

FREQUENTLY ASKED QUESTIONS REGARDING IMPLEMENTATION OF NEW LAW GOVERNING APRN PRACTICE

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

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

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

No. While the new law incorporates the contents previously required for protocols, there are additional requirements for the new practice agreements. Examples of new requirements include provisions relating to controlled substance prescribing and quality assurance measures for clinical standards.

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

No. There is no prior approval requirement, but either Board may request a copy of a practice agreement, which must be submitted within 72 hours of the request. Failure to produce a practice agreement upon request may result in disciplinary action.

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

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

Another important requirement of the new law is that a physician cannot enter into a practice agreement with an APRN performing a medical act, task, or function that is outside the usual practice of the physician or outside of the physician's training or experience. The Medical Board can approve exceptions to this requirement. For example, an internist who only sees adults must not enter into a practice agreement to work with an APRN practicing in a pediatric clinical setting without first obtaining an exception from the Medical Board.

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

Regardless of the employment relationship, the practice agreement establishes the clinical relationship between the physician and APRN who sign it and must comply with their respective professional standards. The physician and APRN are jointly responsible for developing and executing the practice agreement. The practice agreement is a clinical document, not an employment contract. It is intended to be individualized for each APRN

based on the APRN's education, training, and experience and on the type of practice and practice setting. Thus, there is no "one size fits all" standard document that can be used. If a template is provided by an employer, the document must be tailored to fit the specifics of the clinical practice of the APRN and physician working with that particular APRN.

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

6. Who must enter into practice agreements?

All APRNs **except** CRNAs must develop compliant practice agreements. S.C. Code Section 40-33-20(45) specifically refers to nurse practitioner, clinical nurse-midwife and clinical nurse specialist as the categories of APRNs who must enter into practice agreements with either a physician and/or medical staff.

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

Yes. The Board of Nursing previously audited APRN protocols biennially and will continue to audit practice agreements. The new law authorizes the Board of Medical Examiners to audit practice agreements. The Boards will conduct separate audits, utilizing their respective staff and resources. Both Boards have the authority to request a copy of a practice agreement, and the practice agreement must be submitted to the requesting Board within 72 hours. In the event an audit conducted by one Board reveals that a specific practice agreement does not comply with the law, the other Board will be notified of the noncompliance.

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

The Boards will determine whether the practice agreement complies with all statutory requirements, including, but not limited to, medical aspects of care, including the conditions to be treated, medications to be prescribed, and the mechanisms that allow the physician to ensure quality of clinical care and patient safety is maintained in accordance with state and federal laws, executive orders and all applicable Board rules and regulations. Quality assurance mechanisms include, but are not limited to, reasonable chart reviews, pharmacy and SCRIPTS audits, regularly scheduled conferences, designated communication methods and other support activities commensurate with the training, education and experience of the APRN. Auditors performing this function for the Boards will compare the content of the practice agreement under audit to the specific requirements of the practice act. Auditors will also look to make sure that the practice agreement has been executed and followed by all parties and is in effect for the current year.

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

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

10. Does the new law provide for a physician to "supervise" or "collaborate" with an APRN, or does it use another term?

The new law does not use the terms "supervise" or "collaborate" to describe the professional physician-APRN relationship. Instead, the new law uses the terms "work with" and "support" the APRN as it pertains to the physician. It is up to the individual physician and APRN to choose how they describe their clinical relationship within the practice agreement. Neither the Board of Medical Examiners nor the Board of Nursing is looking for any particular language to describe the relationship between the physician and APRN when auditing the practice agreement; however, the professionals are held to the standard of care set forth in their respective practice acts.

11. What are the responsibilities of a physician who enters into a practice agreement with an APRN?

The key responsibility of the physician is to ensure that the quality of clinical care and patient safety is maintained in compliance with state and federal law, executive orders, and Board regulations. The physician must include in the practice agreement the specific mechanisms the physician will utilize to meet that responsibility. Specifically, the physician and APRN should carefully evaluate whether certain components allowed by S.C. Code Ann. § 40-33-34 should be included in a practice agreement based upon the particular APRN's clinical training, experience and clinical setting. The practice agreement must also set out when direct evaluation by or referral to the physician is necessary and how backup consultation will be provided. Finally, the physician must be "readily available" to the APRN which means that the physician must be able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice.

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

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

On May 18, 2018, Governor McMaster signed R.203/S. 345 into law. This new law dramatically changes the manner in which advance practice registered

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

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

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

The Boards will continue to provide additional guidance.

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

With regard to prescriptive authority, it is not sufficient for the practice agreement to give the APRN blanket authorization to prescribe all drugs within a given controlled substance schedule. The new law requires the specific drugs the APRN can prescribe to be listed in the practice agreement. It may be sufficient to list some drugs by category (such as benzodiazepines). The practice agreement should be as specific as reasonably possible with regard to prescriptive authority and with regard to authorized medical acts and the treatments that may be initiated, continued, or modified. The language in practice agreements should not be boilerplate but should be tailored to the individual working relationship.

For example, the prescriptive authority section of a practice agreement of an APRN who practices in a pediatric practice should look very different from that of an APRN who practices in a pain clinic. In the event of an audit or investigation, Board staff should be able to easily determine whether the prescribing practice is consistent with that authorized by the practice agreement.

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

the prescription is written for patients in hospice or palliative care or long term care. C-II controlled non-narcotics medications can be prescribed for 30 days and for each renewal. The physician's written agreement for the subsequent prescription for each patient must be included in the patient chart and is separate from the written practice agreement's general authorization to prescribe controlled substances.

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

There is a specific list of medical acts set out in the new law that APRNs are authorized to perform unless the practice agreement provides otherwise. This list is set out in S.C. Code Ann. § 40-33-34(D)(2)(a)-(e). These are the only acts that fall into this category. Depending on the APRN's education, training, and experience, the physician and APRN may agree that it is appropriate for the APRN to perform these acts or may agree with some and not others. Even if the physician is in agreement with the APRN's performing all of these listed acts, it may be useful to provide affirmative authorization in the practice agreement so there is no confusion.

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

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

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

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

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

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

The Medical Board may approve exceptions to these requirements.

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

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

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

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

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

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

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

- written agreement of the physician with whom the APRN has entered into a practice agreement,¹ unless the prescription is written for patients in hospice or palliative care;
- (6) The inclusion of Schedule II narcotic substances if listed in the practice agreement and as authorized by Section 44-53-300, provided, however, that each prescription must not exceed a thirty (30) day supply for patients in palliative or hospice care or a five (5) day supply for all other patients;
 - (7) The requirement that each prescription must be signed or electronically submitted by the APRN with the prescriber's identification number assigned by the board all prescribing numbers required by law. Written prescription forms must include the name, address and phone number of the APRN **and** physician. Electronic prescription forms must include the name, address, and phone number of the APRN, and, if possible, the physician, through the electronic system. All prescriptions must comply with Section 39-24-20. A prescription must designate a specific number of refills and may not include a nonspecific refill indication; and
 - (8) The authorized prescription must be documented in the patient record of the practice and must be available for review and audit purposes.

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

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

¹ The physician's written agreement for the subsequent prescription for each patient must be included in the patient chart and is separate from the written practice agreement's general authorization to prescribe controlled substances.