

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 341 ARNP Expanded Prescribing Authority, Including Controlled Substances
SPONSOR(S): Green and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 1736 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)	4 Y, 3 N	Rawlins	Collins
2) Health Care			
3) Finance & Tax			
4)			
5)			

SUMMARY ANALYSIS

Health care spending in the United States is projected to reach \$2.8 trillion in 2011, up from \$1.3 trillion in 2000, according to a report by the Centers for Medicare & Medicaid Services (CMS). The CMS report, published March 12, 2002, National Health Affairs, projects that for the entire 2001-2011 period, health spending is expected to grow at an average annual rate of 7.3 percent.

According to U.S. Census data, receipts for non-physician providers grew by 83 percent, from \$10.3 billion to \$18.9 billion between 1987 and 1992, while physician receipts increased by 56 percent, from \$90 billion to \$141 billion. Census data shows that employment by non-physician establishments grew by 50 percent, while jobs in hospitals and physician's offices increased less than 20 percent between 1987 and 1992.

Over the last century, the nurse's specialized role in patient care has been well established, especially in times of war or disasters. A nursing shortage, however, which is capturing national attention, is emerging. Nursing is by far the largest single health care profession, with approximately 2.6 million registered nurses (RNs) licensed to practice in the United States. Over the past fifty years, nursing has changed substantially from a largely supportive role in health care to one with many independent and complex responsibilities in care delivery.

The legal authority to provide and be reimbursed for health care services is tied to state statutes generally referred to as "practice acts," which establish professional "scopes of practice." These practice acts, often differ from state to state, and are a source of considerable tension among the professions; resulting in "turf battles" which clog the legislative agenda across the country. Caught in the middle of these battles, legislators must decide whether new or unregulated disciplines and occupations should be regulated and whether professions currently regulated should be granted expanded practice authority.

HB 341 expands the advanced registered nurse practitioners' (ARNP) prescribing authority to include controlled substances. The bill specifies that an ARNP must register with the Board of Nursing to prescribe medicinal and controlled drugs; provides fees; prohibits prescription of controlled substances for personal use; provides for disciplinary actions; and revises definition of practitioner under Florida Comprehensive Drug Abuse Prevention and Control Act to conform to these provisions.

The bill establishes an effective date of July 1, 2003.

According to the Department of Health: total estimated revenue from licensure fees: \$225,000 in FY 03-04, and \$225,000 in FY 04-05; and total estimated expenses are \$188,290 in FY 03-04 and \$223,721 for FY 04-05.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

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DATE: April 4, 2003

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

- | | | | |
|--------------------------------------|---|-----------------------------|------------------------------|
| 1. Reduce government? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 2. Lower taxes? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 3. Expand individual freedom? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 4. Increase personal responsibility? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 5. Empower families? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |

For any principle that received a "no" above, please explain:

The bill expands the role of government by creating additional regulation for nurse practitioners, but lessens the role in government by providing for additional practice parameters.

B. EFFECT OF PROPOSED CHANGES:

Health care spending in the United States is projected to reach \$2.8 trillion in 2011, up from \$1.3 trillion in 2000, according to a report by the Centers for Medicare & Medicaid Services (CMS). The CMS report, published March 12, 2002, by the National Health Affairs, projects that for 2001-2011 period, health spending is expected to grow at an average annual rate of 7.3 percent.

According to U.S. Census data, receipts for non-physician providers grew by 83 percent, from \$10.3 billion to \$18.9 billion, between 1987 and 1992, while physician receipts increased by 56 percent, from \$90 billion to \$141 billion. Census data show that employment by non-physician establishments grew by 50 percent, while jobs in hospitals and physician offices increased less than 20 percent between 1987 and 1992.¹

Licensure laws have the effect of limiting the supply of health care providers and restrict competition to physicians from non-physician practitioners. The primary result is an increase in physician fees and income that drives up health care costs.²

At a time when government is trying to reduce health spending and improve access to health care, it is imperative to critically examine the extent to which government policies are responsible for rising health costs and the unavailability of health services. It is reported in the Yale Journal on Regulation, that eliminating the roadblocks to competition among health care providers could improve access to health services, lower health costs, and reduce government spending.

Professional licensure laws and other regulatory restrictions impose significant barriers to Americans' freedom of choice in health care. Clark Havighurst, the William Neal Reynolds Professor of Law at Duke University, has pointed out, "Professional licensure laws have long made the provision of most personal health services the exclusive province of physicians. Obviously, such regulation limits consumers' options by forcing them to use highly trained, expensive personnel when other types might serve quite well."³

Yet the freedom to contract--the right of individuals to decide with whom and for what services they will dispose of their earnings--is one of the fundamental rights of Americans. As Chief Justice John

¹ Cato Policy Analysis No. 246 December 15, 1995, "The Medical Monopoly: Protecting Consumers or Limiting Competition?" Sue A. Blevins.

² Ibid.

³ Clark Havighurst, "The Changing Locus of Decision Making in the Health Care Sector," Journal of Health Politics, Policy, and Law 11 (1986): 700.

Marshall said in *Ogden v. Saunders*, "Individuals do not derive from government their right to contract, but bring that right with them into society . . . [e]very man retains [the right] to . . . dispose of [his] property according to his own judgment.

Accordingly, individuals should have the legal right to decide with whom they will contract for the provision and coordination of their health care services: doctors, midwives, nurse practitioners, chiropractors, spiritual healers, or other health care providers.

Health care workforce regulation plays a critical role in consumer protection. For most of this century, the state regulation of health care occupations and professions has established a minimum standard for safe practice and removed the egregiously incompetent. As market and regulatory forces shape the future of health care, particularly the location and content of practice, the structure, and functions of state professional regulation must continue to provide consumers with important protections leading to safe and effective practice.⁴

This ostensible goal of professional regulation – to establish standards that protect consumers from incompetent practitioners – is eclipsed by a tacit goal of protecting the professions' economic prerogatives. This dichotomy of goals has created serious shortcomings that include limited public accountability, and support for practice monopolies that limit access to care and lack of national uniformity.

The Nursing Profession

Over the last century, a career in nursing has grown from an informally trained occupation, to a highly educated, accomplished profession. For example, in the late 1800's, nursing qualifications were described as:

“...Qualifications required to be a successful nurse are necessarily of a high order, and this applies not only to the trained nurse, but to her embryo sister who wishes to adopt nursing as a calling.

In the first place, she must be not only physically, but constitutionally strong. She must be not only well formed, but must have certain powers of resistance. A girl, for example, who is subject to sick headaches...will never make a good nurse. The best type of nursing girl is one who is tall and strong, and who has a certain suppleness of movement. One who is accustomed to play lawn-tennis, who can ride, and skate, and row, makes the best material. If she can dance, especially if she is an enthusiastic dancer, it is a great advantage, for graceful carriage is a thing to be cultivated, and nothing is more distasteful in a sick-room than a suspicion of clumsiness. If in addition to being well formed she is favoured with good looks, it is all in her favour, for doctors readily recognise the influence of an attractive person in the management of refractory patients.”⁵

However, over the last century, the nurse's specialized role in patient care is well established, especially in times of war or disasters.⁶ A nursing shortage, however, is capturing national attention, just when challenges to the health care system are increasing.

Nursing is by far the largest single health care profession, with approximately 2.6 million registered nurses (RNs) licensed to practice in the United States. Over the past fifty years, nursing has changed

⁴ See Pew Health Professional Commission report, “Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation,” October 1998.

⁵ “Ambulance Work And Nursing ---A Handbook On First Aid To The Injured With A Section On Nursing, Etc.,” found in the Library at The Medical Center At The University Of California San Francisco, which was published in Chicago by W. T. Keener & Co. approximately in the late 1890's from a British work published by Cassell & Company, Limited, La Belle Sauvage, London, E.C. No Author is given, www.enw.org/1895-nursing.htm

⁶ Dr. Patricia A. Grady, Director, National Institute of Nursing Research, Witness appearing before the U.S. House of Representatives, Subcommittee on Labor-HHS-Education Appropriations Meeting, March 13, 2002.

substantially from a largely supportive role in health care to one with many independent and complex responsibilities in care delivery. Today, RNs are called upon to conduct physical exams, coordinate pathways of care, provide health education, and perform many other tasks with and without the collaboration of other providers. RNs may be classified into five groups, based on the highest level of education they have completed:

- Associate degree (two-year program based at a community college);
- Diploma (three-year program based at a hospital);
- Baccalaureate degree (four-year college program);
- Master's degree (one- to two-year graduate program); and
- Doctoral degree.⁷

Particularly in underserved areas and long-term care facilities, registered nurses with advanced training--nurse practitioners--are able to provide most basic health services provided by physicians, and at lower costs. The American Nurses Association estimates that of the 2.1 million registered nurses nationwide, approximately 400,000 deliver primary care. Many of them are practicing in managed-care organizations under the supervision of physicians. Some 21,000 nurses have received advanced training at graduate schools of nursing and are licensed nurse practitioners.

Research shows that between 75 and 80 percent of adult primary care, and up to 90 percent of pediatric primary care services could be safely provided by nurse practitioners.⁸ A study by the Office of Technology Assessment found that the outcomes of nurse practitioner care were equivalent to those of services provided by physicians and that nurse practitioners were actually more adept in communication and preventive care. The Office of Technology Assessment study also indicates that increasing access to nurse practitioner services could be especially advantageous for the homebound elderly.⁹

SCOPES OF PRACTICE AUTHORITY

The legal authority to provide and be reimbursed for health care services is tied to state statutes generally referred to as practice acts, which establish professional "scopes of practice." These practice acts often differ from state to state and are a source of considerable tension among the professions; resulting in "**turf battles**" which clog the legislative agenda across the country. Caught in the middle of these battles, legislators must decide whether new or unregulated disciplines and occupations should be regulated and whether professions currently regulated should be granted expanded practice authority.

Further, it is reported that the U.S. would save between \$6.4 and \$8.75 billion a year if nurse practitioners were more widely used. But they are not because "many states impose scope-of-practice regulations that prevent nurses from practicing independently as primary care providers," says Sue Blevins of the CATO Institute. This action suppresses the full potential demand for them because they are not legally free to compete.¹⁰

Scope of Practice in Florida and other states

Currently, Florida's advanced registered nurse practitioners may prescribe medicinal drugs, excluding controlled substances, upon licensure and establishment of a protocol with a physician. Advanced registered nurse practitioners are not included in the list of practitioners able to prescribe controlled substances pursuant to chapter 893, Florida Statutes.

⁷ The Fourth Report of the Pew Health Professions Commission, "Recreating Health Professional Practice for a New Century," December 1998.

⁸ Kochman, p. 8; P. Capan et al., "Nurse-Managed Clinics Provide Access and Improved Health Care," *Nurse Practitioner* 18 (1993): 53-55.

⁹ Office of Technology Assessment, *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives*, Health Technology Case Study 37, OTA-HCS-37 (Washington: U.S. Government Printing Office, December 1986), pp. 5-10.

¹⁰ Institute for Health Freedom, "The Medical Monopoly: Your Tax Dollars Limit the Competition," by Richard Leviton.

However, the national trend over the past decade has shifted from no prescribing authority, to limited prescribing authority, and as of 2003, all but seven states authorize nurse practitioners to prescribe controlled substances. The table below, which is a compilation of the 2000 data from the American Nurses Association, 2003 data from the Florida Nurses Association and staff independent research, illustrates prescriptive authority nationally:

Prescriptive Authority Chart¹¹

State	Type of Practitioner	Drug Schedules Under Which Practitioner Has Authority to Prescribe	Is Practice Agreement Collaboration or Protocol Required to Prescribe?	Remarks
ALABAMA	NP, CNM	Noncontrolled drugs only	YES	Must be in collaborative relationship, working under a protocol.
ALASKA*	NP, ¹² CRNA	II - V	NO	Must have an approved consultation plan.
ARIZONA*	NP	II - V ¹³	NO	Have full prescribing and dispensing privileges. Must have "collaborative," i.e., consultative or referral relationship with a physician. No specific protocol required. Schedules IV-V: 34-day supply.
ARKANSAS	NP, CNS+	II - V	YES	Law allows certified CNSs and NPs to prescribe drugs when in collaborative practice agreement, to include protocols.
CALIFORNIA ¹⁴	NP	II-V	YES	Protocol is required to prescribe. Effective January 1, 2000, NPs can apply for DEA numbers. Law was changed to replace the term "furnishing" with the term "ordering."
COLORADO*	NP, CNS, CNM, CRNA	II-V	NO	Prescriptive authority collaborative agreement must exist; however, law specifically states that nothing shall be construed to limit the liability of the NP to make an independent judgment or to require supervision by a physician.
CONNECTICUT*	NP, CNM, CNS NA	II - V	YES	Limitations on scope of prescriptive authority of CRNA based upon certification. Limitations on Schedules II & III for NP and CNS.

¹¹ See, AMERICAN NURSES ASSOCIATION, www.nursingworld.org/gova/charts/rxce.htm and the Florida Nurses Association.

¹² In Alaska, NP includes, NPs and CNMs, NP=Nurse Practitioner, CNS =Clinical Nurse Specialist, CNM=Nurse Midwife, CRNA=Certified Registered Nurse Anesthetist. Both controlled and noncontrolled drugs require a prescription. Controlled drugs are organized according to schedule (II to V), with the lowest schedule number having the highest potential for abuse. Noncontrolled drugs include antibiotics, analgesics, and anti-inflammatory medications, among others.

¹³ Previously Arizona limited schedules II-III to 48-hr supply and amended law for consistency in schedule IV-V authority. In 1998, they considered changes to Article 5 to include: elimination of 1000-hour work requirement for prescribing and dispensing authority (R4-19-101(1)); (R4-19-507(A.2)); elimination of the submission of the name of the collaborating physician (R4-19-505(b)); (R4-19-507(A.3.h) and R4-19-507(J)); elimination of the renewal of prescribing and dispensing authority; addition of definitions of "administer;" "prescribe;" "dispense;" "clinical nurse specialist;" and addition of title protection for clinical nurse specialists and clarification that NPs should prescribe and dispense within the scope of their practice.

¹⁴ Change in law reported by the California Coalition of Nurse Practitioners.

DELAWARE	APN, CNS, NP	All drugs including controlled II - IV	YES	Must be under collaborative arrangement and in compliance with joint practice committee rules. Rules are being promulgated.
DISTRICT OF COLUMBIA*	NP, CNM, NP, CNM, CNS CRNA	II-V	YES	
FLORIDA (M)	NP CNS	Noncontrolled drugs Only	YES	Under statutory-authorized protocol and practice agreement. CNS can prescribe only if licensed as ARNP.
GEORGIA	NP	None	YES	No independent prescriptive authority, but Advance Practitioner Nurse (APN) can be delegated authority to order controlled substances, medical treatments or diagnostic studies in a public health setting or in certain hospitals and patient clinic settings (ordered under nurse protocols).
GUAM	NP	None	YES	Collaboration is required.
HAWAII	APRN ¹⁵	Noncontrolled drugs only	YES ¹⁶	Exclusionary formulary, cannot order controlled substances. Legislation is pending that would allow APRNs to order controlled substances.
IDAHO	CNS, NP, CRNA, CNM	II - V within scope of practice	YES	Sole promulgation by BON, no formula, no protocol.
ILLINOIS	NP, CNS, CNM	Noncontrolled and controlled III – V	YES	Must have collaborative agreement to be licensed as an APN. Legislation signed 8/13/98.
INDIANA ¹⁷	NP, CNS, CNM	II – V	YES	In collaboration with licensed MDs as evidenced by practice agreement or privileges.
KANSAS	NP, CNM, CNS+	II – V	YES	NPs, CNMs, and CNSs may prescribe under jointly adopted protocols between the nurse and "the responsible physician," including controlled drugs. Effective April 1, 2000, must obtain DEA numbers to prescribe II-V.
KENTUCKY	NP, CNS+, CNM, RNA	Noncontrolled drugs only	YES	Enacted legislation authorizing APNs to prescribe noncontrolled prescriptive authority under a written collaborative agreement with a physician.
LOUISIANA ¹⁸	CNM, NP, CNS	Noncontrolled drugs only except as specifically authorized by the Joint Administration Committee	YES	Joint promulgation of rules by Board of Nursing and Board of Medical Examiners. BON has total enforcement authority.
MARYLAND*	NP ¹⁹	II – V	YES	Written agreement between MD and NP.

¹⁵ In Hawaii, APRN title includes Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

¹⁶ In Hawaii, APRNs must have a collegial agreement with a physician.

¹⁷ In Indiana, Burns Ind. Code Ann. §25-23-1-30 (1995) specifically states that prescriptive authority not required for administration of anesthesia.

¹⁸ Bill signed by Louisiana Legislature to provide limited prescriptive authority in collaborative practice, May 1995.

MASSACHUSETTS*	NP, CNM, Psych CNS	II - VI ²⁰	YES	Orders to manufacturer/wholesalers limited to schedule VI only.
MICHIGAN	NP, CNM, CRNA	II - IV Only	YES	Michigan NPs and CNMs may prescribe both controlled and noncontrolled substances as a delegated act. CRNAs may prescribe noncontrolled substances as a delegated act. ²¹
MINNESOTA*	NP, Psych CNS	II – V	YES	NPs must have agreement with physician in order to prescribe; nurse midwives do not need to.
MISSISSIPPI(M)	NP	Noncontrolled drugs and controlled	YES	Protocols are required in order to prescribe. They must be on file with the BON.
MISSOURI	APN ²² , CNM, CNP, CNS, CRNA	Noncontrolled substances only	YES	Can prescribe non-controlled substances as a delegated medical act through collaborative agreement or protocols and the requirements are jointly determined by BON and BHA through rules.
MONTANA*	NP Nurse Specialist to include: CNM and some CNSs	II – V	NO	No protocol required for prescribing. Schedule II limited to a 72-hour supply.
NEBRASKA	APRN, CRNA	II ²³ III – V	YES - ARNP No - CRNA	ARNPs without master's degrees and/or certain coursework must have protocols to prescribe.
NEVADA*	APN, CNS ²⁴	Noncontrolled substances and controlled	YES	Must also apply to Board of Pharmacy. No controlled substance drugs may be listed in protocol. APNs can only administer and dispense scheduled II-V drugs.
NEW HAMPSHIRE*	NP	II - V	NO	Prescribing only allowed from state formulary for controlled and noncontrolled substances. No protocol required for prescribing.
NEW JERSEY	NP, CNS+	Noncontrolled drugs and controlled	YES	Medication protocols are required to prescribe. No practice protocols are required.
NEW MEXICO*	NP, CNS+	II - V	NO	Formulary certified by the BON. This is an independent practice state for APNs and CNSs.
NEW YORK*	NP, CNM	II - V	YES	Collaborative relationship, with written practice agreements and protocols.

¹⁹ In Maryland, prescriptive authority for NPs only, not for nurse psychotherapists.

²⁰ In Massachusetts, all prescription medications not classified by the federal government as II-V are categorized as Schedule VI.

²¹ In Michigan, controlled substance rulemaking has been proposed.

²² Under new law in Missouri, new APNs must practice under supervision before he/she is allowed to practice independently. In addition, the new APN retains a copy of the collaborative agreement.

²³ In Nebraska, APNs can prescribe schedule III-V drugs without limitation. They can only prescribe schedule II drugs as listed on the state schedule for pain control.

²⁴ If certified as advanced practice nurses in Nevada.

NORTH CAROLINA*	NP	II - V	YES	NPs and CNMs have authority to prescribe drugs including controlled substances according to site-specific protocols. NPs and CNMs may also be approved to compound and dispense drugs by the NCBOP.
NORTH DAKOTA*	NP, CNS+, CNM	II - V	YES	Scope of practice statement is required, to cover collaboration.
	CNS, NP	Noncontrolled drugs	YES	Per formulary under supervision.
OHIO*²⁵	CNM, CNS, NP	II - V²⁶ site restrictions	YES	Per formulary under supervision in written collaborative agreement between physician and APN who is available in person, by radio, telephone, or some other form of communication. APNs are granted limited prescriptive privileges.
OKLAHOMA	CNM, CNS, NP	III - V Noncontrolled drugs	YES	Per exclusionary formulary under supervision.²⁷
OREGON*	NP²⁸	II - V	NO	Pursuant to formulary determined by the Board of Nursing. No protocol required for practice.
PENNSYLVANIA*	CNM, CRNA, NP	Cannot prescribe without a physician's signature	YES²⁹	
RHODE ISLAND*	NP, CNS+	III-V	YES	While NPs cannot apply for their own DEA number, this may change. The DEA is reviewing BON request. Formulary is now required; NP must be in collaboration with MD.
	CNM	III-V	YES	Certified nurse midwives are permitted to apply for their own DEA number.
SOUTH CAROLINA*	NP, CNS	V	YES	Listing of drugs in the MD-approved protocol.
SOUTH DAKOTA	NP	II - IV	YES	NPs must have federal and state DEA numbers to prescribe scheduled medications. Prescriptive authority is considered overlapping scopes of practice and is authorized by the collaborative agreement. There is no review or countersignature required. Schedule II drugs have a 48-hour time limit.
TENNESSEE	NP, CNS, CNM,	II - V³⁰	YES	Upon receipt of a BON Certificate of Fitness to prescribe, nurses in advanced

²⁵ Ohio enacted legislation to give limited prescriptive authority to APNs (House Bill 241). Previously, prescribing was site-restricted.

²⁶ In Ohio, schedule II drugs may be prescribed only if a patient has a terminal condition, the nurse's collaborating physician initially prescribed the drug, and the amount prescribed does not exceed the amount necessary for a single 24-hour period.

²⁷ In Oklahoma, CRNAs have the option to apply for the authority to select, obtain, and administer schedule III-V and legend drugs - subject to an inclusionary formulary under supervision.

²⁸ In Oregon, as of 1999, NPs who have the need for Schedule II medications will have to apply to the DEA for this expansion of prescriptive authority.

²⁹ Although statutory authorization exists in Pennsylvania, joint rules have not been completed by Board of Nursing and Board of Medicine, as of January 2000.

	CRNA			practice may write and sign prescriptions and/or issue drugs. 1997 law dependent upon rules in process, promulgated but in Attorney General's office.
TEXAS	APNs (NPs, CNSs, CNMs, CRNAs)	Dangerous/Legend Drugs (Noncontrolled Substances)	YES	APNs (NPs, CNSs, CNMs, & CRNAs) may prescribe under physician delegation using protocols, standing orders, or other orders. Protocols need not take cookbook approach and should be defined "to promote exercise of professional judgment of APN" BON and BOM have defined broadly as "legal authorization to initiate medical aspects of patient care." Prescriptive authority is site based but most practice sites are covered.
UTAH	APRN	III - V, PA	YES	Utah requires collaboration with a physician. Prescriptive practice collaboration is spelled out in a consultation referral plan, signed by the collaborating physician.
VERMONT*	NP, CNS, CNM, CRNA	II - V	YES	Must prescribe under collaborative guidelines, which do not necessarily spell out formulary. The focus is on scope of practice, referral, consultation, and quality. The BON reviews the agreements.
VIRGINIA	NP ³¹ , CNS +	VI	YES	A practice agreement is required to prescribe, however, Schedule VI are prescribed per formulary.
VIRGIN ISLANDS	CNS, NP	Noncontrolled drugs	YES	Independent prescriptive authority
WASHINGTON*	NP	V	NO	
WEST VIRGINIA*(M)	NP, NMW	III - V	YES	Collaboration agreement is required to prescribe, and must include written guidelines or protocols for prescriptive authority.
WISCONSIN ³² *(M)	NP, CNM, CRNA, CNS	II - V	NO	Independent prescriptive authority, however nurses must facilitate collaboration. Limitations on schedule II drugs nurses can prescribe.
WYOMING*	NP, CNS	III - V and Legend Drugs	YES	The BON is seeking permission from the DEA for nurses who have prescriptive authority to apply for their own independent DEA registration number. NPs must have a plan of referral to work with a physician as needed.

³⁰ In Tennessee, controlled substances prescribing Schedules II through V subject to protocols established with a supervising physician.

³¹ In Virginia, NPs have prescriptive authority with the exception of CRNAs.

³² During 1997 and 1998, the Wyoming Board of Medical Examiners twice proposed rulemaking, which would make the protocols more restrictive. Rules have not been promulgated in final form.

HB 341

The bill specifies that the Board of Nursing is required to create two additional classes of advanced registered nurse practitioners:

- one for those who prescribe medicinal drugs; and
- a second for those who prescribe both medicinal drugs and controlled substances.

Additional Department of Health nursing staff would be required within the board office to process applications and review protocols; a fee up to \$75 is authorized to cover such costs.

Nurse Practitioners who register for controlled substances would be able to expedite treatment of patients in a more timely, efficient manner, especially in those areas of the state that are underserved with primary medical care.

C. SECTION DIRECTORY:

Section 1. Creates s. 464.0125, F.S., to establish requirements for an advanced registered nurse practitioner who prescribes medicinal drugs to register with the Board of Nursing; complete at least 16 hours of continuing education in pharmacology in the biennium; submit a copy of the protocol between the advanced registered nurse practitioner and supervising physician with renewal or sooner; general supervision by the physician; and agreement to maintain medical records for each prescription. Establishes similar requirements for an advanced registered nurse practitioner who prescribes medicinal drugs and controlled substances, with the additional requirements of possessing a mid-level practitioner registration from the Federal Drug Enforcement Administration; completes a course in legal and clinical aspects of prescribing controlled substances; incorporates schedules of controlled substances authorized in the protocol; excludes certified registered nurse anesthetists from these requirements; and allows the board to adopt rules to implement the provisions of the bill.

Section 2. Amends s. 893.02, F.S., to include advanced registered nurse practitioners in the list of practitioners authorized to prescribe controlled substances.

Section 3. Establishes an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See "Fiscal Comments" section of bill analysis.

2. Expenditures:

See "Fiscal Comments" section of bill analysis.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Basic economic principles of supply and demand would argue that the more practitioners available to treat patients, the less it will cost to provide services. Decrease in expenditures for providing basic health care services has a wide range of positive fiscal impacts with the health care industry.

D. FISCAL COMMENTS:

According to the Department of Health, to implement the provisions of this bill will require 3 additional FTEs. The salary and benefits were computed using the annual midpoint of the broad banding pay ranges plus 28.67% for benefits. Salary and benefits are lapsed at 75% for year 1. Recurring expenses for the two Nurse Consultants includes limited travel.

According to the Department of Health, in regards to the generation of revenues, the bill provides for a registration fee to be set by the Board of Nursing not to exceed \$75. The current number of registered nurses is 9,386. It is estimated that approximately 80% would apply for the medicinal drug registration or 7,508, and of this number, 50% would apply for the controlled substances registration. Using 7,500 registrations on a biennial basis to cover estimated expenditures, revenues are estimated at \$225,000 annually (7,500 x \$60 = \$450,000 biennially).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health provided the following information:

“The department will have to create forms and establish initial licensure and renewal procedures for implementation of the two classes of advanced registered nurse practitioners. Nursing staff will be required to evaluate protocols and credentials of advanced registered nurse practitioner for compliance with these standards. The Board of Nursing will create rules to implement.”

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Department of Health provided the following information:

“The Board of Nursing voted to support the concepts within this bill.”

“The Board of Medicine opposes this bill. It has consistently done so based on it’s perception of lack of safety standards for patients and concerns over further opening or expanding of an area that already is cause for concern, controlled substance prescribing. Additionally, the Board has previously heard comments on this issue from physician assistants who believe that such a measure will increase the market advantage of Board of Nursing licensees - ARNPs over Board of Medicine licensees - PAs (Physician Assistants). It is likely that other boards with licensees that prescribe controlled substances will raise similar concerns.”

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES