Senate Bill 345

Senate Bill 345 in a nutshell will do this

- **Replaced the definition of supervision with collaboration for experienced NPs, CNS, CNM for the Collaborative Practice Agreement to bring the laws in conformity with current practice and modernize the law.**
- **Added supervision piece to the definition of collaboration for new graduates with less than 1875 hours (37.5 hours x 50 weeks = 1875 hours)**
- **Replaced Delegated Acts with Additional Acts**
- **Deleted mileage constraints**
- **Added APRNs can sign for Schedule 2**
- **Added APRNs can write for C2 for 30 days, with renewals every 30 days**
- **Removed Ratio constraints**
- **Added authorization for APRNs to:**
  1. **Order PT**
  2. **Provide samples at Free Medical Clinics**
  3. **Sign Handicapped Forms**
  4. **Sign Home Bound Forms**
  5. **Order Hospice**
  6. **Sign Death Certificates**

Senate Bill won't do this:

- **Authorize independent practice for APRNs**
- **Replace physicians with APRNs**
- **Diminish patient care or safety**

How will the bill benefit SC?

Increase access to care for rural, underserved, or urban underserved populations
Reduce costs to local communities and counties by keeping patients out of the ER
Reduce the C-Section rate
Increase prenatal care
Improve chronic disease management
Enhance agencies and hospital systems to reach out to communities for primary care
Create jobs
Improve the health rankings of SC, which is currently an "F"

Who supports Senate Bill 345?

AARP, SC Healthcare Association, Physicians, Agencies, Free Clinics, FQHCs, Rural Health Clinics, Patients, Distinguished Legislators, Long Term Care, APRNs.

Answering Objections on Senate Bill 345

Team based care will disappear without supervision agreements.
False. There is no evidence to support that supervision is critical to safety, quality, or access. The fact is that many states have no such restriction and collaboration continues. It is a requirement of modern day healthcare practice for all health professions and a specific component of the existing scope of practice for CNPs and CNMs for a collaborative practice to be maintained in Senate Bill 345. The Federal Trade Commission cited that Supervision Agreements can actually impede effective collaboration.

The transition to practice (TTP) hours aren't enough.
False. The opposition offers no evidence that a transition to collaborative practice is insufficient. None of the states have collaborative agreement licensure restrictions. Only 2 have TTP requirement, the rest have none, including Iowa which has never required collaborative agreements. 1040 was a reasonable compromise and can be adjusted based upon experience. This too should not be a barrier to NP/NM recruitment.

Why this divorce between the Board of Medicine and Nursing? There should be some physician advisory role in the process?
This isn't a divorce. This is a streamlining of the regulation of nursing practice. No other professional license is subject to dual board licensure even though many professions have overlapping scopes of practice. The National Council State Boards of Nursing strongly opposes dual regulation of APRNs.

There will be two standards of medicine or healthcare.
Unsubstantiated claim. Longitudinal studies over decades indicate that quality of care, safety, and health outcomes, along with patient satisfaction are at least equal if not better when comparisons are made between CNPs and CNMs and their physician colleagues.

MDs have more training and education.
MDs are training to be physicians. Advanced practice nurses are educated and trained and board certified to be Nurse Practitioners and Nurse Midwives. APRNs have **AT LEAST** 5-7 years of education and clinical practice training prior to entering into practice. This equates to 10,000 to 14,000 hours of direct practice. APRNs have overlapping scopes of practice with physicians, just as they do with pharmacists, dieticians, physical therapists.

CNPs and CNMs won't go to rural areas.
False. NP graduates of USC for example, 90% choose to remain in SC, 70% choose to work in primary care, and 52% practice in rural or underserved counties/populations. counties.

South Carolina Coalition for Access to Healthcare Representing over 1500 SC NPs and CNMS

THE HEALTH CARE PROBLEM:

- South Carolina ranks 43rd in the nation in the United Health Foundation's health report card. [1]
- South Carolina is in crisis as we face a critical shortage of primary health care providers.
- With the Affordable Care Act, 800,000 new South Carolinians will have new access to preventive care and annual wellness exams.
- Parts or all of 46 counties in South Carolina are designated as medically underserved by the South Carolina Department of Health and Human Services.
- The American Association of Medical Colleges Center for Workforce Studies predicts that there will be a shortage of about 63,000 physicians by 2015, and 130,600 by 2025. SC Ranks 40th 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 570 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].

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 who receive their master's degree have spent 4-5 years in clinical training by the time they are awarded their degree. NPs 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 education.

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 sixteen 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.
- 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 NP scope of practice in South Carolina by requiring physician supervision is in direct conflict with the educational system and Federal Trade Commission that state NPs to 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 within 45 miles of a physician, making it impossible for APRNS to provide care in rural SC communities. No other state has such a mileage regulation.
- In South Carolina, APRNs have limitations with ordering treatment for patients with disabilities, home health services, hospice care, Schedule II medications, and others.

WHAT NEEDS TO BE DONE:

1. **Legislative regulations must remove barriers to nursing practice in order to increase access and reduce health care costs.**

2. **Barriers that create a burden to be removed include: removing miles rules, supervision requirements, prescriptive limitations and limitations to privileges that impede 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.

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[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.

REMOVE BARRIERS TO PRACTICE

COMMON SENSE APPROACH TO MANAGING HEALTHCARE

HOW DOES SOUTH CAROLINA BENEFIT?

DUTY: CARE, COMMITMENT, COSTS

Ensure patient care outcomes
Meet critical access needs for consumers
Reduce costs to taxpayers

INCREASED 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.

REDUCED COSTS

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 2014-2016, 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.

INCREASED PSYCHIATRIAC OUTPATIENT CARE

Psychiatric providers are scarce in SC. Some SC counties have NO mental health providers. 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.

IMPROVED PATIENT OUTCOMES

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

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

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.

Who supports: Nurse Practitioners, Certified Nurse Midwives, Coalition for Access to Healthcare, SC Healthcare Association, AARP, Federally Qualified Healthcare Centers, Rural Health Centers, Agape Primary Care, Free Medical Clinics, Eau Claire Health Care Cooperative, Physicians Across the SC, South Carolina Nurses Association, American College of Gynecologists, Designated Legislators, SC Healthcare Association.

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

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