hassmiller, S., & Shalala, D. (2010). Broadening the scope of Practice. *New England Journal of Medicine*, 10(1056), 1-4.

An, J., Saloner, R., Tisdale, R., and Ranji, U. (2010). *US Health Care Costs: Background Brief.* Retrieved January 20, 2011 from http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358#1b.

American Nurses Association. *Nursing's Agenda for Health Care Reform, revised 2008.* Retrieved April 20, 2011 from http://nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform.aspx.

Battaglia, L. (2011). Vulnerability of Nurse Practitioners. *Washington Law Review*, 87 (1127), 1127-1160.

Blumenreich, G. (1997). Legal briefs. The nature of supervision. Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=2375.

Blumenreich, G. (1986). Legal briefs. A surgeon's liability for the anesthesia provider: The law according to Dr. Modell. Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=2550.

Blumenreich, G. (2000). Legal briefs. Being smart about malpractice. Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=2337.

Blumenreich, G. (2000). Legal briefs. Supervision. Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=2335.

Blumenreich, G. (2005). Legal briefs. The Doctrine of Corporate Liability. Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=4559.

Van Nest, R. (2006). Can a CRNA medically directed and be an Independent contractor for tax purposes at the same time? Retrieved on May 12, 2011 from http://www.aana.com/resources.aspx?id=4584.

Bankert, M. (2010). *Watchful Care: A History of America's Nurse Anesthetist*. New York, NY:

Continuum, M. (1989). *Thatcher* VS. *History of Anesthesia with Emphasis on the Nurse Specialist*. Philadelphia, PA: JB. Lippincott; 1953-2010.

Labor, Licensing, and Regulation. South Carolina Board of Nursing Disciplinary Actions Against APRNs 1993-2011 and 2015. Retrieved July 8, 2011, September 2016 from http://www.llr.state.sc.us/POL/Nursing/index.asp?file=FinalOrders/Alpha/Alphaorders

Pearson, L. (2010). Annual Update on APRN Practice: State by State Analysis. American Journal of NP.

145. O'Grady, Eileen. (2011). National Council State Board of Nursing. *NCSBN APRN Roundtable Presentation: Health Reform and Emerging APRN Policy Issues.* May 18, 2011.

Pearson, L. (2011). Annual Update on APRN Practice: State by State Analysis. American Journal of NP. Retrieved on February 2011. http://www.pearsonreport.com/tables-maps/category/2011-summary-table/

Department of Veterans Affairs. (2011). *Veterans Health Administration Nursing Handbook: VHA Handbook 2011*. Washington, DC.

Johnston, S. (2011). Office of General Council Electronic Correspondence to Office of Nursing Services, Department of Veterans Affairs. *Memorandum VAPGCADV 7-201.*

Johnston, S . (2011). Office of General Council, Department of Veterans Affairs. *Federal Supremacy and Nursing Scope of Practice. Power Point Presentation.* Professional Staff Group, June 2011.

SC Board of Nursing website. (2011). http://www.llr.state.sc.us/POL/Nursing/

American Association of Colleges of Nursing. (2011). Licensure, Accreditation, Credentialing, and Education. Retrieved February 2011. http://www.aacn.nche.edu/

National Council of State Boards of Nursing. (2011 **).** Licensure, Accreditation, Credentialing, and Education. Retrieved July 2011. https://www.ncsbn.org/index.htm

Federal Trade Commission. (2014). *Policy perspectives: Competition and the regulation of advanced practice nurses.* Washington, DC: Authors. Retrieved from http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

Federal Trade Commission Advisory Opinion (2015) that states House Bill 3078 to remove barriers to practice for Nurse Practitioners and Certified Nurse Midwives will expand access. House Bill 3508 impedes access and is a restraint of trade. Letter to Representative Jenny Horne, SC. November 2015.

Blue Cross Blue Shield: http://blog.bcbsnc.com/2014/04/5-emergency-room-myths-busted/. Retrieved September 23, 2016.

American College of Gynecologist: Supporting Independent Practice for APRNs to Reduce Costs and Improve Access. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000057/Collaborative%20Agreement%20between%20Physicians%20and%20CNMs.CMs%20Dec%20%202011.pdf

SC Department of Health and Human Services: https://www.scdhhs.gov/press-release/behavioral-health-providers

Buppert, C. (2019). NPs vs PAs: What's the difference. *Medscape.* https:///www.medscape.com/viewarticle/917260?uac=129933FG&faf=1&sso=true&impID=2083417&src=WNL_infoc_190904_MSCPEDIT_NPPA-2#vp_2

Bureau of Labor Statistics. Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

McMichael, B., Safriet, B., Buerhaus, P. (2017). The extra-regulatory effect of nurse practitioner scope-of-practice laws on physician malpractice rates. *Medical Care Research and Review*. https://doi.org/10.1177/1077558716686889

McMichael, B., Spetz, J., Buerhaus, P. The association of nurse practitioner scope of practice laws with emergency department use: Evidence from Medicaid expansion. Medical Care. 57(5):362-368, May 2019

McMichael, Benjamin (2020) "Healthcare Licensing and Liability," Indiana Law Journal: Vol. 95 : Iss. 3 , Article 5.

Xu, W., Retchin, S., Buerhaus, P. Dual-eligible beneficiaries and inadequate access to primary care providers. *American Journal of Managed Care*. 2021;27(5)

DesRoches, CM, Clarke, S., Perloff, J., O'Reilly-Jacob, M, Buerhaus P. (2017). The quality of primary care provided by nurse practitioners to vulnerable Medicare beneficiaries. *Nursing Outlook* (2017), doi:10.1016/j.outlook.2017.06.007.

DesRoches, C, Gaudet, J, Perloff, J, Donelan, K., Iezonni, L. Buerhaus, P. (2013). Using Medicare Data to Assess Nurse Practitioner Provided Care. *Nursing Outlook*. 61(6):400-407.

Barnes, H, Richards, M, McHugh, M., & Martsolf, G. Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners, *Health Affairs* 37, no. 6 (June 2018): 908–14, https://www.ncbi.nlm.nih.gov/pubmed/29863933.

Ying, X, Smith, J, & Spetz, J. Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. The *Journal of the American Medical Association* January 1/8, 2019 Volume 321, Number 1, pp 102-105

Xu, W., Retchin, S., Buerhaus, P. (2001). Dual-eligible beneficiaries and inadequate access to primary care providers. *American Journal of Managed Care*. 2021;27(5)

DesRoches, CM, Clarke, S., Perloff, J., O'Reilly-Jacob, M, Buerhaus P. (2017). The quality of primary care provided by nurse practitioners to vulnerable Medicare beneficiaries. *Nursing Outlook* (2017), doi:10.1016/j.outlook.2017.06.007.

DesRoches, C, Gaudet, J, Perloff, J, Donelan, K., Iezonni, L. Buerhaus, P. (2013). Using Medicare Data to Assess Nurse Practitioner Provided Care. *Nursing Outlook*. 61(6):400-407.

Razavi, M., O'Reilly-Jacob, M., Perloff, J., Buerhaus, P. 2020. Drivers of cost differences between nurse practitioner and physician-attributed Medicare beneficiaries. *Medical Care* Feb 2021 59(2):177-184.
Alexander, D. & Schnell, M. Just what the nurse practitioner ordered: Independent prescriptive authority and population mental health. Revised January 9, 2019. WP2017-08 Federal Reserved Bank of Chicago.