2011 SENATE HUMAN SERVICES

SB 2148

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2148
1-18-2011
Job Number 13016

☐ Conference Committee

Committee Clerk Signature AMorrison

Explanation or reason for introduction of bill/resolution:

Relating to prescriptive practice standards for advanced practice registered nurses.

Minutes: Attached testimony.

Chairman Judy Lee, District 13, introduced SB 2148. This will enhance the ability of Nurse Practitioners to provide practice as primary care providers to provide treatment throughout the state of ND. It removes the requirement for collaborative agreement with physicians.

Senator Dever asked if "scope of practice" is appropriately defined in order to allow this but, when necessary, to make the appropriate referrals. She deferred the response to others who would be testifying.

Senator Bowman spoke in support of SB 2148. This would help support health care in rural ND.

Senator Heckaman, District 23, also spoke in support SB 2148. It is a very important part of delivering medical services to our rural areas.

Representative Karen Rohr, District 31. She is a board certified Nurse Practitioner and she encouraged support for SB 2148.

Cal Rolfson, representing ND Nurse Practitioner's Association, introduced those who would be testifying in support of SB 2148.

Cheryl Rising, Family Nurse Practitioner (FNP) and President of NDNPA, practices in Bismarck, ND and testified in support of SB 2148. Attached Testimony #1

Representative Kreidt, co-sponsor of SB 2148, highly recommended the support of SB 2148.

Dr. Billie Madler, Nurse Practitioner in Bismarck and educator of students in graduate nursing programs testified in support of SB 2148. Attached Testimony #2

Senator Dever stated that her testimony seemed to support the bill but also to argue for and expansion of the scope of practice.

Dr. Billie Madler replied that they were not intending to do that. They want to be able to work to the full scope of practice that they already have. The variation from state to state highlights the discrepancies. Nurse practitioners in some states are being used to their full competence. In other states they are not basing what Nurse Practitioners can do on their competence or their scope of practice or education. They are basing it on state laws.

Senator Dever asked then if "our scope of practice" is appropriately defined and if it is defined in the Century Code.

Dr. Billie Madler replied that the scope of practice would be addressed by one of her colleagues. The scope of practice for each nurse practitioner is kept on file in the board of nursing. Each NP has a scope of practice that is specific to the location they are working in. In answer to a question by Senator Judy Lee she agreed that it would be correct to say it is not based on the individual or geographic area but rather whether they happen to be a nurse anesthetist, someone in geriatric care, someone with a specialty, etc.

Senator Berry asked if nurse anesthetists practice independently.

Dr. Billie Madler deferred to the nurse anesthetists in the room.

Kris Todd Reisnour, Nurse Practitioner, testified in favor of SB 2148. Attachment #3 includes a list of supporting signatures.

Senator Uglem asked if ND laws are restricting her scope of practice and what grade would she give ND for their laws.

Kris Todd Reisnour replied that she would give ND a grade of A for their ability to practice. She was lucky to find a physician to sign on as a collaborator since she is independent in her clinic.

Senator Lee pointed out that there have been other bills in recent sessions that dealt with enabling nurse practitioners to work appropriately in a variety of areas.

Gwen Witzel, Family Nurse Practitioner and a primary care provider in rural ND, testified in support of SB 2148. Attached Testimony #4 includes a map showing ND nurse practitioner location and a document from the American Academy of Nurse Practitioners that defines Scope of Practice for Nurse Practitioners. She added that she has consulted with all of the physicians she interacts with throughout the day and she has their signatures. The physicians she has spoken with about this issue agree that this is an unnecessary formality.

Senator Mathern asked how the national healthcare reform impacts what she does and SB 2148. He wondered if there is a connection.

Gwen Witzel stated that the national healthcare reform law is provider neutral language. It has opened up practice to include all healthcare providers. With national healthcare reform

they are trying to improve access to healthcare. They say that there is going to be 32 million people who will now have health insurance and require primary care. There is a primary care physician shortage throughout the nation. By providing neutral language it is improving access to healthcare.

Senator Dever wondered if there are patients that come from MN into ND and if it would make a difference if this bill is passed.

Gwen Witzel replied that those in Fargo-Moorhead see it all the time.

Tracie Mallberg, MD, owner and physician at LilyCare Clinic in West Fargo, ND, testified in support of SB 2148. Attached Testimony # 5

Senator Lee speculated that there is no liability for NP as a collaborating physician. They are just supposed to talk now and then. She asked if that was correct.

Tracie Mallberg responded that is exactly how it had been explained to her.

Karen Larson She is Deputy Director of the Community Healthcare Association of the Dakotas which is a primary care association serving members from community health centers in both SD and ND. She has submitted a letter on behalf of their members. It can be found in Kris Todd's packet. She wanted to confirm that every one of those health center directors wrote in favor of this legislation and are in full support of it. She is extremely proud of what nurse practitioners have done and as long as there is a defined scope of practice, quality assurance, proper regulation, and proven competencies that should be all that is required to do this practice.

Duane Houdek, Executive Secretary of the ND State Board of Medical Examiners, opposed SB 2148. Attached Testimony #6 Responding to the notion that this is just a meaningless formality, he was sorry that is the way nurse practitioners and physicians treat it. That is not the way the board treats it. When it comes to prescribing they send a package to the collaborating physician and ask that physician to respond. The board will hold the collaborating physician accountable for the collaborative agreement. His point is that public protection has to be foremost.

Senator Lee stated that his testimony suggested that the Board of Nursing holds their individuals who they regulate less accountable than the Board of Medical Examiners holds its physician's accountable.

Duane Houdek said that wasn't his intention.

Discussion continued on the implication of his testimony. Mr. Houdek said having two boards looking at a given transaction is better than one not that one is better than the other. The board is reactive. They respond to complaints. They do not expect regular reports from collaborating physicians on the oversight of nurse practitioners.

Senator J. Lee asked what the Board of Medical Examiners was doing to encourage physicians to move into the rural areas where there are none at this time.

Duane Houdek said there has been a lot of talk in the medical community, including the board, of working with the medical school and trying to get people into rural communities. He didn't see where this legislation was a question of access. It is not an impediment for those who are practicing in rural areas.

Senator Mathern asked if there are areas of collaboration going on now in the prescriptive ability.

Duane Houdek said there is a prescriptive committee. They haven't really had discussions on further collaborations. The discussion has always been if there should be less?
His concern was not about the larger hospitals. His concern is about increasing access in small rural areas that might be more isolated. Those are the places that need more collaboration.

Senator Berry asked if it was correct that this bill, if passed, would remove any last vestige of medical oversight over nursing practice of medicine

Duane Houdek said he believed that was true.

Senator Lee pointed out that they are overseen by their own board which oversees their own scope of practice.

Senator Berry said that he was speaking of the medical oversight of the practice of medicine as opposed to the nursing oversight to the practice of medicine. To him those are two very different things.

Senator Lee felt he should differentiate between medical practice and physician practice.

Senator Berry states that physicians receive medical licenses and nurses receive nursing licenses. He went on to explain his concern.

Bruce Levi, Executive Director of North Dakota Medical Association, spoke in opposition to SB 2148. Attached Testimony #7

Nelson Benson, ND Board of Nursing, spoke in support of SB 2148. The Board of Nursing is the regulatory body that oversees the advance practice nurses or the nurse practitioners. They practice within their scope of practice and that the oversight of the board makes sure that happens.

Senator Lee asked for clarification on how it works between a nurse practitioner and a collaborating physician. What is the Board of Nursing's observation about this?

Mr. Benson replied that he doesn't see any issues with the collaboration agreement for the nurse practitioners. The board doesn't hear negative or positive responses. It works well but the board recognizes the concerns of the nurse practitioners and probably would make their practice smoother or less cumbersome.

Constance Kalanec, Executive Director of ND Board of Nursing, states that there are about 400+ nurse practitioners that have prescriptive authority. They are very attuned to what their scopes of practice are and very concerned about keeping their certification current. At the moment she couldn't identify an instance that was scope of practice related. Over the years they have had disciplinary cases like any other profession and they were dealt with swiftly and appropriately. The board agrees that the collaborative agreement has become somewhat of a formality in terms of location. She gave an example of a problem that could arise with the collaborative agreement.

Senator Lee asked what she has observed as Director of the Board of Nursing pertaining to any issues, one way or the other, with collaborative agreement.

Constance Kalanec stated that one of the difficult areas is the military. Another area is distance. Some nurse practitioners have left communities because they were not able to find a collaborative physician. She talked about the paperwork and how some of it is cumbersome.

Senator Berry asked if there is a limit on the number of nurse practitioners a physician can collaborate with.

Constance Kalanec replied there is not.

Sharon McDonald, Family Nurse Practitioner, shared a historical perspective of this. When the merits of giving prescriptive authority to advanced practice nurses was debated by the legislature there was a fear that physicians would not collaborate with them. That was why the deal was worked out to ask for a collaborative physician. The area that is untouched right now is that nurse practitioners collaborate with any physician that has anything to do with the care of the patient they are taking care of. They are always collaborating.

With no further testimony the hearing on SB 2148 was closed

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2148
January 26, 2011
Job Number 13489

☐ Conference Committee

Committee Clerk Signature

Minutes:

Chairman J. Lee opened SB 2148, pertaining to collaborative agreement with a licensed physician, for committee discussion.

Senator Uglem reported that he has had emails from several nurse practitioners that are commenting on the hard time they are having finding a physician to collaborate with. The physician does not want to be bothered. He said he feels the nurse practitioners are qualified through the nursing board and their standards and practices are set. They should be able to work independently, without this one requirement. They do collaborate with doctors on a regular basis. He supports SB 2148.

Senator Gerald Uglem moved a **Do Pass.**

Seconded by **Senator Tim Mathern.**

Senator Spencer Berry voiced his opposition to SB 2148. The main reason being that it removes the last vestige of any medical oversight over nurse practitioners. He said these nurse practitioners will essentially be practicing medicine without oversight, officially, from someone with a medical degree. They are midlevel providers. To him it is a patient care issue that needs oversight.

Senator Judy Lee asked if he thought that particular provision was the only reason nurse practitioners collaborate.

Senator Berry didn't think it's the only one. But he did think having the metric there encourages the communication and will ensure it.

Senator Mathern asked who is on the board that licenses the advanced practice registered nurses.

Discussion followed on the members of the Board of Nursing – their names and degrees.

Senator Tim Mathern stated his decision to support the bill.

Senator Uglem realizing Senator Berry's concern over the practice of medicine pointed out the nurse practitioner must practice within her scope of practice. She cannot go beyond that without discipline. He was supporting SB 2148.

Senator Berry said that the collaborative agreement does not prevent the nurse practitioners from practicing from within their scope of practice. It works now and allows for medical oversight. Having a form of medical oversight over the practice of medicine is important. Removal of this agreement would allow the nurse practitioner to be practicing medicine. They would be diagnosing, treating and prescribing, as it relates to medical conditions.

Senator Lee replied that they are already diagnosing, treating and prescribing.

Senator Berry said they are doing it with some oversight and it is working well. It should continue that way.

Senator Dever was undecided. He didn't see how it is a barrier in itself. It seemed to him like the safeguards come in three different ways: 1. scope of practice 2. institutional requirements are in place and 3. Board of Nursing and their oversight of it.

Chairman Lee offered that the Board of Nursing has a reputation of being fussy about a variety of things. They are very fussy about the performance of the people whom they supervise and oversee. She felt that their scope of practice is tight; their "oversight" with the Board of Nursing is thorough and quite demanding.

Roll call vote 4-1-0. **Motion carried.**

Carrier is **Senator Judy Lee.**

Date: 1-26-2011

Roll Call Vote # _____

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2148

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Uglem Seconded By **Sen.** Mathern

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry		✓			

Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2148: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2148 was placed on the Eleventh order on the calendar.

2011 HOUSE HUMAN SERVICES

SB 2148

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2148
March 9, 2011
Job # 15208

☐ Conference Committee

Committee Clerk Signature Marilyn Kreinzle

Explanation or reason for introduction of bill/resolution:

Relating to prescriptive practice standards for advanced practice registered nurses.

Minutes: "Attached testimony # 1,2,3,4,5,6,7,8,9,10,11,12."

Chairman Weisz: Opened the hearing on SB 2148.

Sen. J. Lee from District 13: Introduced and testified in support of the SB 2148. (See Testimony #1)

Rep. Gary Kreidt from District 33 from New Salem: Testified in support of the SB 2148. We in North Dakota need to better address the State Health care needs and also increase the transparency and accountability of the Nurse Practitioners when prescribing medicine. Also we need to position North Dakota to be competitively to recruit Nurse Practitioners and use them effectively. I feel there is a need to address Critical Health Care issues in rural facilities. I ask for your support of this SB 2148.

Sen. Joan Heckaman from District 23 in New Rockford: Testified in support of the bill. I think all of us realize that health care in the rural areas is at a difficult stage with some of our hospitals cutting back on some of the services, such as obstetrics. One of the things we do count on right now in our rural areas is out Nurse Practitioners. In our rural areas I think this is very important step forward to keep those people in our rural areas. The Nurse Practitioners are some of the stables in our communities. They often have families that are from the community and have gone back for extensive training to get their Nurse Practitioners Degree. I ask for your support for SB 2148.

Sen. Gary Lee District of 22: I am in support of SB 2148. I have many years of experience working with physicians and mid level providers including the advanced practice nurse. No question in my mind that physicians are the best trained and most qualified to deliver health care. There simply isn't enough physician time to be everywhere at all times. We send people all of the time, all over to work at different facilities. So there isn't the physician time to be at all places at all times. We need another excellent provider to make some of those medical decisions and provide the care needed. Secondly we have a medical system that is always burdened with costs. We simply can't afford physicians going to all those location all those times. Thirdly and an important part of the bill starts on

line 9, where it talks about scope of practice. The employer shapes the job description and those prescriptive authorities within the needs and that scope of practice. Physicians in general shape that practice working at that facility. If they move outside of that scope of practice they are then subject to a sanctioned not only by the Board of Nursing but by the employer also, which usually is a physician. This does give protection for the employer and for the patient. I think it is a good bill giving us an opportunity to offer better health care in the state and would encourage your support of SB 2148.

Cal Rolfson: Represents the NDNPA . Announced the order of those testifying for the Nurse Practitioners: Sheryl Rising, Dr. Billy Madler, Chris Todd, Gwen Wetzel and followed by Dr Eric Thompson from Med Center One.

Cheryl Rising: Family Nurse Practitioner (FNP) and president of the ND Nurse Practitioner Association (NDNPA) testified in support of the bill. (See Testimony #2)

Rep. Porter: On the third page of your testimony on the top you talk about direct access to the drug monitoring program of North Dakota Board of Pharmacy. Is that a mandatory or voluntary program for physicians right now?

Cheryl Rising: It is voluntary for both physicians and nurse practitioners.

Dr. Billie Madler: A nurse practitioner and an educator of students in graduate nursing programs in Bismarck. I am testifying in support of the SB 2148. (See Testimony #3)

Rep. Holman: The preparation for advanced practice nurses and Doctors, in the prescriptive practices area, can you compare in contrast?

Dr. Billie Madler: I have not gone to medical school so I cannot give you the preparation for Prescriptive practice. The preparation of Nurse Practitioners is confidentially based, prescriptive and prescribing practices is taught both in box courses specifically in pharmacology and is threaded through out the Nurse Practitioners curriculum.

Rep. Paur: You said you are not a physician. What is your Doctorate in?

Dr. Billie Madler: Doctorate of Nursing Practice

Kris Todd-Reisnour: A FNP testified in support of the bill. (See Testimony #4) (Additional handout See handout #5)

Rep. Paur: Sen. Gary Lee said the scopes of practice by the Hospital Association and Physicians. When you are an independent practice, who sets up your scope of practice?

Kris Todd-Reisnour: Our scope of practice is set by the Board of Nursing. Each Nurse Practitioner writes up there scope of practice. I think what Sen. Lee was discussing was the Credentialing Board of the Hospital. There are 2 different formats that we need to follow to maintain safe practice. I think what you are asking is that in my clinic, what I am I allowed to do?

Rep. Paur: Yes basically.

Kris Todd-Reisnour: That is a clinical privileges' by the hospital. That is different than a scope of practice. It is very confusing. There is the Scope of Practice, which is through the Board of Nursing.

Rep. Paur: You determine that?

Kris Todd-Reisnour: Yes by my training. If I am not comfortable with, I contact my local provider to assist me.

Rep. Paur: The scope of practice he was talking about is different?

Kris Todd-Reisnour: Yes. It is the last page. That is the privileges' form and that allows you to practices what the hospital designates for you to practice.

Rep. Paur: In your case you fill that out also?

Kris Todd-Reisnour: Yes

Chairman Weisz: When you do your scope of practice, which has to be approved by the board of nursing?

Kris Todd-Reisnour: Right.

Gwen Witzel: A Family Nurse Practitioner testified in support of the bill. (See Testimony #6 and a map)

Dr Eric Thompson from MedCenter 1 testified for the North Dakota Nurse Practitioners: He testified in support of the SB 2148. The future of North Dakota and primary care are going to be a difficult setting. There are not very many physicians available and there is a primary care shortage predicted for the nation, much less the state itself. When I came back in 2007 I was the first physician who had left North Dakota in Family Practice to return. Nurse Practitioners can provide good care in the rural areas as they have done for years. They do require a supervisory component but most of the times that become less of an issue as you get more experience with that practitioner. I had supervised them when I formally worked with them in Utah and I have worked with a few of them here. After you work with them for a couple of months you view a few charts and after that, with all of the paper work you have, they become an employee model. You look over what they have done, you get a trust relationship, you supervise and after a while most physicians don't even look at their charts. They just stamp them off and proceed with their daily functions. As far as quality of care, there are certain things in place where they do have in place a lot more pharmacology training then we are required to have to recertify and Family Practice or in most Physician settings. We don't have specifics in Pharmacology but they do. We do get further education as continued medical education to recertify and maintain their license, which they actually have a little more than we do. There are electronic medical records that a lot of places have. As far as Drug Interactions, there are big red flashing lights that come on and some stop caps within the practice of

medicine that would make it easier for physicians and Practitioners to make it a safer environment for their patients. For the future of ND and especially caring for our rural population, it is essential we try and make this easier for our providers in those settings so they will be able to continue to practice and quality care for those areas.

Buzz Benson: CRNA and President of the Board of Nursing testified in support of the bill. (See Testimony #7)

Rep. Porter: Your profession as a nurse anesthetist was changed some time ago that took some of the same collaboration away. So if you could go through a little of your background and how your advanced practice changed.

Buzz Benson: Several years ago we were here in front of you and there was issue with anesthesia and CNA's and Anesthesiologists with supervision. Ultimately the supervision component was removed by the legislature. What I can tell you are the practice did not change. We provided the same scope of practices and we have had no discipline issues. This has been a good move.

Dr. Tracie Mallberg: (See Testimony #8) Handed in testimony.

OPPOSITION

Sen. Spencer Berry from District 27: I am a practicing medical doctor for nearly 25 years testified in opposition of the bill. (See Testimony #9)

Dr Jeff Hofstetter program Director of UND Center for Family Medicine Recidency, an Assistant professor of the UND School of Medicine and Health Sciences in the Dept. of Family and community Medicine and the secretary/treasurer of the ND AFP. I was the chief of staff at the Standing Rock HIS hospital in Fort Yates, ND: He testified in opposition of SB 2148. First we believe this is a solution without a problem. The issue is as close as a cell phone away. (Testimony #10)

Sen. Kilzer from District 47: Testified in opposition. It was back in 1995 that the collaborative agreements were agreed upon after a lot of discussion, which was signed by all parties concerned. This included the nurses who today have apparently have gone 180 degrees and now want to be freed of the shackles of the collaborative agreement. I think that needs further investigation. The results of the fact brought up by the proponents that there was no prescriptive problems, well I would ask you why change it, it seems to be working. I now will go to my experiences. I have been an orthopedic surgeon for 45 years. I have worked with nurse practitioners both in and out of state because in the last 20 years I have done a lot of locum tenants' work out of state. The quality of care does take a dip when working weekends and you are working with Nurse Practitioners who are filling in for family doctors or some other specialty. It has happened in my practice many times, that fractures have been missed and falsely misdiagnosed causing unnecessary referrals. Don't let anyone kid you that 2 years of post college training as a Nurse Practitioner is the same as fully trained practice doctor, it just isn't so. This is a false impression. One of the previous people who testified insulted me a little about years of training, internship and residency don't really matter that much. Nurse Practitioners have 4 years of college and 2

or 3 years after that. A Physician has 4 years of college and then has to go through 4 years of medical school plus one year of internship and 2 to 5 years of residency. Now they have taken out the internship and have added a year to the residency. In my case I have had 9 years beyond college. I still think if you want to be a physician you should take the 3 parts of the National Board of Medical Examination, practices them and come out the front door of the medical school. If you want to do something else, as being a nurse, than that is okay, train that way. I noted in earlier testimony about information in the Institutes of Medicine and the New England Journal of Medicine. There are not too many articles in the New England Journal of Medicine that pertain to a solo practice in North Dakota. This is a Massachusetts publication largely out of the Harvard School. That is a little different then what we have here. I urge you to keep up the quality of medicine we have her in North Dakota and if you vote in favor of this there will be something in the next rung of the latter. I urge you to vote no on SB 2148.

Duane Hodek Executive Secretary of the ND State Board of Medical Examiners: Testified in opposition. (See Testimony #11) A note of reference is that there is more deaths attributed to over dose than highway deaths in the state of Washington. He also included to his testimony that if this really isn't about access and if this really isn't going to increase the number of people and nurse practitioners in small towns and if it is such a minimal thing, why should we get rid of it? It does contribute, from our perspective, to our over view as to what the physicians are doing out there. There is far less concern on the Board of Medical Examiners about a doctor who's at Sanford or a doctor who is at Med Center or any other hospital larger institution, because their institution credentialing practice takes care of a lot of their practices. Regardless of what we say here or the Board of Medical Examiners says in a license, they will tell that physician exactly what she can or cannot do. That is self regulated. We see disproportionately more problems with solo practitioners, free standing surgical clinics or free standing clinics of any kind that does not have that kind of credentialing support or review. If Nurse Practitioners are going to fill the role in rural areas and have more free standing clinics, this is exactly the wrong time to do this, because that is the area that is the hardest and biggest concern.

Rep. Damschen: Are you telling us the only problems you have with physicians and physician's assistance are when they have worked with a Nurse Practitioner?

Duane Hodek: No not at all. We see a disproportionate problem with physician when they are free standing. We see a disproportionate problem with the physicians own practice. It is in those free standing areas not the larger institutions that have the credentialing process.

Rep. Paur: It seems you have a lot of expertise to oversee the prescriptive enforcement of physicians and physician's assistance. If we removed the limitation that would strictly be under the Nursing Board. That would not be under you, is that correct?

Duane Hodek: Yes. We do not pretend to have any authority over the Nurse Practitioners. The Nursing Board does this and does this well. But we would not be able to look at that incident in the way we can now.

Rep. Paur: Do you have any idea of the expertise the Nursing Board has? Is it similar to the Board of Medical Examiners? Do they have the same prescriptive oversight?

Duane Hodek: There are representatives of the Nursing Board here and they could better answer that question.

Chairman Weisz: You stated a particular problem with opioids. With the perspective of your Board, how do you look at addressing this problem?

Duane Hodek: We are doing a number of things. We participated in the Attorney Generals Prescriptive Drug Summits. I go out and do education on this topic at hospitals all the time. We have a pain specialist on board, Dr. Cologne of Minot. We are now putting together the entire pain specialist to talk about how they will collaborate with primary care physicians who do not have the same expertise. We don't have that really good relationship between primary care specialists and pain management specialists. We think that would help a lot. We also passed, as a board, a set of guidelines by the National Federation of Medical Examiners of prescribing opioids.

Courtney Koebele Director of Advocacy for the ND Medical Association: Testified in opposition of the bill. (See Testimony #12) (Passed out a proposed amendment see attachment #13)

Rep. Damschen: In a testimony we heard that a person in western North Dakota could have a collaborating physician in Wahpeton. If that was the case and a new Nurse Practitioner started in western North Dakota and did have that collaborating physician in Wahpeton, what value would that be? What would the benefits be on the treatment on those patients in western North Dakota?

Courtney Koebele: They can speak every two months but they can speak every day or numerous times a day. What this collaborative agreement does is allows for a relationship so they can feel comfortable to address all the issues that arise.

Rep. Damschen: I don't know how this can happen. If the collaborated physician doesn't know the Nurse Practitioner it is kind of hard to establish a relationship to evaluate this person performance or abilities.

Sen. Berry: That is the point of having the ongoing relationship. If it is new there would be more frequent conversations until they become comfortable with each other.

Rep. Damschen: It is kind of which came first, the chicken or the egg with this familiarity with this practice.

Sen. Berry: What is important is the bilateral of that knowledge and what makes for the best care is the continuity.

Rep. Anderson: Is there an exchange where you can tie the nurses and doctors together to form an agreement or how do the doctors and nurses work that out?

Courtney Koebele: I was trying to suggest if they would be willing to sit down and work this out, we would also be willing to work with them. There is no regulatory process that I am aware of. I am relatively new on the job that requires working it out together.

Chairman Weisz: I am taking that Rep Anderson did mean collaborative agreements.

Courtney Koebele: I'm not sure how they get their collaborative agreements.

Chairman Weisz: Closed the hearing on SB 2478.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2148
March 14, 2011
Job # 15397

☐ Conference Committee

Committee Clerk Signature Marlys Kienzle

Minutes: "No attached testimony."

Chairman Weisz: Opened the meeting with SB 2148. There is one suggested amendment that I am aware of. I spoke to those who want the bill would rather the bill died than have the amendment attached to it.

Rep Devlin: I make a motion for a Do Pass on the SB 2148 without the amendment.

Rep Schmidt: Second the motion.

Do Pass Yeas 12 Nay 1 Absent 0

Carrier Rep Porter

Date: 3-14-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2148

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Schmidt

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN	✓	
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON	✓		REP. KILICHOWSKI	✓	
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	✓				
REP. LOUSER	✓				
REP. PAUR		✓			
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 12 No 1

Absent _____

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2148: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2148 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

SB 2148

#1

TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

CHERYL RISING, RN, MS, FNP

TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

CHERYL RISING, RN, MS, FNP

January 18, 2011

Madam Chairman and Committee Members:

I am Cheryl Rising, Family Nurse Practitioner (FNP), and president of the North Dakota Nurse Practitioner Association (NDNPA). I practice in Bismarck, ND. I am here to testify in support of Senate Bill 2148. This bill would eliminate the formality for the North Dakota Board of Nursing (NDBON) to have a physician signed affidavit on file for individual Advanced Practice Registered Nurses (APRNs) to write prescriptions. APRNs in the state of ND have a Masters Degree or Doctorate and are nationally certified. By the year 2015 nurse practitioners will be Doctorate prepared.

There are 4 categories of APRNs-Nurse Practitioners (NPs), Certified Nurse Midwifes, Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNA). There are 430 NPs in the state of ND. The database queried showed 4 NPs were self employed and the other 426 were associated with a health care organization.

In 1992, 19 years ago, the law requiring a physician signed affidavit to be on file was enacted and the NPs were authorized to write prescriptions. Having a signed affidavit is a formality and does not affect quality of care for our patients. Like all health care professionals, NPs consult with the appropriate health care professional as the patient needs dictate.

The Prescriptive Authority Committee of ND has not identified any issues regarding the prescribing practices of NPs. The Prescriptive Authority Committee consists of representatives of the NDBON, ND Board of Medical Examiners, and the ND Board of Pharmacy. Please find attached the minutes and information from the NDBON.

Eliminating the need for a signature would facilitate NPs to serve as part of the solution for improving access to healthcare for citizens of ND. An example of this will be given by one of my colleague's testimony. The NPs will continue to practice within their scope of practice which will not change. NPs scope of practice will continue to be on file at the BON. NPs will continue to consult and collaborate with all health care providers appropriate to their patients care.

This Bill will provide legislation and regulation that is consistent with other western rural states and the National Council of State Boards of Nursing. Please see the attached map, showing 14 typically rural states that have previously removed this barrier.

Advanced Practice Registered Nurses will continue to maintain their own Drug Enforcement Agency registration as in the past.

I ask for you support of Senate Bill 2148.

Cheryl Rising, RN, MS, FNP

President of the NDNPA

Email cdrising@earthlink.net, phone number 701-527-2583

Website for NDNPA is www.ndnpa.org

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881
Telephone: (701) 328-9777 Fax: (701) 328-9785
Web Site Address: http://www.ndbon.org

Workplace Impairment Program: (701) 328-9783

MEMO

TO: **ND Nurse Practitioners Association**

From: **Constance B. Kalanek PhD, RN**
Executive Director

Date: **November 24, 2010**

RE: **Summary of Prescriptive Authority Meetings for 2007-2010**

A meeting of the North Dakota Board of Nursing's Prescriptive Authority Committee has occurred annually according to NDCC 43-12.1 -18. Nursing practice standards. The agenda for the meetings includes the review of all applicants for prescriptive authority in the past year. In the past 10 years or more, the committee has met as required and reviewed the applicants approved in the previous year. The committee has not identified any issues with the NDBON review of the approved applicants. I have attached the 2010-2011 membership list and the minutes for the past three years.

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
January 21, 2009

Present: Board of Nursing members: Dan Rustvang, RN Board Member and Chair;Howard Anderson, Executive Director ND Board of Pharmacy; Duane Houdek, Executive Secretary NDBOME;; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON;

Absent: Gordon Leingang DO, BOME; Rick Detwiller, RPH, Board of Pharmacy

Call to Order: The meeting was called to order by Benson at 5:05 p.m. Introductions were made.

Minutes: The minutes from the January 16, 2008 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2008. Three-eight APRNs were granted prescriptive authority. All applicants met the requirements for prescriptive authority. Discussion ensued.

ND Prescription Drug Monitoring Program – Mr. Anderson provided an update of the ND Prescription Drug Monitoring Program. The program has granted the authority to access the system to additional providers and their surrogates. Mr. Houdek and Dr. Kalanek reported that we have received very positive comments on the program. Mr. Anderson reminded the committee that this program is grant funded and its continuation may be dependent upon receipt of ongoing funds from other sources. Mr. Anderson discussed other options for funding. The next meeting will be the third week of March 2009. At this point in time, the NDBON and NDBOME will not be granted access.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:30 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
January 16, 2008

Present: Board of Nursing members: Buzz Benson RN Board Member and Chair; Patricia Dardis, RN, Family Nurse Practitioner & Clinical Nurse Specialist, BON; Gordon Leingang DO, BOME; Duane Houdek, Executive Secretary NDBOME; Rick Detwiller, RPH, Board of Pharmacy; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON; Dave Peske, NDMA.

Absent: Howard Anderson, Executive Director ND Board of Pharmacy;

Call to Order: The meeting was called to order by Benson at 5:05 p.m. Introductions were made.

Minutes: The minutes from the January 17, 2007 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2007. Three-three APRNs were granted Rx authority. All applicants met the requirements for prescriptive authority. Discussion ensued. Ms. Dardis requested the review for the focus of care be more specific in the future. Mr. Peske asked about nonrenewal for the APRNs.
Note: *The Board does not track specific individuals who do not renew. The aggregate of approximately 700 nurses do not renew annually and approximately 25 are APRNs. Dr. Leingang also asked about the number of APRN Collaborative Agreements a physician can have with APRNs. The rules do not prescribe a specific number but rather leave it to the discretion of the physician, APRN and facility.*

ND Prescription Drug Monitoring Program – Rick Detwiller Mr. Detwiller provided an overview of the ND Prescription Drug Monitoring Program. The program is up and running and utilize an electronic monitoring system to facilitate the transmission and collection of data regarding all controlled substances dispensed to patients in ND and to analyze data and report on the prescribing, dispensing, and use of controlled substances. The system tracks controlled substances and Soma and Tramadol. Approximately 30 states are utilizing a similar system. A news release was sent by Pat Churchill to NDMA which could be useful for newsletters to keep physicians and APRNs informed. Mr. Detwiller reminded the committee that this program is grant funded and its continuation may be dependent upon receipt of ongoing funds from other sources. It was also suggested that the form used to obtain information from the system be placed on appropriate websites.

Other business: Mr. Peske asked about the use of tamper resistant prescription pads by practitioners. He indicated the use of this type of pad would become a requirement in April 08. Discussion ensued.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:45 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
March 11, 2010

Present: Board of Nursing members: Dan Rustvang, RN Board Member and Chair; Howard Anderson, Executive Director ND Board of Pharmacy; Duane Houdek, Executive Secretary NDBOME; Rick Detwiller, RPH, Board of Pharmacy; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON;

Absent: Excused: Gordon Leingang DO, BOME;

Call to Order: The meeting was called to order by Rustvang at 5:10 p.m. Introductions were made.

Minutes: The minutes from the January 21, 2010 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2009. Forty-four APRNs were granted prescriptive authority. All applicants met the requirements for prescriptive authority. Discussion ensued. The current list of Collaborative Physicians and 400 Nurse Practitioners was also reviewed.

ND Prescription Drug Monitoring Program – Mr. Anderson provided an update of the ND Prescription Drug Monitoring Program. The program is working well and utilized by prescriber. Mr. Anderson indicated to the committee that the grant funding has been expended and the NDBOP and UND Center for Rural Health has continued to support it. The next meeting will be the March 25, 2010.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:45 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

NORTH DAKOTA BOARD OF NURSING
2010-2011 PRESCRIPTIVE AUTHORITY COMMITTEE

BOARD OF NURSING

Daniel Rustvang APRN, NP
3324 Primrose Court
Grand Forks, ND 58201
Email: drustvang@altru.org; Telephone- 701-780-6941

Nelson (Buzz) Benson, RN
215 Laredo Dr
Bismarck, ND 58504-7210
Email: bbenson42@bis.midco.net. Telephone- 222-2973(H); 323-6262(W)

Constance Kalanek PhD, RN,
Executive Director
919 So 7th Street, Suite 504,
Bismarck, ND 58504
Email: ckalanek@ndbon.org; Telephone –328-9781

BOARD OF MEDICAL EXAMINERS

Kent Martin, MD
2507 Henry St
Bismarck, ND 58503
Email- Telephone – 323-8654

Duane Houdek
State Board of Medical Examiners
418 E. Broadway, Suite 12
Bismarck, ND 58501 Telephone: 328-6500
E-mail: dhoudek.ndbme@midconetwork.com

BOARD OF PHARMACY

Rick L. Detwiller, R.Ph.
1900 Harbor Drive
Bismarck, ND 58504-0956
rdetwiller@primecare.org Business Phone 701-530-6886
Cell 701-226-3820

Alternate
Bonnie Thom, R.Ph
Member
5372 N. 15th Ave
Granville, ND 58741
Email: velvadrug@srt.com; Telephone: 701-626-1639; 701-338-2911.

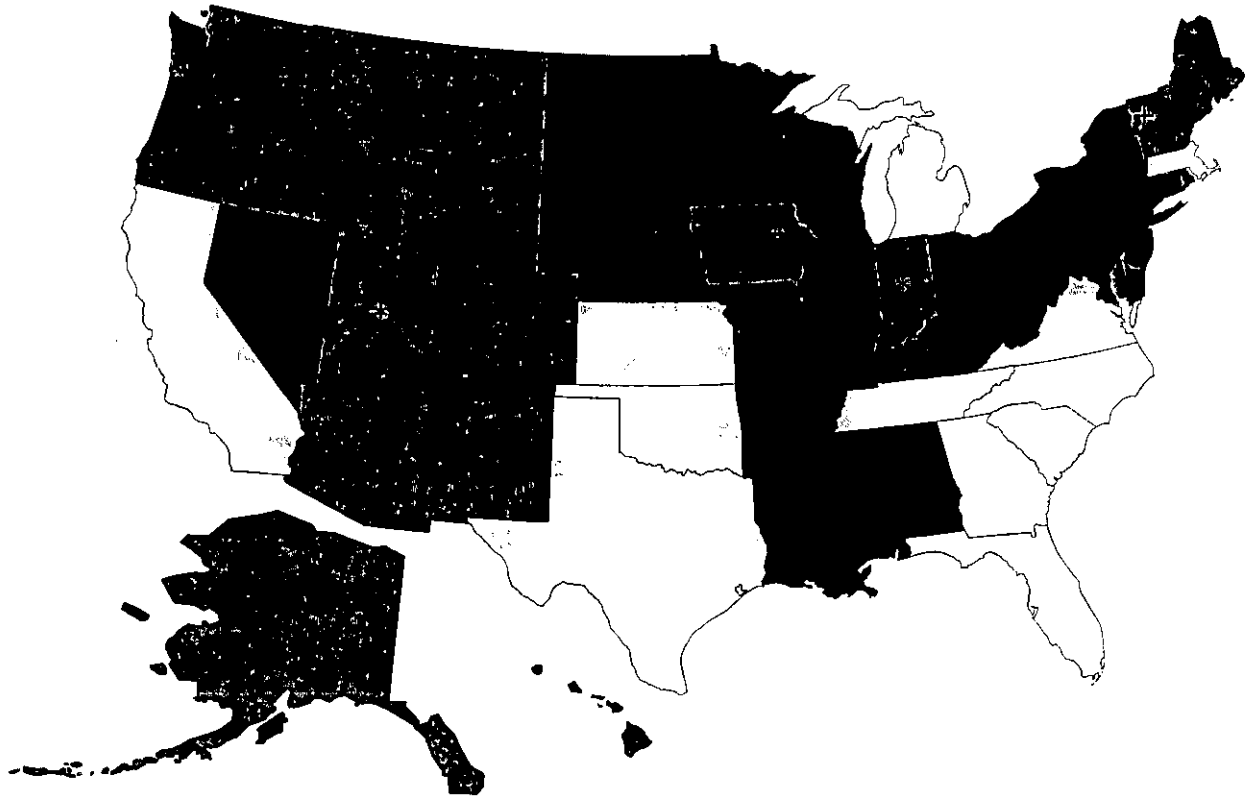
Howard Anderson, Jr., R.Ph.
Executive Director
ND State Board of Pharmacy
P.O. Box 1354
Bismarck, ND 58502-1354 Telephone: 328-9535
ndboph@btinet.net

COURTESY MAILING:

Becky Graner RN
ND Nurses Association
531 Airport Road
Bismarck, ND 58504
Becky@ndna.org
223-1385

Bruce Levi
ND Medical Association
PO Box 1198,
Bismarck, ND 58502-1198
blevi@ndmed.com
223-9475

COLLABORATION/SUPERVISORY LANGUAGE IN STATE PRACTICE ACTS & REGULATIONS FOR NURSE PRACTITIONERS



Plenary Authority (No Physician Relationship Required)

Collaboration with Physician

General Supervision/Delegation by Physician

* Special Conditions

\+ Pending

Source: State Nurse State Practice Acts
And Administration Rules, 2008

The American Academy of Nurse Practitioners is the largest full service Nurse Practitioner organization representing the 125,000 Nurse Practitioners in all Specialties
Update: Oct 23, 2009

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TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

DR. BILLIE MADLER, FNP

January 18, 2011

TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

DR. BILLIE MADLER, FNP

January 18, 2011

Madam Chairperson Lee and Committee Members:

My name is Dr. Billie Madler. I am a nurse practitioner in Bismarck and an educator of students in graduate nursing programs. I am here to testify in support of SB 2148.

Today I would like to share with you a summary of three important national publications pertinent to the objective of this bill. Links to each of these sources is provided at the conclusion of this testimony. I have also attached copies for your each reference.

First, in January of 2010 the Josiah Macy Jr. Foundation [which is a private philanthropy dedicated to improving the health of individuals and the public by advancing the education and training of health professionals] convened a multidisciplinary conference to address the complex issues concerning who will provide primary care. Participants included nurses and physicians from

diverse geographic areas throughout the United States and various sectors affected by the challenges related to primary care. Their conversations pivoted around our country's work to enhance quality, access, and reliability of health care, while working to make health care available for several million who are under or non-insured and sustain efforts to improve our population health. The group documented that in order to accomplish our goals we need to enlarge and strengthen our primary care sectors. Then, the group drew attention to the decreasing number of physicians choosing primary care. They recognized nurse practitioners have proven to be effective primary care providers, but are quoted saying "regulatory and reimbursement policy barriers often prevent efficient and effective use of their services".

A second national publication, recently released on October 5th, 2010 titled the "Future of Nursing" was the result of a 2 year initiative launched by the Robert Wood Johnson Foundation and the Institute of Medicine (IOM). [The IOM was established in 1970 under the charter of the National Academy of Sciences to provide independent, objective, evidence-based advice to policy makers, health professionals, the private sector, and the public.] The committee working on this initiative was charged with producing a report that contained recommendations "for an action-oriented blueprint for the future of nursing,

including changes in public and institutional policies at the national, state, and local levels". One key message of this report is closely related to the goals of the Bill I am asking you to support today.

These experts recommended nurses practice to the full extent of their education and training. Currently, licensing and practice rules differ from state to state, which results in a varying effect on advanced practice registered nurses across the country. For example, several states currently allow advanced practice registered nurses to do what we are asking with this Bill. The IOM committee offered recommendations to a variety of stakeholders including state legislators. They recommend that you, as state legislators, reform the scope of practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. Also, the report recommends the Federal Trade Commission and the Antitrust Division of the Department of Justice review existing and proposed state regulations concerning APRNs to identify those that have anticompetitive effects without contributing to the health and safety of the public. This group urges states with restrictive regulations to change their laws to allow APRNs to provide care to patients in all circumstances in which they are qualified to provide care. These are only two of many recommendations made.

JOSIAH MACY JR FOUNDATION

Co-Chairs' Summary of the Conference

Who Will Provide Primary Care and How Will They Be Trained?

In January 2010 the Josiah Macy, Jr. Foundation convened a conference to address complex issues concerning who will provide primary care and how they will be trained. Participants developed the set of conclusions and recommendations found in this Executive Summary.

A more detailed account of the proceedings, along with the background papers, will be included in a monograph to be published by the Macy Foundation in the next few months.

The Urgency for Change

Abundant evidence shows that healthcare systems with a strong primary care component provide high-quality, accessible, and efficient care. People want primary care providers with whom they can have ongoing relationships. They want to know that when they need help, they have access to someone with knowledge of their health problems and their individual characteristics.

Despite evidence supporting these facts, the healthcare system in the United States has not developed or valued a strong primary care sector, though there are excellent examples of primary care to be found in many regions. The lack of a strong primary care infrastructure across the nation has had significant consequences for access, quality, continuity, and cost of care in this country. It also has had consequences for our health profession educational enterprise and the healthcare workforce, resulting in numbers and geographic distributions of primary care providers that are insufficient to meet current or projected needs.

Regardless of the outcome of current health reform efforts, the country will continue to innovate in attempts to provide access to care to several million additional people and simultaneously improve the health of populations, enhance the patient experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of care. We are facing an economic situation in which the current rate of rise of medical cost is unsustainable, and this situation is exacerbated by an aging population with higher care needs and expectations. These events have created a climate in which it is necessary and appropriate to question the models of care and health professions education on which we have relied.

If we are going to fulfill our nation's promise to the public, and if we are going to produce the healthcare workforce required to accomplish our goals, we will need to enlarge and strengthen the primary care sector of the health system. There is great risk that if we do not do so, a significant portion of the population will continue to be without access to high-quality and efficient care, and healthcare costs will continue to escalate with dire consequences for the economies of individuals and the nation. Because of the magnitude of these problems and the current attempts to reform healthcare, there is great urgency in addressing these issues. These issues have registered in the public and professional consciousness in a way that suggests that unprecedented change is possible. The goal of this change is to produce "better health, better care, lower cost." Failure to act now could put the health of our communities and the economy of the country in jeopardy.

In January 2010, the Josiah Macy, Jr. Foundation convened a conference entitled "Who Will Provide Primary Care and How Will They Be Trained?" Held at the Washington Duke Inn in Durham, North Carolina, the conference was co-chaired by Linda Cronenwett, Ph.D., R.N., FAAN, Professor and Dean Emeritus, School of Nursing, University of North Carolina at Chapel Hill and Victor J. Dzau, M.D., James B. Duke Professor of Medicine, Chancellor for Health Affairs of Duke University and Chief Executive Officer of the Duke University Health System. Attending this important meeting were 49 participants, carefully chosen to represent a diversity of views on primary care, including experts from all professional groups who provide primary care (allopathic and osteopathic physicians, nurse practitioners, and physician assistants) and experts from the various sectors affected by the challenges related to primary care (consumers, academia, practice, science, journalism, government, healthcare policy, payors, and foundations).

Participants arrived in Durham well prepared to discuss the background papers (included in a forthcoming monograph). For each session topic, the list of people contributing insights was impressive. Many conversations continued well into the evenings. Perhaps the most noteworthy observation was the encouraging consensus that emerged among leaders from different parts of the healthcare system—a general agreement about what needs to be done; a willingness to come together to accomplish goals that will benefit patients, families, communities, and health professionals; and a sense of urgency to bring about major changes that will strengthen primary care in our country.

We began our discussions with a review of the history of primary care and our relative lack of investment in population health (included in the definitions of primary healthcare in most of the rest of the world). When Abraham Flexner put medical education on a scientific footing with his 1910 report, medical education as we know it was created. Medical schools were associated with large teaching hospitals, and highly knowledgeable specialists directed departments organized around organ systems. When the National Institutes of Health were formed, these faculties focused on the creation of yet more specialized knowledge. Healthcare payment structures responded to the technologies and science of these specialists, resulting in the healthcare practices we invest in today. As specialty medicine grew in prestige and reimbursement, general internal medicine, general pediatrics, and the more recent specialty of family medicine took a lower place in the hierarchy, reaching the point today in which a medical student who chooses a primary care specialty does so with the knowledge that he or she is leaving substantial dollars of lifetime income on the table.

During this same period, and often in response to shortages of primary care allopathic physicians, the numbers of osteopathic physicians, primary care advanced practice nurses (nurse midwives and nurse practitioners), and physician assistants grew. Each group was trained initially within disciplinary silos, with an emphasis on primary care. Gradually, options for specialist careers in medicine emerged for osteopathic physicians, and the percentage of osteopathic graduates choosing primary care careers diminished. Physician assistants tend to practice where physicians practice. For the most part, therefore, the number of physician assistants in primary care has diminished in accordance with physician practice patterns. Nurse practitioners proved effective in primary care roles, but regulatory and reimbursement policy barriers often prevented efficient and effective use of their services. In many states, such barriers exist to this day.

Meeting participants were enthusiastic about many innovations in primary care today— experiments that use teams of primary care providers; electronic health records and other technologies; and other health professionals in systems of care that meet patient and community needs. But they recognized that these environments were relatively few and far between. Early in our discussions, it became clear that participants believed it would be difficult to alter the downward trajectory of recruitment and retention of primary care physicians, in particular, without significant reforms in reimbursement and care delivery models. Also important is training the next generation of primary care providers within these innovative primary care practice settings, both within and beyond academic health centers. Participants were unanimous in their views that trainees need exposure to effective teams, working within systems that are designed to meet the needs of patients and communities, in order to learn about working in a team-based environment and to appreciate the rich rewards associated with primary care careers.

To ensure these learning environments across the nation, some type of payment reform that

Participants were unanimous in their views that trainees need exposure to effective teams, working within systems that are designed to meet the needs of patients and communities, in order to learn about working in a team-based environment and to appreciate the rich rewards associated with primary care careers.

provides incentives for investment in primary care infrastructures, technologies, and salaries is essential. Frequently, primary care providers are expected to develop the technological and personnel infrastructures necessary to meet the holistic needs of their patients and communities out of their practice incomes.

Participants emphasized repeatedly that a call for greater investment in primary care was not a call for a greater expense in healthcare overall. In numerous studies, the benefits of investments in primary care are clear—overall healthcare costs per capita decline. Without reformed payment structures, however, the frustrations of not being able to meet all expectations become overwhelming, and the inevitable result is a decline in numbers of people choosing primary care careers. The bottom line is this: unless trainees from *all* provider groups witness care being delivered by effective and efficient teams of primary care professionals who have the infrastructures to enable patients, families, and communities to achieve goals for individual and population health, the country will produce fewer and fewer primary care providers and will be unlikely to achieve its goals of reducing overall costs of care while improving healthcare quality and access.

Within this context, participants struggled with whether or not they could address the issues associated with what is referred to broadly as primary healthcare. There was a strong desire to address the broader needs of populations—needs that affect health but derive from a community's access, not only to healthcare, but to systems designed to support other public health, social, and educational needs. The participants considered the possibilities of new forms of primary care, through which society might hold healthcare systems accountable for both individual and population health goals. However, in order to have recommendations of substance that could change outcomes in the foreseeable future, participants decided to focus on the central questions posed to them at the start of the conference: namely, who should deliver primary care and how should the primary care practitioners of the future be trained?

As co-chairs, we were gratified to achieve a remarkable consensus on many issues of substance related to these questions, particularly the idea that *all* health professionals need training that ensures they have the skills to lead and work effectively in teams, to represent the interests of the public in ensuring a strong primary care infrastructure, and to expect, within their careers, to assume their share of accountability for continuously improving access to care, care coordination, costs of care, and quality of outcomes related to individual and population health. Health professionals need to develop attitudes that welcome patients as partners in care, moving beyond the current model of intermittent, facility-based contacts. And they need experience with the use of new tools, such as information technology; online monitoring and assessment; and supports for self care, home-based care, and virtual tele-health interactions, all of which will be part of primary care in the future. These overarching themes led directly to recommendations designed to improve the training of all primary care providers.

We left the conference inspired by the passion and commitment of the participants and with the development of a consensus that would move us toward a preferred future—a future in which our society's needs for primary care would be met effectively. It is our distinct privilege to have co-chaired this important meeting and to share with you the conference conclusions and recommendations.

Conclusions and Recommendations

CONCLUSION I

In order to meet societal needs for primary care and train the right primary care professionals in the right numbers with the right competencies for the most appropriate roles, healthcare systems need incentives to dramatically change the way primary care is valued, delivered, and integrated in evolving healthcare systems. We will not attract and retain sufficient numbers nor achieve the needed geographic distribution of primary care providers unless there is a greater proportional investment in primary care. Our students and trainees must be educated throughout their clinical training in practices that deliver first-contact, comprehensive, integrated, coordinated, high-quality, and affordable care. These practices require teams of professionals who give care that elicits patient and provider satisfaction under conditions of clearly defined roles, effective teamwork, patient engagement, and transparency of outcomes.

Recommendation 1

Create financial and other incentives for the development of innovative models of primary care and the advancement of knowledge about outcomes that allow us to identify best practices in the achievement of high-value primary care. Strategies may include the following:

- A competitive process for the establishment of Centers of Excellence in Primary Care
- Mechanisms that analyze and better define the roles of various health professionals in best- practice, high-value primary care models
- Development and improvement of national metrics for assessment of patient and population health
- Mechanisms for the diffusion of knowledge about best practices, such as the proposed Primary Care Extension Program.

Recommendation 2

Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes.

Recommendation 3

Promote stronger ties between academic health centers and other primary care sites and the communities they serve, setting goals and standards for accountability for primary prevention as well as individual and population health. All health systems, including the primary care practices embedded within them, should be accountable for quality and cost outcomes through well-tested, nationally recognized metrics that address the needs of populations and individuals, with data that are transparent and that can be used for the continuous improvement of models of care.

Recommendation 4

Invest in primary care health information technologies that support data sharing, quality improvement, patient engagement, and clinical care, with the aim of continuously improving the health and productivity of individuals and populations.

Recommendation 5

Recognizing that current payment systems create incentives for underinvesting in primary care services, implement all-payor payment reforms that more appropriately recognize the value contributed by primary care through such mechanisms as global payments linked to patient complexity and accountability for the provision of healthcare services, including preventive services, care coordination across settings, chronic disease management, and 24/7 accessibility. Improved costs and quality of health outcomes for patients and populations should be rewarded. In addition, implement legislation that will standardize insurance reimbursement reporting requirements to reduce administrative costs inherent in a multi-payor system.

CONCLUSION II

In addition to the critical challenges outlined above in the organization and financing of healthcare, current health professional educational models are generally inadequate to attract, nurture, and train the primary care workforce of the future.

Recommendation 1

Create incentives for innovative projects in health professions education, enlisting funding partners from government, industry, philanthropy, and payors in order to develop models of excellent, high-performing, and advanced interprofessional primary care.

Academic health centers, working with teaching community health centers, area health education centers (AHECs), and other training sites are the logical entities to advance such innovations. Strategies could include the development of Primary Care Translational Centers of Excellence that would perform primary care research and evaluation and provide team-based education, with emphasis on the study of new models of primary care and health delivery transformation.

Recommendation 2

Medical schools, nursing schools, and other schools for the health professions, which hold the societal responsibility for the education of health professionals, have an opportunity and obligation to increase the size and strength of the primary care workforce. Leaders of health professional schools should implement actions known to increase the number of students and trainees choosing careers in primary care. These actions include the following:

- Establishing programs to prepare and attract a more socioeconomically, racially, and geographically diverse student body
- Revising admission standards to include more emphasis on social science and humanities and the personal qualities of applicants
- Implementing and expanding scholarship and loan repayment programs in partnership with health systems, governmental agencies, and communities for those pursuing careers in primary care
- Promoting early exposure to primary care practices for all students
- Creating longitudinal immersion clinical experiences in community primary care settings
- Implementing special primary care tracks for students and trainees.
- Establishing and strengthening departments of family medicine within schools of medicine.

Recommendation 3

Interprofessional education should be a required and supported part of all health professional education. This change is especially important for primary care. Regulatory, accreditation, reimbursement, and other barriers that limit members of the healthcare team from learning or working together should be eliminated.

Recommendation 4

The Department of Health and Human Services, through its appropriate agencies and divisions, should be granted additional funding to support interprofessional training, preparation of the primary care workforce, and leadership development programs to produce clinicians to take the lead in new models of primary care. Strategies to accomplish these goals could include the following:

- Expansion of Title VII and Title VIII funding and authority to jointly fund interprofessional programs
- Expansion of Title VII and Title VIII funding to address faculty shortage and educational underinvestment in the development of faculty for primary care
- Increase in AHEC funding to expand its pipeline programs in primary care and to provide community-based, interprofessional educational experiences for all primary care health professions students
- Resumption of the Primary Care Health Policy Fellowship and creation of new programs to prepare clinician-leaders for new models of practice
- Provision of adequate scholarships and loan repayment programs to provide clinicians to underserved areas and to improve diversity
- Expansion and direction of funding for graduate medical, nursing, and physician assistant educational programs (Medicare Graduate Medical Education funding, Title VII, Title VIII) to support trainees and training infrastructure costs in ambulatory settings, including teaching community health centers, AHECs, academic outpatient clinics, and other community-based programs.

CONCLUSION III

Recognizing that the healthcare system is dynamic and will continue to evolve, strong leadership will be needed to advance the science, teaching, practice, and policy development relevant to primary care.

Recommendation 1

Develop leaders with a focus on advancing the curricula and learning opportunities for preparing competent primary care clinicians, scientists, and policymakers of the future.

Medical, nursing, and other health profession school faculties should form partnerships with educators from other disciplines, such as business and law, to develop novel educational opportunities for advancing primary care leadership, research, policy, and advocacy. As a routine part of their education, primary care students should be exposed to mentored opportunities to participate in healthcare improvement and policy development and to function within interprofessional and interdisciplinary leadership teams.

Recommendation 2

Support the further development of science and the scientific leadership necessary to advance the translation of best practices into primary care delivery for the improvement of patient and community health. Initiatives could include the following:

- Funding career development for scientists that can create improved national metrics for assessment of individual and population health
- Providing targeted funding through Clinical Translational Science Awards, National Research Service Awards, and Health Research Services Awards for scientists focused on primary care
- Developing a national healthcare workforce analysis and policy capability for ensuring an adequate and well-prepared primary care workforce over time.

Recommendation 3

Recognize the need to include representatives of all primary care providers in the leadership of delivery systems and in groups that are responsible for developing healthcare policies at the state and federal level.

Cronenwett L & Dzau V. Chairman's Summary of the Conference. In: Culliton B, editor. Who Will Provide Primary Care and How Will They Be Trained?, 2010; Durham, NC. Josiah Macy, Jr. Foundation; 2010.

Conference Participants

Linda Cronenwett, Ph.D., R.N., FAAN*
University of North Carolina at Chapel Hill
School of Nursing
Co-Chair

Victor J. Dzau, M.D.*
Duke University
Duke University Health System
Co-Chair

Ruth Ballweg, M.P.A., P.A.-C.
MEDEX Northwest Division of Physician Assistant Studies

Richard J. Baron, M.D., FACP
American Board of Internal Medicine Foundation
Greenhouse Internists, PC

Michael S. Barr, M.D., M.B.A., FACP
American College of Physicians

Bobbie Berkowitz, Ph.D., R.N., FAAN
University of Washington
School of Nursing

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Health Affairs

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Sophie Davis School of Biomedical Education
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Kevin Grumbach, M.D.
Family and Community Medicine
University of California, San Francisco

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Healthcare Transformation IBM Patient-Centered Primary Care Collaborative

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Upper Cardozo Health Center

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Annals of Family Medicine
Case Western Reserve University

Barbara Starfield, M.D., M.P.H.
The Johns Hopkins Primary Care Policy Center

Valerie E. Stone, M.D., M.P.H.
Massachusetts General Hospital
Harvard Medical School

George E. Thibault, M.D.*
Josiah Macy, Jr. Foundation

Reed V. Tuckson, M.D., FACP
UnitedHealth Group

Kenneth Veit, D.O.
Philadelphia College of Osteopathic Medicine

Macy Foundation
George E. Thibault, M.D.*
Marc A. Nivet, Ed.D.*
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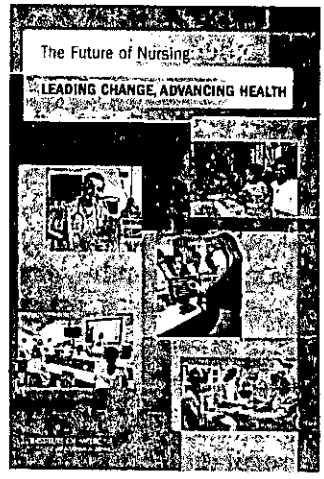
The Future of Nursing
Leading Change, Advancing Health



With more than 3 million members, the nursing profession is the largest segment of the nation's health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs. A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing.

Nurses practice in many settings, including hospitals, schools, homes, retail health clinics, long-term care facilities, battlefields, and community and public health centers. They have varying levels of education and competencies—from licensed practical nurses, who greatly contribute to direct patient care in nursing homes, to nurse scientists, who research and evaluate more effective ways of caring for patients and promoting health. The committee considered nurses across roles, settings, and education levels in its effort to envision the future of the profession. Through its deliberations, the committee developed four key messages that structure the recommendations presented in this report:

A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

accurate predictions of workforce needs, and coordination of the collection of data on the health care workforce at the state and regional levels. All data collected must be timely and publicly accessible.

Conclusion

The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role.

The recommendations presented in this report are directed to individual policy makers; national, state, and local government leaders; payers; and health care researchers, executives, and professionals—including nurses and others—as well as to larger groups such as licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health.

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The NEW ENGLAND JOURNAL of MEDICINE

Broadening the Scope of Nursing Practice

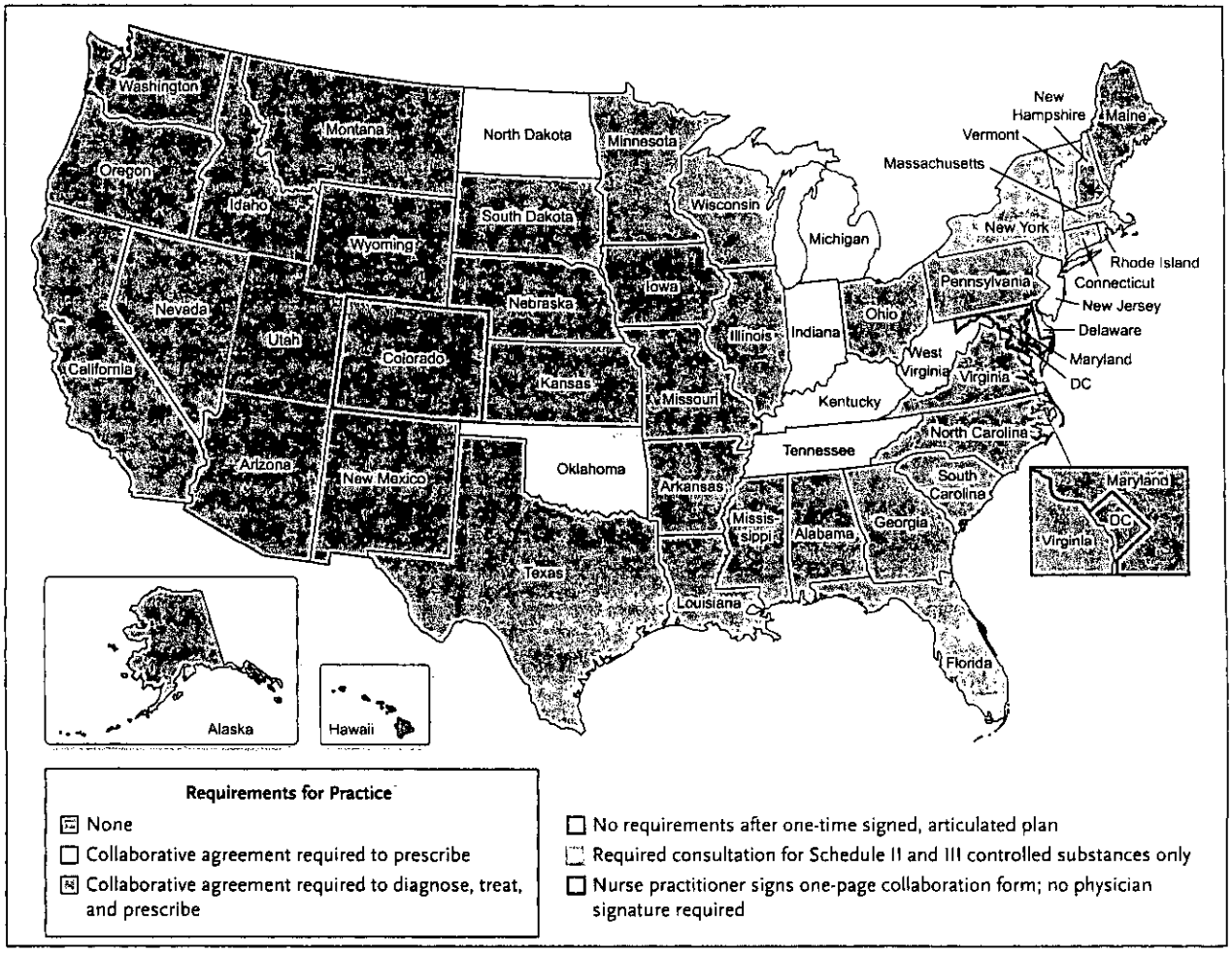
Julie A. Fairman, Ph.D., R.N., John W. Rowe, M.D., Susan Hassmiller, Ph.D., R.N., and Donna E. Shalala, Ph.D.

The Affordable Care Act promises to add 32 million Americans to the rolls of the insured at a time when there is a shortage of primary care providers. There is broad consensus that the next phase of reform must slow the growth of health care costs and improve value through payment reforms, including bundling of payments and payments for episodes of care. Some savings will derive from implementation of innovative models of care, such as accountable care organizations, medical homes, transitional care, and community-based care. We believe that if we are to bridge the gap in primary care and establish new approaches to care delivery, all health care providers must be permitted to practice to the fullest extent of their knowledge and competence. This will require establishing a standardized and broadened scope of practice for advanced-practice registered nurses — in particular, nurse practitioners — for all states.

Comment on this article at NEJM.org

Nurses' role in primary care has recently received substantial scrutiny, as demand for primary care has increased and nurse practitioners have gained traction with the public. Evidence from many studies indicates that primary care services, such as wellness and prevention services, diagnosis and management of many common uncomplicated acute illnesses, and management of chronic diseases such as diabetes can be provided by nurse practitioners at least as safely and effectively as by physicians.[1] After reviewing the issue, an Institute of Medicine (IOM) panel recently reiterated this conclusion and called for expansion of nurses' scope of practice in primary care.[2]

Some physicians' organizations argue that physicians' longer, more intensive training means that nurse practitioners cannot deliver primary care services that are as high-quality or safe as those of physicians. But physicians' additional training has not been shown to result in a measurable difference from that of nurse practitioners in the quality of basic primary care services.[1,2] We are not arguing that nurse practitioners are substitutes for these physicians, but rather that we should consider how primary care services can be more effec-



Scope-of-Practice Regulations for Nurse Practitioners, According to State.
Data are from the AARP (http://championnursing.org/aprnmap).

tively provided to more people with the use of the full primary care workforce.

The critical factors limiting nurse practitioners' capacity to practice to the full extent of their education, training, and competence are state-based regulatory barriers. States vary in terms of what they allow nurse practitioners to do, and this variance appears not to be correlated with performance on any measure of quality or safety. There are no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of physicians in less restrictive states has changed or deteriorated.

There is variation in several aspects of practice, including requirements for prescribing privileges, oversight and chart reviews, and the maximum "collaboration ratios" for nurse practitioners working with physicians. In some states, nurses cannot certify home health care visits or stays in skilled nursing facilities or hospice, order durable equipment, admit patients to hospitals without a physician's supervision or collaborative agreements, or prescribe medications without physician oversight. Nurses tend to move from more restrictive to less restrictive states, and from primary to specialist care, with a resulting loss of access to care for patients. Credentialing and payment are also linked to state regulations: more restrictive states are less likely than those allowing independent practice to credential nurse practitioners as primary care providers.[2,3]

Sixteen states plus the District of Columbia have already

liberalized and standardized their scope-of-practice regulations and allow nurse practitioners to practice and prescribe independently (see map). Several other states are reconsidering their laws to allow independent practice and to adopt the Advance Practice Nurse (APRN) Model Act generated by the National Council of State Boards of Nursing. Under such laws, nurse practitioners may practice independently and be accountable "for recognizing limits of knowledge and experience, planning for the management of situations beyond [their] expertise; and for consulting with or referring patients to other health care providers as appropriate."[4]

The trend toward easing restrictions is propelled by recent reports from several blue-ribbon panels. In addition to the IOM report, which specifically targets regulatory barriers, several policy briefs from other organizations, including the Macy Foundation, support broader scope-of-practice boundaries. One of the largest consumer groups, the AARP (formerly the American Association of Retired Persons), also supports an expanded role for nurse practitioners in primary care.

In addition to the data on the quality of care, the expected dramatic increase in demand for primary care services from Americans with insurance, and the impending shortage of primary care providers, there are several other reasons to relax state regulations. Effective implementation of new delivery models, such as medical homes and accountable care organizations, which would provide chronic disease management and transitional care, requires the establishment of interdisciplinary teams in which nurses provide a range of services, from case management to health and illness management. Such an expanded scope of practice and team-based approaches including nurse practitioners have been shown to improve quality and patient satisfaction and reduce costs at the Veterans Administration Health System, Geisinger Health System, and Kaiser Permanente.[2]

Reductions in cost associated with broadening nurse practitioners' scope of practice can be seen elsewhere as well. In U.S. retail clinics, where cost savings have been documented, nurse practitioners provide most of the care. But retail clinics have been slow to expand in states with more restrictive scope-of-practice regulations. Research in Massachusetts shows that using nurse practitioners or physician assistants to their full capacity could save the state $4.2 billion to $8.4 billion over 10 years and that greater use of retail clinics staffed primarily by nurse practitioners could save an additional $6 billion.[3]

Since nurse practitioners' education is supported by federal and state funding, we are underutilizing a valuable government investment. Moreover, nurse practitioner training is the fastest and least expensive way to address the primary care shortage. Between 3 and 12 nurse practitioners can be educated for the price of educating 1 physician, and more quickly.[5]

Despite the robust rationale for broadening nurse practitioners' scope of practice, key medical organizations oppose the idea. The American Medical Association, the American Osteopathic Association, the American Academy of Pediatrics, and the American Academy of Family Physicians all support requiring direct supervision of nurse practitioners by physicians. As health care reform advances, implementation of payment reforms — including global or bundled team-based payments and medical home–based payments — may ease professional tensions and fears of substitution while enhancing support for an increased scope of nursing practice.

Legal considerations also seem to favor such a trend. The Federal Trade Commission recently evaluated proposed laws in three states and found several whose stringent requirements for physician supervision of nurses might be considered anticompetitive. The agency has also investigated proposed state policies that would protect professional interests rather than consumers.[2]

This is a critical time to support an expanded, standardized scope of practice for nurses. Economic forces, demographics, the gap between supply and demand, and the promised expansion of care necessitate changes in primary care delivery. A growing shortage of primary care providers seems to ensure that nurses will ultimately be required to practice to their fullest capacity. Fighting the expansion of nurse practitioners' scope of practice is no longer a defensible strategy. The challenge will be for all health care professionals to embrace these changes and come together to improve U.S. health care.

The views expressed in this article are those of the authors and do not necessarily represent those of their institutions.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania School of Nursing, Philadelphia (J.A.F.); the Robert Wood Johnson Foundation Initiative on the Future of Nursing, Institute of Medicine, Washington, DC (J.A.F., J.W.R., S.H., D.E.S.); the Department of Health Policy and Management, Mailman School of Public Health, Columbia University, New York (J.W.R.); and the University of Miami, Miami (D.E.S.).

See also related letters to the Editor (10.1056/NEJMc1013895).

This article (10.1056/NEJMp1012121) was published on December 15, 2010, at NEJM.org.

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EDITORIAL

Jeff Susman, MD
Editor-in-Chief

It's time to collaborate—not compete—with NPs

It is time—time to abandon our damagingly divisive, politically Pyrrhic, and ultimately unsustainable struggle with advanced practice nurses (APNs). I urge my fellow family physicians to accept—actually, to *embrace*—a full partnership with APNs.

Why do I call for such a fundamental change in policy? First, because it's the reality.

In 16 states, nurse practitioners already practice independently. And in many more states, there is a clear indication that both the public and politicians favor further erosion of barriers to independent nursing practice. Indeed, such independence is outlined in "The Future of Nursing: Leading Change, Advancing Health," published by the Institute of Medicine (IOM) in October 2010. Among the IOM's conclusions:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Second, I believe our arguments against such a shift in policy don't hold up. Despite the endless arguments about outcomes, training, and patient preferences, I honestly believe that most nursing professionals—just like most physicians—practice within the bounds of their experience and training.

Arguments FPs make against APNs sound like specialists' arguments against us.

Indeed, the arguments family physicians make against APNs sound suspiciously like specialists' arguments against us. (Surely, the gastroenterologists assert, their greater experience and expertise should favor colonoscopy privileges only for physicians within their specialty, not for lowly primary care practitioners.) Rather than repeating the cycle of oppression that we in family medicine battle as the oppressed, let's celebrate differences in practice, explore opportunities for collaboration, and develop diverse models of care.

Third, I call for a fundamental shift in policy because I fear that, from a political perspective, we have much to lose by continuing to do battle on this front. Fighting fractures our support and reduces our effectiveness with our legislative, business, and consumer advocates.

Finally, I'm convinced that joining forces with APNs to develop innovative models of team care will lead to the best health outcomes. In a world of accountable health care organizations, health innovation zones, and medical "neighborhoods," we gain far more from collaboration than from competition.

As we ring in the new year, let's stop clinging to the past—and redirect our energies toward envisioning the future of health care.

Jeff Susman, MD

jfp@neoucom.edu

#3

TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

Kris Todd-Reisnour, FNP, CCD, ONP-C

January 18, 2011

TESTIMONY

TO

SENATE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

Kris Todd-Reisnour, FNP, CCD, ONP-C

January 18, 2011

Madame Chairman Lee and Committee Members

My name is Kris Todd-Reisnour. I am a Family Nurse Practitioner (FNP) and I am here to testify in favor of SB 2148. I am one of the 4 Nurse Practitioners (NPs) in the state who are self-employed. I own and operate Dakota Osteoporosis in Bismarck. In this clinic I diagnose, educate and treat patients for osteoporosis and orthopaedic problems. Patient referrals come to me from physicians, other NPs, chiropractors, therapists as well as others. My collaborating physician is Dr. Biron Baker at Medcenter One.

I am also a contract employee for a local medical facility seeing residents in long term care facilities for health problems. When necessary I contact other health

care providers regarding medications and recommendations. The health care provider I choose to contact may be a Family Practice physician, the NP who manages the dialysis unit, the surgeon when you find a mass or your favorite pharmacist depending on the patient's need. All NPs collaborate with the appropriate health care provider when practice and prescriptive issues arise. That is part of our training.

I am the Secretary for NDNPA and represent our group on the Department of Human Services Medicaid Advisory Committee. We have gathered a significant number of signatures from physicians, hospital board members, pharmacists and county commissioners in support of the amendment. Dr Kent Martin who was appointed by the North Dakota Board of Medicine to the Prescriptive Authority Committee is also a supporter of the amendment. The Ashley Hospital Board of Directors have all signed in support. We have received letters of support from many organizations: Community HealthCare Association of the Dakotas, AARP, American Academy of NPs, American College of NPs, National Council of State Boards of Nursing and many others listed for you.

As Secretary I also receive emails from recruiting agencies and organizations at least monthly. They ask me to send out information to our membership regarding job openings for NPs in North Dakota communities. In the last two months there have been requests from Towner, New Town, Oakes and Grand Forks.

After working with Lee Boyles, Administer of Oakes Community Hospital he sent me a note I would like to share with you. "Thomas Cooper did share with me the proposed bill to remove the collaborating physician piece for prescriptive authority. I'm all in favor of this! I agree 100% that it helps improve access to care

in our rural areas, while maintaining high quality of care, and also helps keep healthcare costs affordable. I've signed the support page for you and attached it to this email. I think mid-level practitioners, both NPs and PAs are outstanding providers. I feel they can truly help us in our rural communities, and our opportunity in Oakes allows them to really grow their scopes of practice as well...clinic, hospital, ER, etc.

In closing I would like to leave you with a question. One of our members is a NP who practices in Westhope with a 76 year-old collaborating physician. When he is no longer practicing will she be able to find a new collaborating physician outside the community? Or will the community lose two health care providers?

I urge you to support Senate Bill 2148. Thank you for allowing me to share my thoughts with you today. This Bill is not only important to me but also to healthcare access in North Dakota.

AARP North Dakota
107 W. Main Avenue
Suite 125
Bismarck, ND 58501

T 1-866-554-5383
F 701-255-2242
TTY 1-877-434-7598
www.aarp.org/nd

Cheryl Rising
North Dakota Nurse Practitioner Association
8300 Burnt Creek Island Road
Bismarck, ND 58503

Dear Ms. Rising,

North Dakota residents need access to high quality health care offered by primary care providers, especially in our underserved rural and urban communities. Along with the rest of the country, our state is facing a shortage of primary care providers who can care for people of all ages, but particularly those with multiple chronic conditions. Consider the numbers, according to a 2010 study by the University of North Dakota, 89% of North Dakota's counties are partially for fully designated as Primary Care Health Professional Shortage Areas.

Nurse practitioners are part of the solution; North Dakota has 350 nurse practitioners. But state laws limit our ability to access the care they provide.

North Dakota state legislators and the Governor have an opportunity to bring much needed primary care to tens of thousands of North Dakota residents with the bill introduced by Senator Lee, which would amend and re-enact Section 43-12. 1-18 of the North Dakota century code relating to the prescriptive standards for advanced practice registered nurses (APRNs). Such a legislative change would make fundamental and necessary changes to how nurse practitioners can provide the health care services for which they are trained, skilled and licensed.

Nurse practitioners and other APRNs provide primary care and women's health services, and help patients manage chronic conditions such as diabetes, among other important health services. Yet, North Dakota laws limit the consumer's ability to access these services by requiring nurse practitioners and other APRNs to practice under physician supervision, through a collaborative agreement. This is particularly troubling for our residents who live in rural areas, where a severe shortage of physicians is prevalent, making it a challenge for nurse practitioners to find physicians for oversight. If enacted, this bill would eliminate waiting periods of up to six months for nurse practitioners to provide care. These waiting periods delay APRNs' ability to write prescriptions, diagnose problems, refer patients to specialists and perform diagnostic testing. As a result, North Dakota residents struggle with undiagnosed ailments, go without medication, and their health declines.

That is why AARP North Dakota urges the State Legislature and the Governor to remove barriers that prevent APRNs from providing the health care services we need.

APRNs are registered nurses with advanced training in preventing, diagnosing, and treating illness, licensed to write prescriptions. These health care professionals hold two nursing degrees (an undergraduate and Master's degree), and must complete supervised clinical training and testing by national accrediting bodies in nursing. Similar to other health care professionals, once certified by the state, APRNs broaden their skill-base through continuing education and experience. APRNs

are educated and trained to do what we need them to do – care for those who need primary, preventive, and chronic care.

Studies demonstrate that APRNs deliver safe and effective health care to all populations, across settings, and in many specialties. In fact, research shows no difference in outcomes of primary care delivered by APRNs and physicians, including patient health status, number of prescriptions written, return visits requested, or referrals to other providers. A recent review of the quality and effectiveness of care provided by APRNs from 1990 to 2008 found that APRNs provide as high a quality of care as physicians.

North Dakota already faces a severe shortage of health care providers. We will benefit by removing barriers that prevent APRNs from practicing to their full level of education, expertise and licensure.

Janis S Cheney, Senior State Director

AARP North Dakota

Altru
Health System

P.O. Box 6002
Grand Forks, ND
58206-6002
(701) 780-5000 *phone*
altru.org *web*

October 19, 2010

Cheryl Rising
President of NDAPN
905 Dodge Circle
Bismarck, North Dakota 58501

Cheryl,

I am sending this letter to you, offering our support for the legislative change – so Nurse Practitioners would no longer need a collaborative letter with a physician for prescriptive practices. As president of the North Dakota Organization of Nurse Execs, I give you the support of our organization for this legislation. Good luck.

Sincerely,

Margaret Reed RN

Margaret Reed, RN
Chief Nurse Executive
Altru Health System

South Dakota

1400 West 22nd Street
Sioux Falls, SD 57105-1570

phone: (605) 357-1515
fax: (605) 357-1510

25th Anniversary

CHAD

Community HealthCare Association of the Dakotas

North Dakota

1003 East Interstate Avenue
Suite 1
Bismarck, ND 58503

phone: (701) 221-9824
fax: (701) 221-0615

January 11, 2011

To Members of the 62nd Legislative Assembly:

On behalf of the member Community Health Centers in North Dakota, I am writing in support of the proposed legislation to modernize and update the requirements of their advance practice registered nurse standards found in SB 2148.

In reviewing the rationale and the literature put forward by the American Academy of Nurse Practitioners, our North Dakota Health Center members support the ability of Nurse Practitioners to meet the intent of their scope of practice with the changes proposed in the legislation. Nurse Practitioners have proven to be valuable also providers of health care, particularly primary health care, in North Dakota. The Practice Act governing their work and standards should be allowed to stand on their own and to reflect the quality of their preparation and competencies.

Sincerely,

Karen E. Larson

Karen E. Larson, Deputy Director

C: Scot Graff, CEO
Sharon Ericson, Valley Community Health Centers
Patricia Patron, Family HealthCare Center
Joan Altenbernd, Migrant Health Services
Faye Hagen, Northland Community Health Center
Dawn Berg, Coal Country Community Health Center

Cavalier County, North Dakota
Office of Auditor

901 Third Street - Suite 15
Langdon, ND 58249
(701) 256-2229
(701) 256-2546 (fax)

Dawn Roppel - Auditor
Lisa Gellner - Deputy Auditor
Pam Lafrenz - Office Clerk

Honorable Senator Judy Lee

We, the Cavalier County Commissioners, voted at our December 21, 2010, meeting to support the elimination of the requirement for a physician signature on Nurse Practitioner prescriptive privilege licensure. We believe it is an unnecessary formality which does not improve quality or safety of NP practice. We believe, also, NP's assess, diagnose, and treat acute and chronic diseases. The passage of this bill eliminating the signature requirement will improve access to healthcare and position North Dakota to improve the recruiting of NP's into this fine state. We believe this will help eliminate the primary care provider shortage in North Dakota. We want to take this opportunity to thank you for sponsoring this bill, and again, reiterate our support for it. We appreciate the endless hours and dedication our NP's do in our community and county.

Cavalier County Commissioners

CUNEA
College and University Nursing Education Administrators

Dakota Nursing Program

Dickinson State University
Department of Nursing

Jamestown College
Department of Nursing

Medcenter One
College of Nursing

Minot State University
Department of Nursing

Sitting Bull College
Department of Nursing

[redacted]th Dakota State
[redacted]lege of Science
Department of Nursing

North Dakota State University
Department of Nursing

United Tribes Technical College
Department of Nursing

University of Mary
Division of Nursing

University of North Dakota
College of Nursing

November 29, 2010

To NDNPA:

The College and University Nursing Education Administrators (CUNEA) has voted to support the legislative bill to eliminate the required signature for prescriptive privileges for advanced practice registered nurses.

Respectfully,

Kelly Buettner-Schmidt, Co-Chair

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881
Telephone: (701) 328-9777 Fax: (701) 328-9785
Web Site Address: http://www.ndbon.org

Workplace Impairment Program: (701) 328-9783

To: **ND Nurse Practitioners Association**
Cheryl Rising APRN, FNP, President

From: **ND Board of Nursing**
Buzz Benson RN, President

Re: **Support of proposed legislation to amend the NDCC 43-12.1 -18. Nursing Practice Standards**

Date: **September 28, 2010**

The North Dakota Board of Nursing met on September 16, 2010 and discussed the request for NDBON support for the legislative proposal to amend NDCC 43-12.1-18 Nursing Practice Standards. The NDBON reviewed the Nurse Practices Act as it relates to the submission of a collaborative agreement for granting prescriptive authority for APRNS. Brian Bergeson, SAAG, reviewed applicable law related to the collaborative agreement and determined that this was a requirement in the NDCC 43-12.1-18 Nursing Practice Standards.

Therefore the Board made the following motion:

Motion: Rustvang, seconded by Traynor to:

SUPPORT A LEGISLATIVE PROPOSAL TO AMEND NDCC 43-12.1-18 NURSING PRACTICE STANDARDS THAT WOULD ELIMINATE THE REQUIREMENT OF A COLLABORATIVE AGREEMENT WITH A LICENSED PHYSICIAN FOR PRESCRIPTIVE AUTHORITY.

Roll call vote: Anderson, yes; Benson, yes; Christianson, yes; Frank, yes; LaLonde, yes; Levi, yes; Rustvang, yes; Smith, yes; Traynor, yes;
9 yes, 0 no, 0 absent. Motion carried.

Thank you for this opportunity to provide support for the APRNs to practice to their full scope of practice.

NDANA
North Dakota Association of Nurse Anesthetists
P.O. Box 1755 • Bismarck, ND 58502-1755 • Phone 701-221-7797 • Fax 701-224-9824 • ndana@aptnd.com • www.ndana.org

Chery Rising
North Dakota Nurse Practitioner Association
905 Dodge Circle
Bismarck, ND 58503

November 4, 2010

Ms. Rising:

The North Dakota Association of Nurse Anesthetists supports the NDNPA proposal to remove the requirement for collaborative agreements from the regulation of nurse practitioners.

The North Dakota Association of Nurse Anesthetists represents more than 200 advanced practice, Certified Registered Nurse Anesthetists, practicing in all settings across the state. From urban to rural facilities, sole provider and in a team approach, CRNAs provide safe, quality care, administering anesthesia to the vast majority of North Dakota patients. This care allows surgical, obstetrical, and trauma stabilization services in hospitals and clinics, increasing access to health care throughout our state.

NDANA supports CRNAs practicing to the fullest extent of the scope of practice. ND law does not, and never has required physician supervision of the CRNA or any collaborative arrangement with a physician for the administration of anesthesia. It has been our position that any such requirement is not in the best interest of the health care of ND citizens as it would create barriers to access. Additionally, national studies have shown no difference in outcomes where the CRNA practices with or without physician supervision.

The NDANA board received your information proposing to "Update the regulation requirements of nurse practitioners to improve healthcare workforce utilization in North Dakota while maintaining safety." Your proposal to remove the requirement for collaborative agreements is consistent with the NDANA position to improve access to safe, quality healthcare throughout ND. Additionally, NDANA agrees with your position that such requirements "...do not assure patient safety, improve quality of care, or lead to meaningful intra-disciplinary or integrated practice." In fact, often such requirements, especially in a rural state like ND, limit access to meet the healthcare needs of the citizens.

Sincerely,

Jody Slominski, CRNA, MSN

Jody Slominski, CRNA, MSN
President

NDNA

PO Box 292 ✧ Mandan, ND ✧ 58554
701-223-1385

The Nursing Scope and Standards of Practice, 2nd Ed. published in 2010 by the American Nurses Association lists the standards of practice for all nurses. These standards include assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The standards of coordination of care, health teaching and promotion, consultation and prescriptive authority and treatment further define the standard of implementation. Consultation and prescriptive authority and treatment are specifically aimed at the advanced practice nurse. To complete the list of standards, the standards of professional performance include: ethics, education, evidence-based practice, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health. These standards are foundational in practice descriptions for the Registered Nurse and subsequently the APRN, thus being the basis for state law and regulation which further define criteria for the licensure and description of the scope of practice.

The APRN scope of practice already mandates the APRNs use a process that ensures patient safety by following well accepted national standards of practice. It is expected that all nurses as well as advanced practice nurses fulfill their contract with society by being accountable to the public by meeting the Scope and Standards of Practice and the Code of Ethics. The Nurse Practices Act and Rules and Regulations further promote safety through self regulation and individuals are further overseen by institutional policy and procedures, credentialing and reviews all based upon these Codes and Standards.

Based on the solid foundation upon which the APRN scope of practice has been developed, and the fundamental belief that practice is self-governing and that the standards describe accountabilities to society, NDNA fully supports removal of the regulatory requirement for collaborative agreement for prescriptive privileges as presently written in the ND Nurse Practices Act.

Shanda Rose PhD, RNBC
NDNA President

ACNP

AMERICAN COLLEGE OF NURSE PRACTITIONERS

December 14, 2010

To whom it may concern,

This letter is being sent in support of the North Dakota Nurse Practitioner Association's legislative efforts to change the Nurse Practice Act, Chapter 43-12.1-18 Nursing Practice Standards. Currently the standard reads that in order to have prescriptive authority NPs must "include evidence of a collaborative agreement with a licensed physician." The NDNPA is seeking to remove this barrier to full, appropriate NP practice.

There are currently fifteen states that do NOT require NPs to have any type of relationship with a licensed physician to prescribe medications, with many of them having prescriptive "independence" for over 20 years.

In July of 2008, the National Council of State Boards of Nursing released its document "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education." In this document, the definition of an APRN "includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and **prescription of pharmacologic** and non-pharmacologic interventions" (p.7). (www.ncsbn.org/170.htm) Removal of the clause "include evidence of a collaborative agreement with a licensed physician" will bring the North Dakota Nurse Practice Act into alignment with the recommendations and direction of the National Council of State Boards of Nursing, and remove barriers to full and appropriate practice for Nurse Practitioners and their patients.

Should you want any further information regarding Nurse Practitioners having independent prescribing privileges, please feel free to contact me at President@ACNPweb.org.

Regards,

Marsha Siegel

Marsha Siegel, EdD, FNP-BC
President
ACNP Board of Directors

ACNP ❖ 1501 Wilson Boulevard, Suite 509 ❖ Arlington, VA 22209
Tel: 703/740-2529 ❖ Fax: 703/740-2533 ❖ Email: ACNP@acnpweb.org ❖ www.acnpweb.org

AMERICAN ACADEMY OF NURSE PRACTITIONERS

Incorporated 1985

Administration: PO Box 12846 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: admin@aanp.org · Web Site: www.aanp.org

Office of Health Policy: PO Box 40130 · Washington, DC 20016 · 202-966-6414 · Fax: 202-966-2856 · E-mail: dcoffice@aanp.org

Journal (JAANP): PO Box 12965 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: journal@aanp.org

December 1, 2010

Senator Lee
North Dakota State Capitol
600 East Boulevard
Bismarck, North Dakota 58505

Re: Updating the Regulatory Statutes for Nurse Practitioner Prescribing (ND Century Code 43-12.1-18)

Dear Senator Lee,

On behalf of the American Academy of Nurse Practitioners (AANP), our North Dakota nurse practitioners members and the patients served by the North Dakota nurse practitioner community, I am writing to express support for the proposed updates to nurse practitioner prescribing section of 43-12.1-18 of the North Dakota Century Code.

Nurse practitioners are primary care providers who evaluate, diagnose, order and interpret diagnostic tests, and initiate and monitor treatments—including writing prescriptions. For nearly half a century, nurse practitioners have cultivated a track record for providing high quality, safe and cost effective care across all care settings. Today, North Dakota is in a situation where we have well equipped clinicians that are restricted from providing care at the top of their education and abilities because of outdated legislative and regulatory language. Discussions with our North Dakota nurse practitioner members have made it clear that the outdated requirement for a collaborative agreement with a physician for nurse practitioner prescribing is failing to add safety, quality, integrated communication, or coordination to patient care. Instead, it has become an unnecessary formality that has set up barriers to practice, decreased access to care, and clouded the public transparency around prescribing accountability.

The AANP recommends the removal of the outdated requirement for a collaborative agreement for prescribing. In fact, AANP is not alone in recommending that outdated legislative barriers to practice be removed.

- The Institute of Medicine, "The Future of Nursing: Leading Change, Advancing Health," publication released October 2010 recommends that "advanced practice registered nurses should be able to practice to the full extent of their education and

training." To achieve this goal, the IOM committee recommends that state legislatures "reform the scope-of-practice regulations to confirm to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules"

- The Josiah Macy Foundation's 2010 "Who will provide primary care and how will they be trained?" summary recommends that "policies be changed to remove barriers that make it difficult for nurse practitioners and physicians assistants to serve as primary care providers and leaders of the patient-centered medical home of other models of primary care delivery."
- Consumer groups are additionally supporting updating practice regulation to provide for greater access. In March 2010, the AARP released the following policy statement, "Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification."

- 14 states and the District of Columbia have already adopted similar updates that no longer require links to a physician for practice and prescribing—some states have had these updates for over a decade.

The proposed language update to 43-12.1-18 is consistent with these national recommendations and with the national trends in regulating nursing practice. This language update will help address the healthcare workforce challenges facing North Dakota, and maintain the strong commitment to public safety and quality of nurse prescribing under the direct authority of the Board of Nursing. This change to the regulation of nurse practitioner prescribing will not alter the scope of practice.

The American Academy of Nurse Practitioners, along with our North Dakota membership, respectfully asks the Legislature to ensure that North Dakota effectively utilizes the healthcare workforce by updating 43-12.1-18 to align with the National Council of State Boards of Nursing (NCSBN) regulatory framework for advanced practice nurses. We appreciate the opportunity to provide comment to this legislative process and its implication to care delivery. If there are any questions regarding the AANPs comments, please contact our health policy office at (202) 966-6414.

Sincerely,

Tay Kopanos, DNP, NP
Director of Health Policy, State Government Affairs

SIGNATURES of SUPPORTING PHYSICIANS

Corey Arcelay, MD

Biron Baker, MD

Robert Bathurst III, MD

Gretchen Belzer Curl, MD

Paula Bercier, MD

Paul Beauclair, MD

Jan Bexell-Gierke, MD

Kurt Datz, DO

Kent Diehl, MD

Jon Dickson, MD

Russell Emery, MD

Napoleon Espejo, MD

Siri Fibiger, MD

Kevin Folkers, MD

Greg Glasner, MD

Michael Grandison, DO

Thomas Hardis, MD

David Hartfield, MD

Mary Holm, MD

Anthony Johnson, MD

Richa Kaushik, MD

Kenneth Kihle, MD

John Kim, MD

Darwin Lange, MD

Gordon Leingang, DO

Keith Lesterburg, MD

Tracie Mallberg, MD

Candelaria Martin, MD

Kent Martin, MD

Robert Martino, MD

Steve Mattson, MD

Thomas Matzke, MD

John Mickelson, MD

Kristi Midgarden, MD

Niral Patel, MD

Suresh Patel, MD

David Pengilly, MD

Mark Peterson, MD

William Pryatel, MD

Sandra Robinson, DO

Ben Roller, MD

Kinsey Schultz Piatz, MD

Fauna Shruji, MD

Philip Sondrol, MD

Stuart Smith, MD

Sherry Stein, MD

Eric Thompson, MD

Tom Thorson, MD

Michael Tilus, MD

Michelle Tincher, MD

Udom Tinsa, MD

Matthew Viscito, MD

Karin Willis, MD

Terry Wolf, DO

Marcel Young, MD

#3

NDNPA
North Dakota
Nurse Practitioner Association

North Dakota Nurse Practitioners are requesting your support with legislation to amend the Nurse Practice Act to eliminate the requirement for physician signature for prescriptive privileges.

This change is consistent with the position of the National Council of State Boards of Nursing and will:

- Eliminate barriers to NP practice.
- Increase access to care for patients in our state
- Will position ND more competitively in recruiting primary care NPs
- Will allow ND Nurse Practice Act to be more consistent with other western rural states to help work toward having Compact NP practice among neighboring states.
- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Lara Linde MD
(Signature)

Essentia Health-Fargo
(Practice Location) South University

Lara Linde MD
(Print name)

(Signature)

(Practice Location)

(Print name)

(Signature)

(Practice Location)

(Print name)

NPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) Grand Forks (Practice Location)

Mark Peterson, MD
(Print name)

(Signature) Grand Forks (Practice Location)

Terry A. Smith DO
(Print name)

(Signature) (Practice Location)

(Print name)

701-258-4428

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Deborah K Johnson PhD PMHCNS,BC — Minot ND
(Signature) (Practice Location)

Deborah K Johnson
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA

North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Wm Patel MD
(Signature)

ND State Hospital
(Practice Location)

William Patel MD
(Print name)

(Signature)

(Practice Location)

(Print name)

(Signature)

(Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) Fargo (Practice Location)

(Print name)

(Signature) Fargo (Practice Location)

Jon L. Dickson, MD
(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Ben Roller MD
(Signature)

St. Alexius Medical Center Bismarck, ND.
(Practice Location)

Ben Roller MD
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment. to include physician assistants

(Signature) (Practice Location)

Dr. Gordon Leingang, DO, FACEP
COL, MC, SFS, ARNG
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Karin K Willis, MD
(Signature)

UND Center for Family Medicine
Bismarck, ND 58501
(Practice Location)

Karin K Willis MD
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) Sanford Health
(Practice Location)

Thomas J. Mattke
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) Wolthope N.D. (Practice Location)

KENNETH WICHLE
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA

North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) Marlo East (Practice Location)

Anthony Johnson
(Print name)

(Signature) Mandan East (Practice Location)

Terry Wolf
(Print name)

(Signature) (Practice Location)

(Print name)

I agree with the recommendation to update the Nurse Practice Act and eliminate the statutory requirement for physician signature for prescriptive privileges for Nurse Practitioners.

(Signature) Cavalier County Memorial Hospital
(Practice Location)
Michael Grandison
(Print name)

(Signature) Cavalier County Memorial Hosp Langdon ND
(Practice Location)
SURESH K. PATEL MD
(Print name)

(Signature) Rolla, ND Locum Tenens
(Practice Location)
Sandra Jean Robinson DO
(Print name)

(Signature) Grand Forks + Langdon, ND
(Practice Location)
Mark Peterson, MD
(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

(Signature) — LilyCare Clinic - West Fargo (Practice Location)

Tracie M. Mathern MD
(Print name)

(Signature) — Human Clinic, Grand Forks (Practice Location)

Matthew Visaya, MD
(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Ranelle Turman CNP
(Signature)
Ranelle Turman CNP
(Print name)

OB-GYN - Sanford Health
(Practice Location) Fargo ND

Lynette K Skatvold
(Signature)
LINDA K. Skatvold
(Print name)

OB-GYN Sanford Health
(Practice Location) Fargo ND

Kristi A Lindgren
(Signature)
Kristi A Lindgren MD
(Print name)

OB-GYN Sanford Health Fargo ND
(Practice Location)

NDNPA
North Dakota
Nurse Practitioner Association

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I am in favor of this amendment.

JuAnn J Stromme DNP
(Signature)

Spirit Lake Health Center
Fort Totten, ND 5833
(Practice Location)

JUANN F. STROMME, DNP
(Print name)

Michael R Tilus PsyD, MP
(Signature)

Spirit Lake Health Center,
Ft. Totten, ND
58335
(Practice Location)

Michael R. Tilus, Psy D, Medical Psychologist
(Print name)

Candelaria Martin Arndt
(Signature)

Same as above
(Practice Location)

Candelaria Martin Arndt
(Print name) (Collaborating Physician)

FROM:

FAX: 701-258-9423

MARCI KETTERLING & CAREY RIVINIUS

I agree with the recommendation to update the Nurse Practice Act and eliminate the statutory requirement for physician signature for prescriptive privileges for Nurse Practitioners.

K A Diell MD — (Signature)

Elgin, ND — (Practice Location)

Kent A. Diell MD — (Print name)

(Signature)

(Practice Location)

(Print name)

(Signature)

(Practice Location)

(Print name)

(Signature)

(Practice Location)

(Print name)

(Signature)

(Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
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I am in favor of this amendment.

(Signature)	Minnetohe Health Center (Practice Location)
CD Arcelay, MD (Print name)	
(Signature)	(Practice Location)
(Print name)	
(Signature)	(Practice Location)
(Print name)	

NDNPA

North Dakota
Nurse Practitioner Association

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I am in favor of this amendment.

(Signature) _____ (Practice Location) MinotND Trinity Hospital

MARCEL YOUNG
(Print name)

Steve Matteson (Signature) MINOT, ND - TMC (Practice Location)

STEVE MATTSON
(Print name)

Paula Bercier (Signature) Minot ND TMC (Practice Location)

Paula Bercier MD.
(Print name)

Nora Rasmusson FNP-C

Nora Rasmusson FNP-C minot, N.D. TMC

NDNPA
North Dakota
Nurse Practitioner Association

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- Will **NOT** change the NP scope of practice
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I am in favor of this amendment.

Richa Kaushik — Bismarck VA clinic
(Signature) (Practice Location)
RICHA KAUSHIK
(Print name)

Kevin Folkers MD — Bismarck VA Clinic
(Signature) (Practice Location)
Kevin Folkers
(Print name)

Debra K Orley PharmD — Bismarck VA Clinic
(Signature) (Practice Location)
Debra K Orley
(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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I am in favor of this amendment.

G. G. Glasser MD — Essentia Health
(Signature) (Practice Location)

G. G. GLASSER
(Print name)

Mary K. Holman — Essentia Health
(Signature) (Practice Location)

Mary K. Holman MD
(Print name)

(Signature) (Practice Location)

(Print name)

NDNPA
North Dakota
Nurse Practitioner Association

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Kristi Midgarden MD — Park River, N.D.

(Signature) (Practice Location)

Kristi Midgarden MD

(Print name)

_____ _____

(Signature) (Practice Location)

_____

(Print name)

_____ _____

(Signature) (Practice Location)

_____

(Print name)

NDNPA

North Dakota
Nurse Practitioner Association

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- Eliminate barriers to NP practice.
- Increase access to care for patients in our state
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- Will **NOT** change the NP scope of practice
- Will **NOT** change quality of care for patients

I am in favor of this amendment.

Russell J Enany NP — (Signature)
Russell J Enany — (Print name)
MedCenter One — (Practice Location)

(Signature)
Bicon Baker — (Print name)
Medcenter One — (Practice Location)

(Signature)
(Practice Location)

(Print name)

NDNPA

North Dakota
Nurse Practitioner Association

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I am in favor of this amendment.

Darwin Caye
(Signature)

Mandan ND
(Practice Location)

Darwin Caye
(Print name)

WIC Medcenter
(Practice Location)

Eric Thompson MD
(Print name)

(Signature)

(Practice Location)

(Print name)

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I am in favor of this amendment.

Nina Klein FNP-C
(Signature)
NINA KLEIN
(Print name)
Ashley Medical Center
(Practice Location)

Lori Bichler FNP-C
(Signature)
Lori Bichler
(Print name)
Ashley Medical Center
(Practice Location)

(Signature)
Udom Tinsatul, MD
(Print name)
Ashley Medical Center/
(Practice Location) Ashley Clinic PC

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I am in favor of this amendment.

(Signature) Ashley ND (Practice Location)

Link J. Golz Hosp. Board President
(Print name)

(Signature) Ashley ND (Practice Location)

Cindy Jenner
(Print name)

(Signature) Ashley ND (Practice Location)

Fern Haugen
(Print name)

(Ashley medical Cent Board Members)

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(Signature) Ashley NP (Practice Location)

Paul Nies
(Print name)

(Signature) Ashley NP (Practice Location)

Floyd Helfenstein
(Print name)

William E. Kretschmar Ashley ND (Practice Location)

William E. KRETSCHMAR
(Print name)

Ashley Medical Center Board Members

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Jason Schmidt — Ashley, ND
(Signature) (Practice Location)
Jason Schmidt Board Member
(Print name)

Darlene Nagy-Aemisegger — Ashley ND
(Signature) (Practice Location)
Kathleen Nagy
(Print name)

Jerry Vaagen CFO — Ashley Med Center
(Signature) (Practice Location)
JERRY CEO
(Print name)

Ashley Medical Center

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(Signature) FARGO - ESSENTIA
(Practice Location)

JILL FISBECK
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

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John H. Kim, M.D. — Essentia Health, Fargo, ND
(Signature) (Practice Location)

John H. Kim, M.D.
(Print name)

ESSENTIA HEALTH, FARGO, ND
(Signature) (Practice Location)

DAVID HARTFIEL, MD.
(Print name)

Jon Bexell-Pierce, MD — Essentia Health, Fargo ND
(Signature) (Practice Location)

Jon Bexell-Pierce, MD
(Print name)

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(Signature) (Practice Location)

Dr. Terry J Burrell
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

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Kent Martin MD
(Signature)

MEDCENTER ONE
(Practice Location)

KENT MARTIN
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

_____
(Signature)

_____
(Practice Location)

_____
(Print name)

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G Belzer - Curl — Mandan

(Signature) (Practice Location)

G Belzer - Curl

(Print name)

Tom Thorson MD — Mandan

(Signature) (Practice Location)

TOM THORSON MD

(Print name)

(Signature) (Practice Location)

(Print name)

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Patel — (Signature)
Niral Patel, ND — (Print name)
BFCN — (Practice Location)
Bismarck

(Signature)
(Print name)
(Practice Location)
Bismarck

(Signature)
David Pengilly — (Print name)
BFCS — (Practice Location)
Bismarck

FAX to 701-222-0707

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(Signature) Minot ND
(Practice Location)

Kurt Datz DO
(Print name)

(Signature) (Practice Location)

(Print name)

(Signature) (Practice Location)

(Print name)

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(Signature) BFCS (Practice Location) Bismarck

Kinsey Shultz Piatz MD
(Print name)

(Signature) BFCS (Practice Location) Bismarck

Sherry Stein MD
(Print name)

(Signature) BFCS (Practice Location) Bismarck

(Print name)

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(Signature)

Sanford Health Occupational Med.
(Practice Location) Fargo, ND

ROBERT M. MARTINO, M.D.
(Print name)

(Signature)

Sanford Health Occupational Medicine Fargo, ND
(Practice Location)

John Beaudair ND
(Print name)

(Signature)

Sanford Health Occupational Medicine Fargo, ND
(Practice Location)

John Mickelson, DO
(Print name)

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(Signature)

Khawaja Fauzia Chugtai
(Print name)

Family HealthCare Center
306 Fourth St N
Fargo ND 58102-4820
(Practice Location)

(Signature)

NAPOLEON R ESPEJO
(Print name)

Family HealthCare Center
306 Fourth St N
Fargo ND 58102-4820
(Practice Location)

(Signature)

(Print name)

(Practice Location)

FAXED 11/23/10

#4

TESTIMONY

TO

SENATE HOUSE AND HUMAN SERVICE

COMMITTEE

62ND ND LEGISLATIVE ASSEMBLY

BY

GWEN WITZEL NP, FAMILY NURSE

PRACTITIONER,

AANP REGION 8 DIRECTOR

January 18, 2011

TESTIMONY

TO

SENATE HOUSE AND HUMAN SERVICE COMMITTEE

62ND ND LEGISLATIVE ASSEMBLY

BY

GWEN WITZEL NP, FAMILY NURSE PRACTITIONER,

AANP REGION 8 DIRECTOR

January 18, 2011

Madame Chairman and members of the committee

My name is Gwen Witzel, Family Nurse Practitioner (FNP) and a primary care provider in a rural community in ND, and I am here to testify in support of Senate Bill 2148. I practice in a critical access hospital covering the clinic, emergency room and have hospital admitting privileges. I was selected as ND 2009 Rural Health Provider of the Year, which is an award presented by the Center for Rural Health, UND, and the School of Medicine and Health Sciences. I mention this to demonstrate that my practice is busy and recognized as providing quality health care.

My collaborating physician for prescriptive privileges is Dr Tracie Mallberg who is a Family Practice Physician and owner of Lilycare Clinic in Fargo which is 180 miles from my practice location. Dr Mallberg and I do not practice together, nor is she responsible for my practice, and is not responsible for reviewing my medical records. I had requested Dr Mallberg to sign the affidavit when she was doing locum coverage at the facility I work. During that time my community did not have any regular physician on staff. Her signature on my license meets the requirement of the law but does not provide for any direct oversight of my practice or my prescriptive writing. This is why we feel the physician signature requirement is an unnecessary formality.

Having a physician signature on my APRN license is not needed. As a Nurse Practitioner I diagnose, and treat acute and chronic health conditions, order lab and x-ray tests and interpret results and prescribe medication. NPs have been recognized as primary care providers in ND since 1992. The collaborative agreement states that the NP is required to consult with a collaborative Physician or another physician in her absence once every two months in regard to some prescriptive practice. As a NP I collaborate with other health care providers on a daily basis. The person with whom I consult is based on the need of the patient.

Most often the physician consulted is not the physician who has her signature on my license at the Board of Nursing.

As you have heard the testimony of my colleagues the requirement to have a physician signature on my license at the Board of Nursing is a formality that does not improve quality or safety of practice. There have been a number of studies done and all have shown NP practice is safe and of high quality. (AANP Quality of Nurse Practitioner document) The nation is moving forward to eliminate barriers to NP practice. This will improve access to healthcare and address the issue of the increasing numbers of people who will be needing primary care services.

There are communities in ND that do not have any healthcare provider. By eliminating the requirement for physician signature will open doors for NPs to practice in areas that may not currently have providers. Also we are working toward making the Nurse Practice Act similar from state to state to allow NP practice across state lines. This will help to decrease the shortage of primary care providers particularly in rural ND.

Eliminating the physician signature requirement for my prescriptive practice will not change my scope of practice. (AANP Scope of Nurse Practitioner Practice document) Also it will not change the quality review process that is already established in most practices to assure quality of care. All that will change is the unnecessary paper on file at the Board of Nursing.

I am requesting your support of Bill 2148 to move ND forward to be consistent with recommendations from the National Council of State Boards of Nursing and a host of other national and state organizations and to improve access to healthcare in ND.

Thank you for your support

Gwen Witzel FNP

Family Nurse Practitioner, Langdon ND

American Academy of Nurse Practitioner Region 8 Director (ND, SD, UT, MO, WY, CO)

gtwitzel@utma.com

Scope of Practice for Nurse Practitioners

American Academy of Nurse Practitioners

PROFESSIONAL ROLE

Nurse Practitioners are licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. According to their practice specialty they provide nursing and medical services to individuals, families and groups. In addition to diagnosing and managing acute episodic and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention. Services include, but are not limited to ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, and prescription of pharmacologic agents and non pharmacologic therapies. Teaching and counseling individuals, families and groups are a major part of nurse practitioner practice.

As licensed independent practitioners, nurse practitioners practice autonomously and in collaboration with health care professionals and other individuals to assess, diagnose, treat and manage the patient's health problems\needs. They serve as health care researchers, interdisciplinary consultants and patient advocates.

EDUCATION

Entry level preparation for nurse practitioner practice is at the master's, post master's or doctoral level. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long term health care settings. Self-directed continued learning and professional development beyond the formal advanced education is essential to maintain clinical competency.

ACCOUNTABILITY

The autonomous nature of the nurse practitioner's advanced clinical practice requires accountability for health care outcomes. Insuring the highest quality of care requires national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continuing professional development and maintenance of clinical skills. Nurse practitioners are committed to seeking and sharing knowledge that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research, and applying findings to clinical practice.

RESPONSIBILITY

The role of the nurse practitioner continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, nurse practitioners combine the roles of provider, mentor, educator, researcher and administrator. Members of the profession are responsible for advancing the role of the nurse practitioner and insuring that the standards of the profession are maintained. This is accomplished through involvement in professional organizations and participation in health policy activities at the local, state, national, and international levels.

Administration
P.O. Box 12846
Austin, TX 78711
p 512.442.4262
f 512.442.6469
www.aanp.org

Office of Health Policy
P.O. Box 40130
Washington, DC 20016
p 202.966.6414
f 202.966.2856

Position Statement on Nurse Practitioner Prescriptive Privilege

American Academy of Nurse Practitioners

The American Academy of Nurse Practitioners (AANP) advocates that nurse practitioners have unlimited prescriptive authority (this includes dispensing privileges) in their scope of practice.

Nurse practitioners are licensed independent advanced practice nurses who have completed a formal educational program beyond that of the registered nurse. Nurse practitioners have advanced education in pathophysiology, pharmacology and clinical diagnosis and treatment that prepares them to diagnose and prescribe medications and treatments in their specialty area. Nurse practitioners make independent and collaborative decisions about the health care needs of individuals, families, and groups across the life span.

Over four decades of research conclude that nurse practitioners provide safe, cost-effective, high-quality health care. Prescribing medications and devices is essential to the nurse practitioner's practice. Restrictions on prescriptive authority limit the ability of nurse practitioners to provide comprehensive health care services.

Nurse practitioners are regulated by state boards of nursing or other state designated agencies. Nurse practitioners serve as members of state boards of nursing and advisory councils for advanced practice nurses. This process promotes public safety and competent nurse practitioner practice.

AANP recommends that state boards of nursing regulate nurse practitioner practice and prescriptive authority. AANP also advocates that nurse practitioners be nationally certified and obtain annual continuing education credits in pharmacology.

The ability of nurse practitioners to prescribe, without limitation, legend and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies is essential to provide cost-effective, quality health care for the diverse populations they serve across the life span.

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American Academy of Nurse Practitioners

Quality of Nurse Practitioner Practice

Administration
P[redacted]x 12846 • Austin, TX 78711
[redacted]42.4262 • *f* 512.442.6469
[redacted]anp.org

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Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965, and for 45 years, research has consistently demonstrated the high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. ***Archives of Internal Medicine, 151*****(4), 694-698.**
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

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.**
Bakerjian conducted and extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. ***Nursing Research, 44*****(6), 332-9.**
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office. (1979). ***Physician extenders: Their current and future role in medical care delivery.*** **Washington, D.C.: US Government Printing Office.**
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. ***Journal of Advanced Nursing, 40*****(6), 771-730.**
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. ***Medical Decision Making, 26,*** **9-17.**
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal, 324,* 819-823.
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews.* 2006, Issue 1.
This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (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.
The outcomes of care in the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. *Nursing Economics, 20*(4), 174-179.
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast , PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association, 283*(1), 59-68.
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

Office of Technology Assessment. (1986). *Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis.* Washington D.C.: US Government Printing Office.
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have." (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

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

The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lips, and microalbumin levels and were more likely to be at target for lipid levels.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner, 1*(1), 28-32.

The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

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

A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sacket, D.L., Spitzer, W. O., 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.

A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

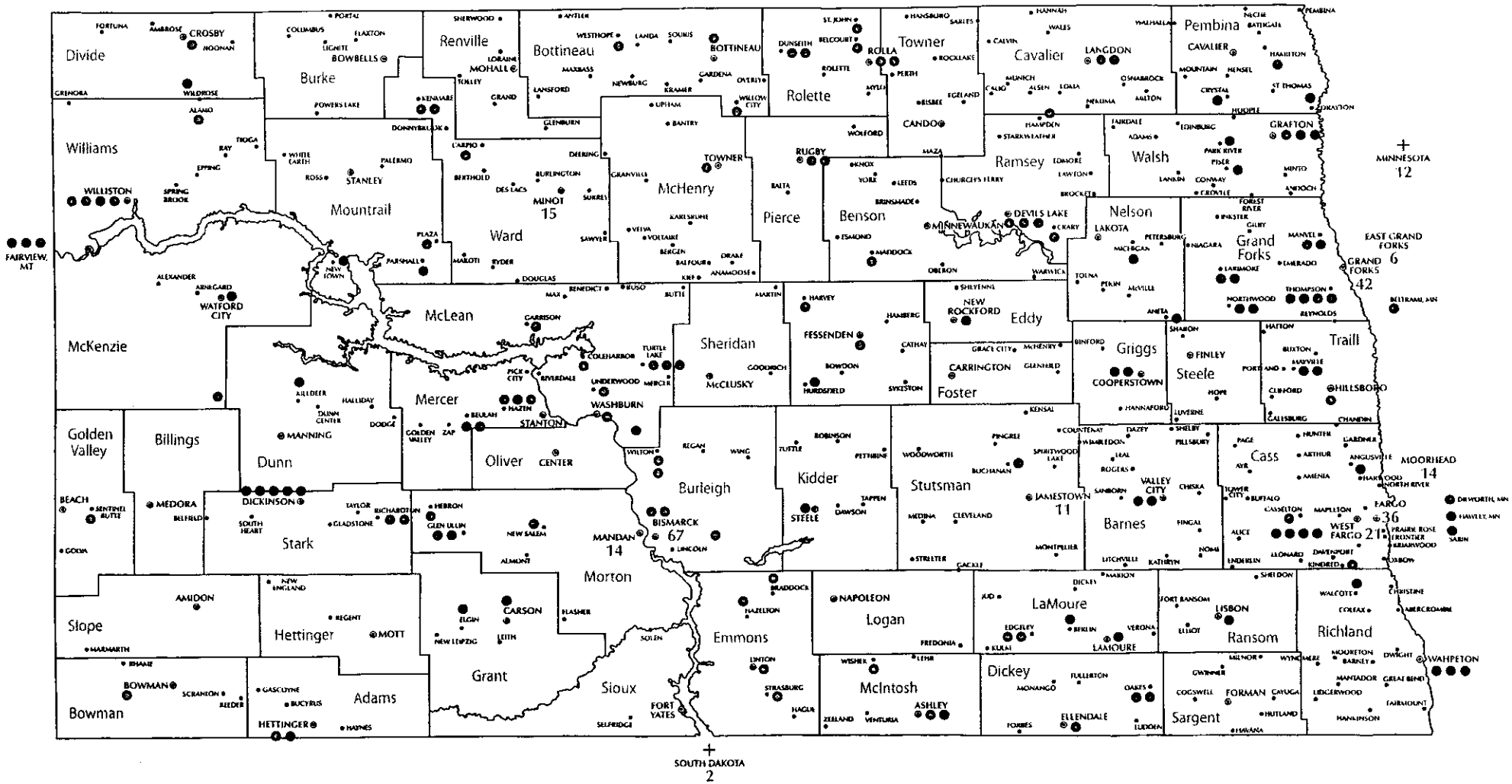
Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation, 9*(2).

The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

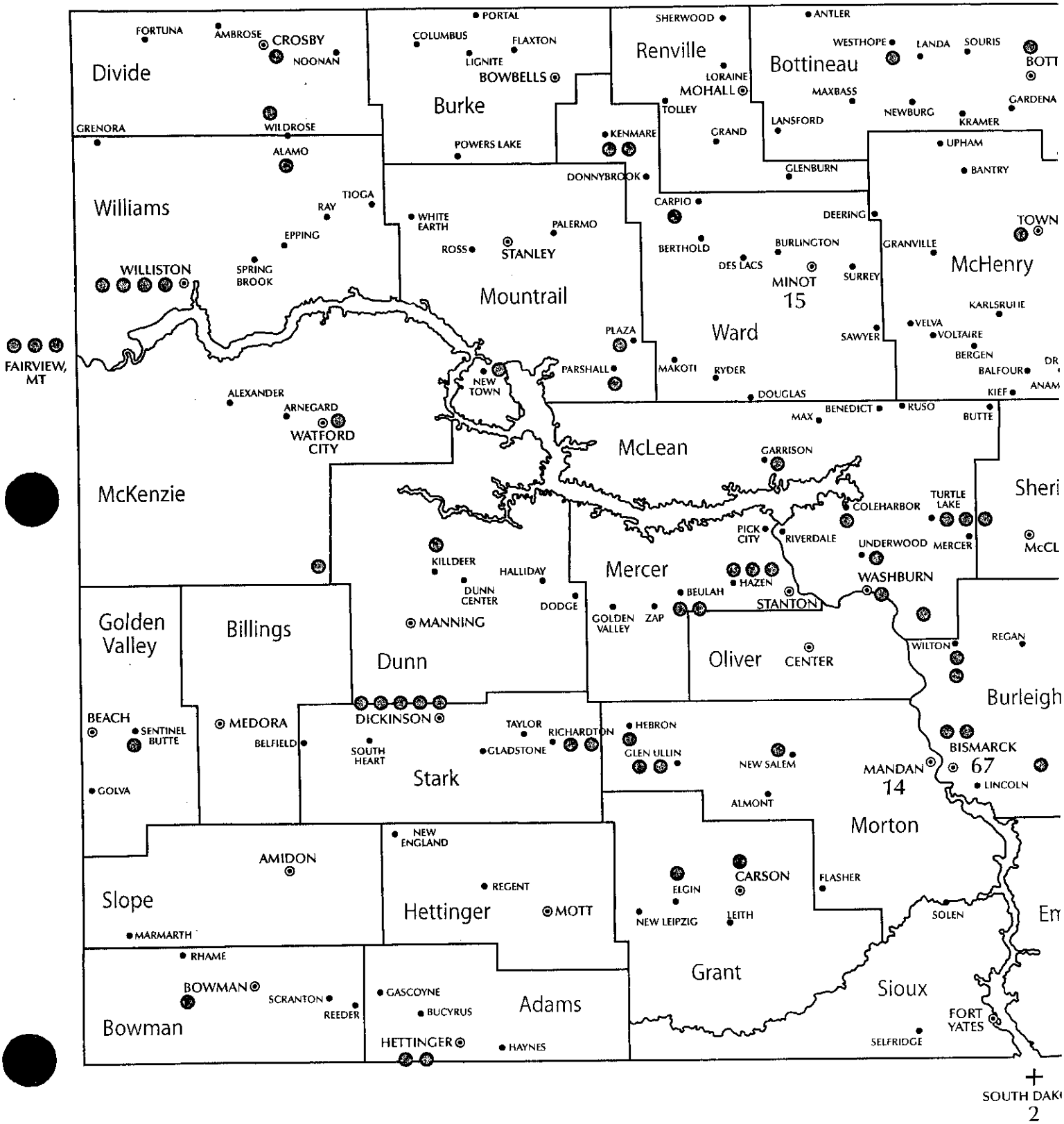
Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hacket, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. *New England Journal of Medicine, 290* (3), 252-256.

This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

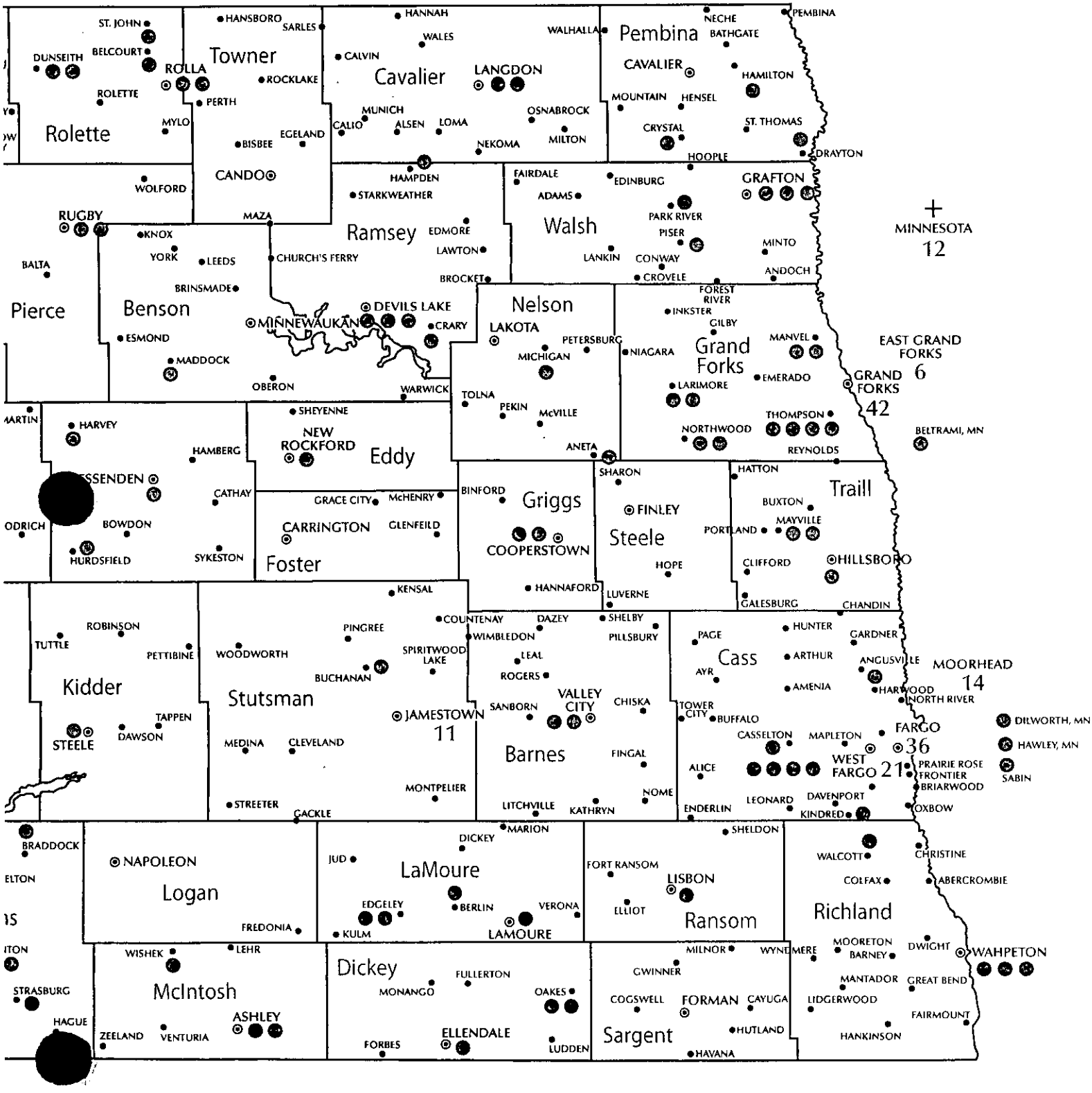
North Dakota Nurse Practitioner Locations



North Dakota Nurse



Practitioner Locations



#5

TESTIMONY TO

SENATE HOUSE AND HUMAN SERVICE COMMITTEE

62ND ND LEGISLATIVE ASSEMBLY

BY

Tracie M. Mallberg, M.D.

Owner and physician at

LILYCARE CLINIC,

West Fargo, ND

Madame Chairman and members of the committee;

My name is Dr. Tracie Mallberg. I am a family practice physician and I practice in my own facility; LilyCare Clinic in West Fargo, ND. I opened my clinic in June of 2008. Prior to that time I was a partner in a locum tenens firm and I provided services to many of the rural communities and Emergency Departments around the state. The rural communities that I worked with were typically staffed by Nurse Practitioners as the primary healthcare providers.

I have had the opportunity to work closely with many of the Nurse Practitioners across ND. In my experience, the quality of care, the dedication to community and adherence to scope of practice has been exemplary. While I was

providing physician services in Langdon, ND I became very familiar with the practice of Gwen Witzel, FNP. I have a great respect for Ms. Witzel and her dedication to the community in which she practices. After several return visits to Langdon I was approached by Ms. Witzel with regard to acting as her collaborating physician for prescriptive privileges. At that point, I was completely unaware of the requirement and when I was approached I needed to research this to try and understand the requirements that this signature encompassed. I was surprised by the frivolity of the requirement. The signature requires that Gwen is required to consult with myself or another physician once every two months with regard to some prescriptive practice. As a provider in ND; Physician, Nurse Practitioner or otherwise, collaboration regarding patient issues takes place on a near daily basis.

This requirement has no effect on patient care, chart review or practice methods. Nurse Practitioners of North Dakota have proven to have a high quality of practice and deserve the respect of those in a lawmaking positions to recognize formalities and rules of practice that improve quality of patient care.

Thank you for your time and consideration in this matter.

Tracie M. Mallberg M.D. Family Practice

#6

SENATE HUMAN SERVICES COMMITTEE

S.B. 2148

January 18, 2011

Testimony of Duane Houdek
North Dakota State Board of Medical Examiners

Madam Chairman, members of the Senate Human Services Committee, my name is Duane Houdek, Executive Secretary of the North Dakota State Board of Medical Examiners. On behalf of the Board, I testify in opposition to Senate Bill 2148.

By statute, the role of the Board of Medical Examiners is to regulate the practice of medicine in North Dakota. For over 120 years, our single mission has been to protect the public. That duty includes sanctioning physicians when they violate the disciplinary laws of the state, something we do rigorously.

I can tell you that prescribing cases–especially the prescribing of pain medications–are among the most complex cases we review. The correct prescription of opioids is an extremely difficult and nuanced matter.

The importance of correctly prescribing pain medications and other controlled substances is especially elevated today, as we know that prescription drugs have become the drug of choice for many and prescription drug abuse is a most serious societal problem. Prescription opioids are now responsible for more overdose deaths and emergency room visits than heroin and cocaine combined.

Recently , I sat through a hearing in the House IBL committee regarding the narcotic prescribing to Workforce Safety and Insurance claimants. WSI provided evidence of 10 providers who, together, prescribed 59% of all narcotics to WSI claimants in the state. Three of those providers were family nurse practitioners. I am not saying <u>any</u> of the prescribing, by nurse practitioner or physician, was improper. Volume, in and of itself, does not indicate the quality of practice. I mention this to you to point out that prescribing of pain medication can be a big part of practice, and no provider is immune from the demands for prescription pain medication.

This is an area where the need for public protection is especially acute. I understand that your job, as policy makers, is oftentimes to balance competing interests. In this case, at this time,

I suggest to you that prescribing of controlled substances by nurse practitioners needs more collaboration, not less. That oversight of such prescribing needs to be enhanced, not diminished.

It does not appear that the benefit to the public, whether measured in terms of access to service or quality of care, is particularly improved by this proposed legislation. It does appear that the risk to the public of incorrect prescribing of potentially dangerous drugs is, if anything, increased. For that reason, the board is opposed to this bill.

Thank you for the opportunity to testify. I will try to answer any questions you may have.

NORTH DAKOTA MEDICAL ASSOCIATION

1622 East Interstate Avenue
Post Office Box 1198
Bismarck, North Dakota
58502-1198

(701) 223-9475
Fax (701) 223-9476
www.ndmed.org

Testimony in Opposition to SB 2148
Senate Human Services Committee
January 18, 2011

Madam Chairman Lee and Committee Members, I'm Bruce Levi and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

The North Dakota Medical Association initially reviewed SB 2148 through an ad hoc committee comprised of the following physicians, who reaffirmed existing NDMA policy:

Steven P. Strinden, MD, Fargo

Kimberly T. Krohn, MD, Minot

A Michael Booth, MD, Bismarck

Fadel Nammour, MD, Fargo

Catherine E. Houle, MD, Hettinger

Shelly A. Seifert, MD, Bismarck

While the North Dakota Medical Association recognizes the critical roles performed by advanced practice registered nurses as part of the multidisciplinary team that provides high quality and efficiently delivered health care, the Association opposes SB 2148 for the following reasons:

1. The collaborative prescriptive agreement required by NDCC 43-12.1-18 is a very important and necessary patient safety tool that ensures that advanced practice registered nurses are exercising prescriptive authority consistent with their level of training and skills.

2. The proposed removal of the collaborative prescriptive agreement will change nurse practitioner scope of practice; state law should continue to recognize the limits of the clinical and pharmacotherapy training of advanced practice registered nurses and continue to recognize the need for physician collaboration in prescriptive practice.

3. The proposed removal of the collaborative prescriptive agreement will not increase access to care for patients; the collaborative prescriptive agreement is not a barrier in the sense that it limits advanced practice registered nurses from practicing to the full level of their training and clinical skills.

4. The proposed removal of the collaborative prescriptive agreement will result in independent practice that equates to the practice of medicine; while advanced practice registered nurses provide many core primary care services, they are not interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The collaborative prescriptive agreement appropriately recognizes the differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care.

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1. The collaborative prescriptive agreement required by NDCC 43-12.1-18 is a very important and necessary patient safety tool that ensures that advanced practice registered nurses are exercising prescriptive authority consistent with their level of training and skills.

The proponents of this legislation minimize the collaborative prescriptive agreement requirement in section 43-12.1-18 as a ministerial "signature" requirement. It is much more than that. The collaborative prescriptive agreement is a very important patient safety provision that ensures that advanced practice registered nurses are providing care consistent with their level of training and skills. It underscores the value of all health care professionals working together in a coordinated, team-based fashion which is recognized as an optimal approach to providing quality, patient-centered care.

The collaborative prescriptive agreement does not prevent advanced practice registered nurses from practicing to the full extent of their training and experience as part of a collaborative team. It is simply a tool used by the vast majority of states to protect the public, including many states in our region - Minnesota, South Dakota, Nebraska, Kansas and Wisconsin which require a collaborative or supervisory agreement not just for prescriptive

authority but for diagnostic and treatment practice as well. North Dakota is one of about eight "hybrid" states that require only a collaborative prescriptive agreement and do not require a collaborative or supervisory agreement for diagnosis and treatment. Yet overall, 35 states still recognize the importance of collaboration or supervision by a physician in the prescriptive practice of advanced practice registered nurses.

As asserted, the collaborative prescriptive agreement does require the signature of a physician. What that signature represents is a collaborative prescriptive agreement that sets forth the manner of review and approval of the planned prescriptive practices for the advanced practice registered nurse. The plan identifies the broad classifications of drugs or devices to be commonly prescribed by the nurse practitioner, identifies the methods and frequency of the collaboration for prescriptive practices, "which must occur as client needs dictate, but no less than once every two months," identifies methods of documentation of the collaborative process regarding prescriptive practices, and identifies arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician [NDAC 54-05-03.1-09(4)]. The administrative rules of the North Dakota Board of Nursing relating to the collaborative prescriptive agreement are attached.

That is what the signature represents – a tool that provides assurance that there is collaboration to ensure that the prescriptive authority is consistent with the nurse practitioner's training and experience. It is not onerous. It does not prevent nurse practitioners from practicing to the full extent of their training and experience.

In the 2009 legislative session, the North Dakota Nurse Practitioners Association argued successfully to the legislature for status as Medicaid primary care case managers. In their testimony it was argued that primary care case manager status "will not change or affect our collaborative agreement." [Testimony of Cheryl Rising, RN, MS, CNRN, FNP, January 20, 2009, Sen. Human Services Committee]. Clearly, the collaborative agreement may be an inconvenience to some nurse practitioners, but the inconvenience of the collaborative prescriptive agreement does not affect the ability of a nurse practitioner from practicing to the full extent of their education and training, whether it be as a primary care case manager with Medicaid or in general prescriptive practice.

With a shortage of both physicians and nurses and millions more insured Americans, health care professionals will need to continue working together to meet the surge in demand for health care. A collaborative team approach to care - with each member of the team playing the role he or she has been educated and trained to play - has a proven track record of success and helps to ensure that patients get safe, high-quality care and value for their health care spending.

2. The proposed removal of the collaborative prescriptive agreement will change nurse practitioner scope of practice; state law should continue to recognize the limits of the clinical and pharmacotherapy training of advanced practice registered nurses and continue to recognize the need for physician collaboration in prescriptive practice.

Although nurses are critical to the health care team, there is no substitute for a physician's education and training. Physicians come with seven or more years of postgraduate education and more than 10,000 hours of clinical experience. We believe this difference in education and training matters. It matters during times of medical emergencies. It matters in primary care situations when seemingly "simple" conditions actually mask underlying, complex conditions. And it matters to ensure that the right diagnosis and treatment plan, including the right prescription if necessary, is made from the beginning to help save patients money on unnecessary prescriptions, tests and referrals.

Nurse practitioner groups nationally in their literature belabor the general notion that collaboration is not the same as "supervision," especially if compared to the use of the term "supervision" in the administrative rules of the North Dakota Board of Medical Examiners in the regulation of physician assistants who "provide patient services under the supervision and responsibility of a physician who is responsible for the performance of that assistant" [NDAC 50-03-01-01]. If collaboration means to "*work jointly with others*," it certainly is in the best interests of patients that nurse practitioners and physicians work together, particularly in prescribing controlled substances. The collaborative prescriptive agreement recognizes differences in the training and skills between the medical and nursing professions, and simply places the physician and nurse practitioner in the position of working together in prescriptive practice to ensure that patients receive prescriptions that are medically necessary and appropriate to the diagnosis.

3. The proposed removal of the collaborative prescriptive agreement will not increase access to care for patients; the collaborative prescriptive agreement is not a barrier in the sense that it limits advanced practice registered nurses from practicing to the full level of their training and clinical skills.

NDMA recognizes that difficulties in securing access to qualified physicians in rural or underserved areas provide at first glance what seems to be a legitimate rationale on which to lobby for expanded scope of practice. However, NDMA has always looked first to what's best for patients. It has always argued that solutions to actual or perceived shortages or barriers simply do not justify expansions in scope of practice of any non-physician that expose patients to unnecessary or unintended health risks due to limitations in the education and training of any non-physicians.

The collaborative prescriptive agreement has not diminished access to care for North Dakota patients. There currently are no restrictions on the diagnostic and treatment services provided by an advanced practice registered nurse, which allows the nurse practitioner to practice across the state with only a collaborative prescriptive agreement in place with a physician. The map of North Dakota provided as part of our NDMA testimony, prepared by the American Medical Association in 2008 shows that advanced practice registered nurses in North Dakota practice in many rural communities in which physicians do not. Certainly, the existence of the collaborative prescriptive agreement has not stopped nurse practitioners from practicing in rural areas across the state.

The collaborative prescriptive agreement has been used in North Dakota for many years. It was not perceived as a problem by nurse practitioners in the 2009 session when Medicaid primary care case manager status was sought. It should not be eliminated now simply for the purported purpose of making it more convenient for out-of-state nurse practitioners to gain a license in our state, or eliminated to pursue a license compact with states west of North Dakota that have public policies in place that are not consistent with North Dakota or states south and east of North Dakota. The collaborative prescriptive agreement serves an important purpose in protecting the public. Its proposed elimination is simply a solution to a problem that does not exist.

4. The proposed removal of the collaborative prescriptive agreement will result in independent practice that equates to the practice of medicine; while advanced practice registered nurses provide many core primary care services, they are not interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The collaborative prescriptive agreement appropriately recognizes the differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care.

The history of the nurse practitioner profession began in the late 1960s as a way to provide basic primary care services and advice to people in regions where physicians were scarce, and has become today a profession that seeks to be allowed to deliver the same medical care that physicians do under the auspice of advanced practice nursing [AMA Scope of Practice Data Series: *Nurse Practitioners*, October 2009].

A frequently-heard comment from physicians discussing "scope of practice" issues of other health care professionals is: "If they want to practice medicine, they ought to go to medical school." Certainly, over the years physician organizations have taken positions on issues relating to the independent practice by advanced practice registered nurses. The American Medical Association opposes enactment of any legislation to authorize the independent practice of medicine by any individual who is not licensed to practice medicine. The position of the American Academy of Family Physicians is that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician, and should not function as an independent health practitioner.

The American College of Physicians recently made the following observations in response to the recent Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, which advocates reliance on collaborative, multidisciplinary, team-based care to improve the quality and delivery of care in a transformed health care system. The observations capture many of the underlying concerns of physicians and the blurring of differences in training and skills between the medical and nursing professions, yet recognize the importance of our professions working together, rather than apart, in the delivery of care:

The American College of Physicians strongly supports this [collaborative, multidisciplinary, team-based care] model. Nurses, physician assistants, physicians, and other health care professionals should practice to the full level of their training and clinical skills, working as part of a collaborative team, and inappropriate barriers that stand in their way should be examined and revised accordingly.

We agree that certified nurse practitioners can provide many core primary care services, but it is important that this not be misunderstood as suggesting that nurses are interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The two professions are complementary but not equivalent. For diagnostic evaluation of clinical presentations that are not straightforward and for ongoing management of complex or interacting medical problems, the most appropriate clinician is a physician who has received in-depth training in the diagnosis and treatment of conditions affecting all organ systems and who can effectively integrate current and evolving scientific knowledge with the delivery of clinical care. Any examination of state licensing laws, as the IOM recommends, should therefore distinguish between inappropriate restrictions on nurses or other licensed health care professionals that prevent them from practicing to the full level of their training and experience as part of a collaborative team and laws designed to ensure that licensed health care professionals are providing care consistent with their level of training and skills.

The IOM has done a great service by providing a comprehensive set of recommendations that, although focusing on the nursing profession, appropriately emphasize the importance of physicians, nurses, physician assistants, and other health care professionals working together to provide high-quality, patient-centered care, through delivery systems (such as the patient-centered medical home) that use everyone's skills and training optimally. It is essential, however, that further discussions of and communications relating to the IOM report provide sufficient clarity on the issues to prevent misunderstanding. Care should be taken by everyone involved in the implementation of the IOM recommendations to ensure that they are not misconstrued as blurring the important differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care. [J. Fred Ralston, Jr., MD, Steven E. Weinberger, MD, American College of Physicians, *Nurses' Scope of Practice,* New England Journal of Medicine, Dec. 2010].

As previously stated, NDMA's position is that the collaborative prescriptive agreement, rather than placing a barrier to advanced practice registered nurses practicing to the full level of their training and clinical skills, instead promotes patient safety and physicians and advanced practice registered nurses *working together* in a collaborative, multidisciplinary, team-based approach to care that benefits North Dakota patients.

Thank you for the opportunity to present the views of the North Dakota Medical Association. NDMA urges the Committee to vote a "DO NOT PASS" on SB 2148.

54-05-03.1-09. Requirements for prescriptive authority. Applicants for prescriptive authority shall:

1. Be currently licensed as an advanced practice registered nurse in North Dakota.

2. Submit a complete, notarized prescriptive authority application and pay the fee of fifty dollars.

3. Provide evidence of completion of thirty contact hours of education or equivalent in pharmacotherapy related to the applicant's scope of advanced practice that:

   a. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority; or

   b. Other methods that may be approved by the board.

4. Submit an affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice. The affidavit must address all of the following areas:

   a. Broad classifications of drugs or devices to be commonly prescribed by the advanced practice registered nurse;

   b. Methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate, but no less than once every two months;

   c. Methods of documentation of the collaboration process regarding prescriptive practices; and

d. Alternative arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997; April 1, 2004; March 24, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-02(7), 43-12.1-09(2)(c)(d)

54-05-03.1-10. Authority to prescribe.

1. A permanent advanced practice registered nurse license with the addition of prescriptive authority shall be issued following review and approval of the completed application by the board.

2. Between meetings of the board, board staff may review the prescriptive authority application and grant a temporary permit to prescribe if all the requirements are met.

3. The advanced practice registered nurse with prescriptive authority may prescribe drugs as defined by chapter 43-15-01 pursuant to applicable state and federal laws. Notice of the prescriptive authority granted will be forwarded to the board of pharmacy.

4. A prescriptive authority license does not include drug enforcement administration authority for prescribing controlled substances. Each licensee must apply for and receive a drug enforcement administration number before writing prescriptions for scheduled drugs.

5. The licensee may prescribe, administer, sign for, dispense, and procure pharmaceutical samples following state and federal regulations.

6. The signature on documents related to prescriptive practices must clearly indicate that the licensee is an advanced practice registered nurse.

7. The advanced practice registered nurse with prescriptive authority may not prescribe, sell, administer, distribute, or give to oneself or to one's spouse or child any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug.

8. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient's sexual partner or partners, without

there having been an examination of that patient's sexual partner or partners.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2004; January 1, 2009.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-11. Prescriptive authority renewal. Prescriptive authority is valid for the same period of time as the applicant's advanced practice registered nurse and registered nurse license. The applicant for renewal must:

1. Renew the applicant's registered nurse license.

2. Submit verification of current certification by a national nursing certification body in the specific area of nursing practice.

3. Submit a completed advanced practice registered nurse with prescriptive authority renewal application.

4. Pay the advanced practice registered nurse renewal fee of forty dollars and the fifty dollar renewal fee for prescriptive authority.

5. Provide evidence of completion of fifteen contact hours of education during the previous two years in pharmacotherapy related to the scope of practice. These contact hours may fulfill the registered nurse renewal continuing education requirement. The education or its equivalent as approved by the board may include academic credits, attendance at approved seminars and courses, or participation in approved correspondence or home study continuing education courses.

6. Submit a verification of affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice. The affidavit must address all of the following areas:

   a. Broad classifications of drugs or devices to be commonly prescribed by the advanced practice registered nurse;

   b. Methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate, but no less than once every two months;

   c. Methods of documentation of the collaboration process regarding prescriptive practices; and

d. Alternative arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

History: Effective March 1, 1992; amended effective November 1, 1996; June 1, 2001; April 1, 2004; March 24, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-12. Change in physician collaboration regarding prescriptive authority. The advanced practice registered nurse or the collaborating physician may terminate the relationship at any time. The advanced practice registered nurse must notify the board in writing within five working days of the termination. An affidavit of collaboration with another licensed physician must be submitted when there is a change in the licensed physician providing the collaboration. The affidavit and a revised scope of practice statement must be submitted within sixty days of the change in collaboration with a licensed physician.

History: Effective March 1, 1992; amended effective November 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-13. Suspension or enjoining of prescriptive authority. The prescriptive authority granted to an advanced practice registered nurse may be temporarily suspended or enjoined according to provisions of North Dakota Century Code chapters 28-32 and 32-06, when the advanced practice registered nurse has:

1. Failed to maintain current licensure as an advanced practice registered nurse or failed to meet prescriptive authority requirements;

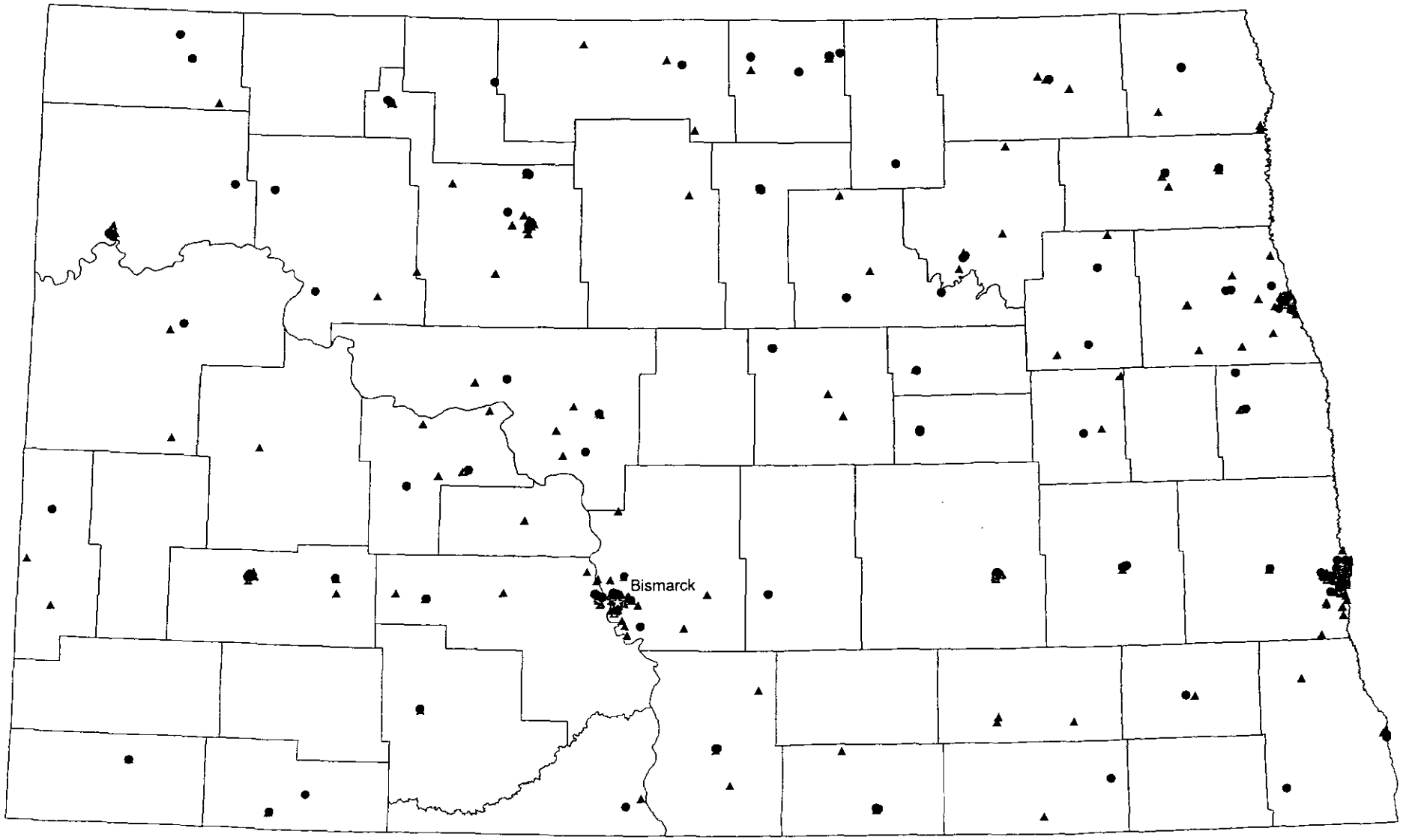
2. Prescribed outside the scope of practice or for other than therapeutic purposes;

3. Violated any state or federal law or regulation applicable to prescriptions; or

Following final board action notice of suspension or injunctive action regarding prescriptive authority will be forwarded to the board of pharmacy and the collaborating physician.

History: Effective March 1, 1992; amended effective November 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

North Dakota Primary Care Physician to Advanced Practice Registered Nurse Distribution Comparison



● = the location of one or more actively practicing Primary Care Physicians (n = 555)

▲ = the location of one of more actively practicing Advanced Practice Registered Nurses (n = 286)

Data Source: American Medical Association, American Osteopathic Association (2008) and the North Dakota Board of Nursing (June 2008)

AMA AMERICAN MEDICAL ASSOCIATION

National Center for the Analysis of Healthcare Data (2008)

CORRESPONDENCE

Nurses' Scope of Practice

TO THE EDITOR: The Perspective articles "Broadening the Scope of Nursing Practice" by Fairman et al.[1] and "Nurses for the Future" by Aiken[2] highlight the need to use the best available evidence when considering how to ensure that patients have access to health care. The truth is, however, that the Institute of Medicine (IOM) recommendations are not sufficiently evidence-based. The IOM itself acknowledged that "as the IOM committee considered how best to inform health care workforce policy and development, it realized it could not answer several basic questions about the workforce numbers and composition that will be needed by 2025."[3]

As the American Medical Association has argued elsewhere,[4] with a shortage of both physicians and nurses and millions more insured Americans, health care professionals will need to continue working together to meet the surge in demand for health care. A physician-led team approach to care — with each member of the team playing the role he or she has been educated and trained to play — has a proven track record of success and helps to ensure that patients get high-quality care and value for their health care spending. The IOM recommendations point to physician-led models of team-based care as an example of the optimal approach.[3]

A new study shows that 80% of patients expect to see a physician when they come to the emergency department, with more than half of those surveyed willing to wait 2 additional hours to be cared for by a physician.[5] Although nurses are critical to the health care team, there is no substitute for a physician's education and training. Physicians have 7 or more years of postgraduate education and more than 10,000 hours of clinical experience. Most nurse practitioners have just 2 to 3 years of postgraduate education and less clinical experience than is obtained in the first year of a 3-year medical residency. These additional years of physician education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.

We are committed to expanding the health care workforce so that patients have access to the care they need when they need it. Research shows that in states where nurses can practice independently, physicians and nurses continue to work in the same urban areas, so increasing the independent practice of nurses has not helped to solve the problem of shortages in rural areas.[6,7] Efforts to encourage health care professionals to work in areas where shortages loom must be based on the best available evidence if we are to increase access to care for all patients.

Cecil B. Wilson, M.D.
American Medical Association
Chicago, IL

Karen J. Nichols, D.O.
American Osteopathic Association
Chicago, IL

Roland Goertz, M.D.
American Academy of Family Physicians
Leawood, KS

O. Marion Burton, M.D.
American Academy of Pediatrics
Elk Grove Village, IL

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

1. Fairman JA, Rowe JW, Hassmiller S, Shalala DE. Broadening the scope of nursing practice. N Engl J Med 2010. DOI: 10.1056/NEJMp1012121.
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3. Institute of Medicine. The future of nursing: leading change, advancing health. Washington, DC: National Academies Press, 2010.
4. Patchin RJ. AMA responds to IOM report on future of nursing. October 5, 2010. (http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.shtml.)

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7. American Medical Association GeoMapping Initiative. Chicago: AMA, 2008.

TO THE EDITOR: In their Perspective article, "Broadening the Scope of Nursing Practice," Fairman et al. highlight the findings and recommendations of the recent Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health.*[1] The report advocates reliance on collaborative, multidisciplinary, team-based care to improve the quality and delivery of care in a transformed health care system. The American College of Physicians strongly supports this model. Nurses, physician assistants, physicians, and other health care professionals should practice to the full level of their training and clinical skills, working as part of a collaborative team, and inappropriate barriers that stand in their way should be examined and revised accordingly.

We agree that certified nurse practitioners can provide many core primary care services, but it is important that this not be misunderstood as suggesting that nurses are interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The two professions are complementary but not equivalent. For diagnostic evaluation of clinical presentations that are not straightforward and for ongoing management of complex or interacting medical problems, the most appropriate clinician is a physician who has received in-depth training in the diagnosis and treatment of conditions affecting all organ systems and who can effectively integrate current and evolving scientific knowledge with the delivery of clinical care. Any examination of state licensing laws, as the IOM recommends, should therefore distinguish between inappropriate restrictions on nurses or other licensed health care professionals that prevent them from practicing to the full level of their training and experience as part of a collaborative team and laws designed to ensure that licensed health care professionals are providing care consistent with their level of training and skills.

The IOM has done a great service by providing a comprehensive set of recommendations that, although focusing on the nursing profession, appropriately emphasize the importance of physicians, nurses, physician assistants, and other health care professionals working together to provide high-quality, patient-centered care, through delivery systems (such as the patient-centered medical home) that use everyone's skills and training optimally. It is essential, however, that further discussions of and communications relating to the IOM report provide sufficient clarity on the issues to prevent misunderstanding. Care should be taken by everyone involved in the implementation of the IOM recommendations to ensure that they are not misconstrued as blurring the important differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care.

J. Fred Ralston, Jr., M.D.
Steven E. Weinberger, M.D.
American College of Physicians
Philadelphia, PA

Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

These letters (10.1056/NEJMc1013895) were published on December 15, 2010, at NEJM.org.

1. Institute of Medicine. The future of nursing: leading change, advancing health. Washington, DC: National Academies Press, 2010.

Additional Correspondence

Human Service Committee

Dear Senators Lee, Uglem, Berry, Dever, and Mathern,

I am writing to ask for your support of SB 2148. This bill will eliminate the language requiring Nurse Practitioners to have a collaborating MD. We practice independently, we are very educated, and it is because of us that most of the rural clinics are still in existence.. Many nurse practitioners cannot find a MD to collaborate with them, thus preventing them from practicing. When this happens thousands of our rural patients do not have access to care. A great percentage of the rural clinics nationwide are staffed by nurse practitioners thus keeping these clinics open. In North Dakota it is very difficult to recruit MD's to our major cities much less recruiting them to the rural areas. If we can eliminate this language, nurse practitioners will be able to staff most of the clinics in need. There are currently many states that have eliminated the MD collaboration language thus increasing access to care. Your support would be greatly appreciated.

Warm regards,

Sandra

Sandra K. Sund MSN,FNP-BC

90 3rd St. E.
Westhope, ND 58793

Senator Judy Lee #1

Floor speech SB 2148, January 2011

SB 2148 would remove the current requirement that Advance Practice Registered Nurses (APRNs) have a collaborative agreement with a licensed physician.

There are 4 categories of APRNS—Nurse Practitioners (NPs), Certified Nurse Midwives, Clinical Nurse Specialists (CNSs) and Certified Registered Nurse Anesthetists (CRNAs). APRNs in North Dakota have a Masters or Doctors degree and are nationally certified. By 2015 nurse practitioners will be Doctorate prepared. They have their own Drug Enforcement Agency (DEA) numbers, just as physicians do.

There are 430 NPs in North Dakota who are regulated by the Board of Nursing and obligated to complete appropriate continuing education in their specialties and work within their appropriate scope of practice. Most work within health care organizations, but several have independent practices. They are overseen by the Board of Nursing which strictly enforces the laws and rules for nurses.

The current provision requiring a collaborating physician says that an APRN needs to consult no less than once every two months in order to meet the terms of the law. Nurse Practitioners diagnose and treat acute and chronic health conditions, order lab and x-ray tests, interpret results, and prescribe medication. In reality, APRNs consult every day with other health professionals, based on the needs of their patients. She may consult with a family practice physician, the NP in a dialysis unit, refer the patient to a specialist or a surgeon after finding a mass, or call the pharmacist to determine appropriate medication management. A Nurse Practitioner does not wait until the 2-month interval to consult; she does it daily with whoever is appropriate for

that patient's needs. The collaborating physician may or may not be the most appropriate choice.

A diverse group of people have stated their support for SB 2148, including a number of physicians, hospital board members, pharmacists, community healthcare associations, AARP, the National Council of State Boards of Nursing, and rural government officials who see the need to provide health care coverage in their areas.

The opinions of physicians are divided. The ND Board of Medical Examiners and the ND Medical Association have taken official positions opposing SB 2148. They are committed to the need for oversight of nurses by physicians, because of the differences in their areas of practice. Their goals are honorable, too, in having high standards of care for North Dakota citizens, a goal that we all share. On the other hand, there are several physicians who have signed individual letters of support for the elimination of the collaborative agreement. There are several professions with overlapping areas of practice, such as podiatrists and orthopedists, and physical therapists and chiropractors. Each is regulated by its own board.

It is important to note that the goal of all parties here is excellent care being available to all citizens of North Dakota. Part of the challenge is that it is difficult to recruit physicians not only to rural areas, but to urban areas as well. It is sometimes difficult for rural NPs to find a physician to sign, if their physician leaves, and they would prefer to work with a local physician. There are Nurse Practitioners located all over the state, as you can see from the map which I had distributed to the Senators' desks. Three important national publications have printed articles concerning the quality of primary care and who

provides it. The professionals discussed complex issues including quality, access, and reliability of health care, work force issues, and how to improve our citizens' health. Their report states that in order to accomplish the goals, we need to enlarge and strengthen our primary care sectors. One of the groups recognized the decreasing number of physicians choosing primary care. They recognized nurse practitioners as having proven to be effective primary care providers, but said "regulatory...barriers often prevent efficient and effective use of their services". A second publications recommended nurses practice to the full extent of their education and training. Current licensing and practice rules differ from state to state, which has an impact on where NPs will practice. This Institute of Medicine report recommended that states reform the scope of practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. That is what 2148 is attempting to do.

The New England Journal of Medicine issue from December 15, 2010 stated that care provided by nurse practitioners is as safely and effectively provided as the care provided by physicians. The Journal was also concerned about states' regulatory barriers to practice.

The Prescriptive Authority Committee of ND has not identified any issues regarding the prescribing practices of NPs. That Committee has members from the Board of Nursing, Board of Medical Examiners, and Board of Pharmacy.

The future of health care, particularly in rural areas, requires a broad range of health professionals to deliver appropriate care. Access to health care will be more easily provided, if Nurse Practitioners can work

independently, within their scope of practice. Other western rural states have made this change, and putting ND in step with them may help with recruiting NPs from out of state, too. 16 states + DC have already made this change, and there has been no increase in any concerns with prescribing.

If there were demonstrated risks to the quality of care being provided by Nurse Practitioners, I would not be supporting SB 2148. This bill will not change how NPs consult and refer patients. They are well educated professionals who will still be required to continue to consult with healthcare providers who are appropriate for their patients. But recognizing the need to have highly qualified primary care providers as part of the solution to access to health care, and after having considered all of the testimony provided, your Senate Human Services committee voted 4-1 to support SB 2148, and we ask the Senate to concur.

#2

TESTIMONY

TO

HOUSE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

CHERYL RISING, RN, MS, FNP

March 9, 2011

Mr. Chairman and Committee Members:

I am Cheryl Rising, Family Nurse Practitioner (FNP), and president of the North Dakota Nurse Practitioner Association (NDNPA). I practice in Bismarck, ND. I am here to testify in support of Senate Bill 2148.

This bill would eliminate the formality for the North Dakota Board of Nursing (NDBON) to have a physician signed affidavit on file for individual Advanced Practice Registered Nurses (APRNs) to write prescriptions. APRNs in the state of ND have a Masters Degree or Doctorate and are nationally certified.

There are 4 categories of APRNs. They are: Nurse Practitioners (NPs), Certified Nurse Midwifes, Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNA). There are 430 NPs in the state of ND. 4 NPs are self employed and the other 426 are associated with a health care organization like a hospital or clinic.

In 1992, 19 years ago, the law requiring a physician signed affidavit to be on file with the NDBON was enacted and the NPs were authorized to write prescriptions. Having a signed affidavit is a formality and does not affect quality of care for our patients. Like all health care professionals, NPs consult with the appropriate health care professional as the patient needs dictate, that may be daily, depending on the patient need.

You may hear in opposing testimony that quality of care is at risk if APRNs don't have this required policy of consulting with a physician once every two months. Those concerns come primarily from a few competing physicians, while at the same time, dozens of other consulting physicians ask you to pass this Bill.

Some question how we can show that NP care is safe and appropriate. You will hear in testimony from the NDBON that each NP will have in their scope of practice how quality review will be accomplished in their own practice and organization. This is already being accomplished in many NP practice areas but not formally documented in our scope of practice. In states that have no collaborative agreement requirement for prescriptive privileges there has been no negative impact in prescribing safety.

For example, the Prescriptive Authority Committee of ND has not identified any adverse issues regarding the prescribing practices of NPs. The Prescriptive Authority Committee consists of representatives of the NDBON, ND Board of Medical Examiners, and the ND Board of Pharmacy. Please find attached selected minutes and information from the NDBON regarding these meetings of the Prescriptive Authority Committee.

Many NPs also voluntarily register and participate in direct access to the drug monitoring program of the North Dakota Board of Pharmacy. They are able to identify any patient where there may be a concern with narcotic abuse. They are able to determine with this data if a patient is getting drugs from other providers or pharmacies. There currently are 80 NPs registered in the program. The NPs that have in-patient clients only and work in controlled environments may not register for this program.

Eliminating the need for a signature would facilitate NPs to serve as part of the solution for improving access to healthcare for citizens of ND. An example of this will be given by one of my colleague's testimony. If a NP is unable to find a physician to sign an affidavit and they are the only health care provider in the community, that clinic or office (typically rural) will have to close. That rural community will be left with no health care provider. The NP "for the sake of their patient" needs to prescribe medication in order to practice. The NPs will continue to practice within their scope of practice which will not change. NPs scope of practice will continue to be on file at the BON. NPs will continue to consult and collaborate with all health care providers on a regular basis appropriate to their patients care.

This Bill will provide legislation and regulation that is consistent with other western rural states and the National Council of State Boards of Nursing. Please see the attached map, showing 16 typically rural western states that have previously removed this barrier.

Advanced Practice Registered Nurses will continue to maintain their own Drug Enforcement Agency(DEA) registration as in the past which is separately issued by the DEA, just as it is separately issued to the physicians.

I ask for your support of Senate Bill 2148.

Cheryl Rising, RN, MS, FNP

President of the NDNPA

Email cdrising@earthlink.net, phone number 701-527-2583

Website for NDNPA is www.ndnpa.org

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881
Telephone: (701) 328-9777 Fax: (701) 328-9785
Web Site Address: http://www.ndbon.org

Workplace Impairment Program: (701) 328-9783

MEMO

TO: **ND Nurse Practitioners Association**

From: **Constance B. Kalanek PhD, RN**
Executive Director

Date: **November 24, 2010**

RE: **Summary of Prescriptive Authority Meetings for 2007-2010**

A meeting of the North Dakota Board of Nursing's Prescriptive Authority Committee has occurred annually according to NDCC 43-12.1 -18. Nursing practice standards. The agenda for the meetings includes the review of all applicants for prescriptive authority in the past year. In the past 10 years or more, the committee has met as required and reviewed the applicants approved in the previous year. The committee has not identified any issues with the NDBON review of the approved applicants. I have attached the 2010-2011 membership list and the minutes for the past three years.

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
January 21, 2009

Present: Board of Nursing members: Dan Rustvang, RN Board Member and Chair;Howard Anderson, Executive Director ND Board of Pharmacy; Duane Houdek, Executive Secretary NDBOME;; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON;

Absent: Gordon Leingang DO, BOME; Rick Detwiller, RPH, Board of Pharmacy

Call to Order: The meeting was called to order by Benson at 5:05 p.m. Introductions were made.

Minutes: The minutes from the January 16, 2008 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2008. Three-eight APRNs were granted prescriptive authority. All applicants met the requirements for prescriptive authority. Discussion ensued.

ND Prescription Drug Monitoring Program – Mr. Anderson provided an update of the ND Prescription Drug Monitoring Program. The program has granted the authority to access the system to additional providers and their surrogates. Mr. Houdek and Dr. Kalanek reported that we have received very positive comments on the program. Mr. Anderson reminded the committee that this program is grant funded and its continuation may be dependent upon receipt of ongoing funds from other sources. Mr. Anderson discussed other options for funding. The next meeting will be the third week of March 2009. At this point in time, the NDBON and NDBOME will not be granted access.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:30 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
January 16, 2008

Present: Board of Nursing members: Buzz Benson RN Board Member and Chair; Patricia Dardis, RN, Family Nurse Practitioner & Clinical Nurse Specialist, BON; Gordon Leingang DO, BOME; Duane Houdek, Executive Secretary NDBOME; Rick Detwiller, RPH, Board of Pharmacy; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON; Dave Peske, NDMA.

Absent: Howard Anderson, Executive Director ND Board of Pharmacy;

Call to Order: The meeting was called to order by Benson at 5:05 p.m. Introductions were made.

Minutes: The minutes from the January 17, 2007 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2007. Three-three APRNs were granted Rx authority. All applicants met the requirements for prescriptive authority. Discussion ensued. Ms. Dardis requested the review for the focus of care be more specific in the future. Mr. Peske asked about nonrenewal for the APRNs.
Note: *The Board does not track specific individuals who do not renew. The aggregate of approximately 700 nurses do not renew annually and approximately 25 are APRNs. Dr. Leingang also asked about the number of APRN Collaborative Agreements a physician can have with APRNs. The rules do not prescribe a specific number but rather leave it to the discretion of the physician, APRN and facility.*

ND Prescription Drug Monitoring Program – Rick Detwiller Mr. Detwiller provided an overview of the ND Prescription Drug Monitoring Program. The program is up and running and utilize an electronic monitoring system to facilitate the transmission and collection of data regarding all controlled substances dispensed to patients in ND and to analyze data and report on the prescribing, dispensing, and use of controlled substances. The system tracks controlled substances and Soma and Tramadol. Approximately 30 states are utilizing a similar system. A news release was sent by Pat Churchill to NDMA which could be useful for newsletters to keep physicians and APRNs informed. Mr. Detwiller reminded the committee that this program is grant funded and its continuation may be dependent upon receipt of ongoing funds from other sources. It was also suggested that the form used to obtain information from the system be placed on appropriate websites.

Other business: Mr. Peske asked about the use of tamper resistant prescription pads by practitioners. He indicated the use of this type of pad would become a requirement in April 08. Discussion ensued.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:45 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

PRESCRIPTIVE AUTHORITY COMMITTEE
MINUTES
March 11, 2010

Present: Board of Nursing members: Dan Rustvang, RN Board Member and Chair; Howard Anderson, Executive Director ND Board of Pharmacy; Duane Houdek, Executive Secretary NDBOME; Rick Detwiller, RPH, Board of Pharmacy; Board Staff Constance Kalanek Ph.D., RN Executive Director.

Guests: Brian Bergeson, Attorney at Law, Special Assistant Attorney General NDBON;

Absent: Excused: Gordon Leingang DO, BOME;

Call to Order: The meeting was called to order by Rustvang at 5:10 p.m. Introductions were made.

Minutes: The minutes from the January 21, 2010 meeting were approved by consensus.

Review of APRNs Granted Prescriptive Authority in 2009. Forty-four APRNs were granted prescriptive authority. All applicants met the requirements for prescriptive authority. Discussion ensued. The current list of Collaborative Physicians and 400 Nurse Practitioners was also reviewed.

ND Prescription Drug Monitoring Program – Mr. Anderson provided an update of the ND Prescription Drug Monitoring Program. The program is working well and utilized by prescriber. Mr. Anderson indicated to the committee that the grant funding has been expended and the NDBOP and UND Center for Rural Health has continued to support it. The next meeting will be the March 25, 2010.

Next Meeting: Annually.

Adjournment: The meeting adjourned at approximately 5:45 p.m.

Minutes Prepared by: Constance B. Kalanek PhD, RN

NORTH DAKOTA BOARD OF NURSING
2010-2011 PRESCRIPTIVE AUTHORITY COMMITTEE

BOARD OF NURSING

Daniel Rustvang APRN, NP
3324 Primrose Court
Grand Forks, ND 58201
Email: drustvang@altru.org; Telephone- 701-780-6941

Nelson (Buzz) Benson, RN
215 Laredo Dr
Bismarck, ND 58504-7210
Email: bbenson42@bis.midco.net. Telephone- 222-2973(H); 323-6262(W)

Constance Kalanek PhD, RN,
Executive Director
919 So 7th Street, Suite 504,
Bismarck, ND 58504
Email: ckalanek@ndbon.org; Telephone –328-9781

BOARD OF MEDICAL EXAMINERS

Kent Martin, MD
2507 Henry St
Bismarck, ND 58503
Email- Telephone – 323-8654

Duane Houdek
State Board of Medical Examiners
418 E. Broadway, Suite 12
Bismarck, ND 58501 Telephone: 328-6500
E-mail: dhoudek.ndbme@midconetwork.com

BOARD OF PHARMACY

Rick L. Detwiller, R.Ph.
1900 Harbor Drive
Bismarck, ND 58504-0956
rdetwiller@primecare.org Business Phone 701-530-6886
Cell 701-226-3820

Alternate
Bonnie Thom, R.Ph
Member
5372 N. 15th Ave
Granville, ND 58741
Email: velvadrug@srt.com; Telephone: 701-626-1639; 701-338-2911.

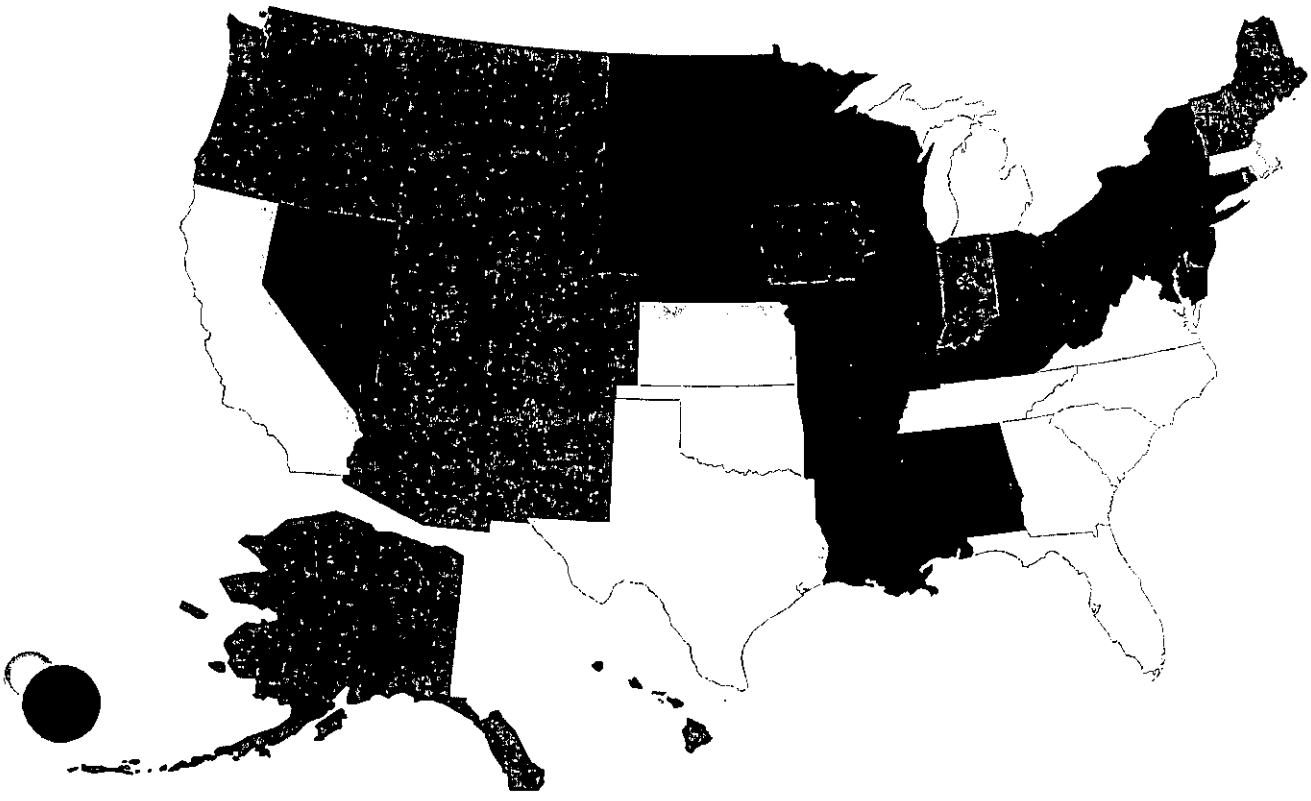
Howard Anderson, Jr., R.Ph.
Executive Director
ND State Board of Pharmacy
P.O. Box 1354
Bismarck, ND 58502-1354 Telephone: 328-9535
ndboph@btinet.net

COURTESY MAILING:

Becky Graner RN
ND Nurses Association
531 Airport Road
Bismarck, ND 58504
Becky@ndna.org
223-1385

Bruce Levi
ND Medical Association
PO Box 1198,
Bismarck, ND 58502-1198
blevi@ndmed.com
223-9475

COLLABORATION/SUPERVISORY LANGUAGE IN STATE PRACTICE ACTS & REGULATIONS FOR NURSE PRACTITIONERS



Plenary Authority (No Physician Relationship Required)

Collaboration with Physician

General Supervision/Delegation by Physician

* Special Conditions

\+ Pending

Source: State Nurse State Practice Acts
And Administration Rules, 2008

The American Academy of Nurse Practitioners is the largest full service Nurse Practitioner organization representing the 125,000 Nurse Practitioners in all Specialties

Update: Oct 23, 2009

#3

TESTIMONY

TO

HOUSE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

DR. BILLIE MADLER, FNP

MARCH 9, 2011

Mr. Chairperson and Committee Members:

My name is Dr. Billie Madler. I am a nurse practitioner in Bismarck and an educator of students in graduate nursing programs. I am here to testify in support of SB 2148.

Today I would like to share with you a summary of three important national publications pertinent to the objective of this bill. Links to each of these sources is provided at the conclusion of this testimony. I have also attached copies for your each reference.

First, in January of 2010 the Josiah Macy Jr. Foundation [which is a private philanthropy dedicated to improving the health of individuals and the public by advancing the education and training of health professionals] convened a multidisciplinary conference to address the complex issues concerning who will provide primary care. Participants included nurses and physicians from diverse geographic areas throughout the United States and various sectors affected by the challenges related to primary care. Their conversations pivoted around our country's work to enhance quality, access, and reliability of health care, while working to make health care available for several million who are under or non-insured and sustain efforts to improve our population health. The group documented that in order to accomplish our goals we need to enlarge and strengthen our primary care sectors. Then, the group drew attention to the decreasing number of physicians choosing primary care. They recognized nurse practitioners have proven to be effective primary care providers, but are quoted saying "regulatory and reimbursement policy barriers often prevent efficient and effective use of their services".

A second national publication, recently released on October 5th, 2010 titled the "Future of Nursing" was the result of a 2 year initiative launched by the Robert Wood Johnson Foundation and the Institute of Medicine

(IOM). [The IOM was established in 1970 under the charter of the National Academy of Sciences to provide independent, objective, evidence-based advice to policy makers, health professionals, the private sector, and the public.] The committee working on this initiative was charged with producing a report that contained recommendations "for an action-oriented blueprint for the future of nursing, including changes in public and institutional policies at the national, state, and local levels". One key message of this report is closely related to the goals of the Bill I am asking you to support today.

These experts recommended nurses practice to the full extent of their education and training. Currently, licensing and practice rules differ from state to state, which results in a varying effect on advanced practice registered nurses across the country. For example, several states currently allow advanced practice registered nurses to do what we are asking with this Bill. The IOM committee offered recommendations to a variety of stakeholders including state legislators. They recommend that you, as state legislators, reform the scope of practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. Also, the report recommends the Federal Trade Commission and the Antitrust Division of the Department of Justice review existing and proposed state regulations concerning APRNs

to identify those that have anticompetitive effects without contributing to the health and safety of the public. This group urges states with restrictive regulations to change their laws to allow APRNs to provide care to patients in all circumstances in which they are qualified to provide care. These are only two of many recommendations made.

The last national publication that I would like to draw attention to was published this past December 15th in the New England Journal of Medicine. The article cited evidence from many studies indicating that primary care services, including management of both acute and chronic conditions as well as provision of wellness and preventative care is "provided by nurse practitioners at least as safely and effectively as by physicians" (my emphasis) and that the "critical factors limiting nurse practitioners' capacity to practice to the full extent of their education, training, and competence are state-based regulatory barriers" (my emphasis). This variation from state to state has been found to contribute to nurse practitioners moving to states with less restrictive practices. This factor will not help advance healthcare in a rural state like ours.

Finally, I would like to draw your attention to the attached contribution written by Dr. Jeff Susman, MD, the editor and chief of The Journal of Family Practice. He makes four cogent arguments for why it is important to

remove regulatory barriers. First he cites the IOM report I reviewed earlier. Second, he believes NPs, practice within "the bounds of their experience and training". Third, he fears that it is not a viable political position for physicians to continue to "battle on this front". And finally, and in my opinion most importantly, he identifies that future of healthcare requires such change.

Opponents to this bill will argue that the educational preparation of APRNs is not equivalent to physicians and then try to link that difference to rationale for preventing this bill's passage. We acknowledge that the educational preparation between physicians and NPs is different, but resist the idea this difference makes one professional group more equipped than the other to function within their scope of practice. Furthermore, we identify many strengths the model of NP education. First, unlike physicians, all NPs have spent years (10 on average) working in their profession prior to advancing their education. During this time they have compiled countless hours caring for patients, including administration and monitoring of medications. Secondly, NP students determine their patient population at the time of entry to an NP program. This focus allows their educational preparation to be tailored to the needs of patients in that particular population focus. Thirdly, NP education is competency-based, not time

based. This fact means NPs student must demonstrate they have acquired the knowledge and skills necessary before they can progress. Competency based education has been the standard in nursing education for some time. Recently other professions, including medicine are reconsidering their time based approach to education and looking at competency based models. Dr. William Hueston, a member of the American Academy of Family Physician Commission on Education has been quoted saying, "Both in medical student education and residency, we have clung to the belief that if you spend a certain amount of time learning about something, then you must know it..... That's as ridiculous as thinking that a teenager should be given a license just because he or she spent a set number of hours behind the wheel of a car. Most importantly, our group agrees that the measurement of effectiveness should be measured on patient outcomes. "In over 100 studies on care provided by both nurse practitioners and physicians, not a single study has found that nurse practitioners provide inferior services. In fact, these studies have shown NPs have the same or better patient outcomes when compared to physicians" (AANP).

With this bill, our goal is to continue to provide high quality care to the citizens of ND. We wish to sustain and improve access to care while

seeing to the effective and efficient provision of care for our patients.

Thank you for your time and your support of SB 2148.

Respectfully submitted,

Dr. Billie Madler, FNP
President Elect NDNPA
701-400-4693

Resources

American Academy of Nurse Practitioners. (2011). Clinical Outcomes: The Yardstick of Educational Effectiveness.

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Co-Chairs' Summary of the Conference

Who Will Provide Primary Care and How Will They Be Trained?

In January 2010 the Josiah Macy, Jr. Foundation convened a conference to address complex issues concerning who will provide primary care and how they will be trained. Participants developed the set of conclusions and recommendations found in this Executive Summary.

A more detailed account of the proceedings, along with the background papers, will be included in a monograph to be published by the Macy Foundation in the next few months.

The Urgency for Change

Abundant evidence shows that healthcare systems with a strong primary care component provide high-quality, accessible, and efficient care. People want primary care providers with whom they can have ongoing relationships. They want to know that when they need help, they have access to someone with knowledge of their health problems and their individual characteristics.

Despite evidence supporting these facts, the healthcare system in the United States has not developed or valued a strong primary care sector, though there are excellent examples of primary care to be found in many regions. The lack of a strong primary care infrastructure across the nation has had significant consequences for access, quality, continuity, and cost of care in this country. It also has had consequences for our health profession educational enterprise and the healthcare workforce, resulting in numbers and geographic distributions of primary care providers that are insufficient to meet current or projected needs.

Regardless of the outcome of current health reform efforts, the country will continue to innovate in attempts to provide access to care to several million additional people and simultaneously improve the health of populations, enhance the patient experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of care. We are facing an economic situation in which the current rate of rise of medical cost is unsustainable, and this situation is exacerbated by an aging population with higher care needs and expectations. These events have created a climate in which it is necessary and appropriate to question the models of care and health professions education on which we have relied.

If we are going to fulfill our nation's promise to the public, and if we are going to produce the healthcare workforce required to accomplish our goals, we will need to enlarge and strengthen the primary care sector of the health system. There is great risk that if we do not do so, a significant portion of the population will continue to be without access to high-quality and efficient care, and healthcare costs will continue to escalate with dire consequences for the economies of individuals and the nation. Because of the magnitude of these problems and the current attempts to reform healthcare, there is great urgency in addressing these issues. These issues have registered in the public and professional consciousness in a way that suggests that unprecedented change is possible. The goal of this change is to produce "better health, better care, lower cost." Failure to act now could put the health of our communities and the economy of the country in jeopardy.

In January 2010, the Josiah Macy, Jr. Foundation convened a conference entitled "Who Will Provide Primary Care and How Will They Be Trained?" Held at the Washington Duke Inn in Durham, North Carolina, the conference was co-chaired by Linda Cronenwett, Ph.D., R.N., FAAN, Professor and Dean Emeritus, School of Nursing, University of North Carolina at Chapel Hill and Victor J. Dzau, M.D., James B. Duke Professor of Medicine, Chancellor for Health Affairs of Duke University and Chief Executive Officer of the Duke University Health System. Attending this important meeting were 49 participants, carefully chosen to represent a diversity of views on primary care, including experts from all professional groups who provide primary care (allopathic and osteopathic physicians, nurse practitioners, and physician assistants) and experts from the various sectors affected by the challenges related to primary care (consumers, academia, practice, science, journalism, government, healthcare policy, payors, and foundations).

Participants arrived in Durham well prepared to discuss the background papers (included in a forthcoming monograph). For each session topic, the list of people contributing insights was impressive. Many conversations continued well into the evenings. Perhaps the most noteworthy observation was the encouraging consensus that emerged among leaders from different parts of the healthcare system—a general agreement about what needs to be done; a willingness to come together to accomplish goals that will benefit patients, families, communities, and health professionals; and a sense of urgency to bring about major changes that will strengthen primary care in our country.

We began our discussions with a review of the history of primary care and our relative lack of investment in population health (included in the definitions of primary healthcare in most of the rest of the world). When Abraham Flexner put medical education on a scientific footing with his 1910 report, medical education as we know it was created. Medical schools were associated with large teaching hospitals, and highly knowledgeable specialists directed departments organized around organ systems. When the National Institutes of Health were formed, these faculties focused on the creation of yet more specialized knowledge. Healthcare payment structures responded to the technologies and science of these specialists, resulting in the healthcare practices we invest in today. As specialty medicine grew in prestige and reimbursement, general internal medicine, general pediatrics, and the more recent specialty of family medicine took a lower place in the hierarchy, reaching the point today in which a medical student who chooses a primary care specialty does so with the knowledge that he or she is leaving substantial dollars of lifetime income on the table.

During this same period, and often in response to shortages of primary care allopathic physicians, the numbers of osteopathic physicians, primary care advanced practice nurses (nurse midwives and nurse practitioners), and physician assistants grew. Each group was trained initially within disciplinary silos, with an emphasis on primary care. Gradually, options for specialist careers in medicine emerged for osteopathic physicians, and the percentage of osteopathic graduates choosing primary care careers diminished. Physician assistants tend to practice where physicians practice. For the most part, therefore, the number of physician assistants in primary care has diminished in accordance with physician practice patterns. Nurse practitioners proved effective in primary care roles, but regulatory and reimbursement policy barriers often prevented efficient and effective use of their services. In many states, such barriers exist to this day.

Meeting participants were enthusiastic about many innovations in primary care today— experiments that use teams of primary care providers; electronic health records and other technologies; and other health professionals in systems of care that meet patient and community needs. But they recognized that these environments were relatively few and far between. Early in our discussions, it became clear that participants believed it would be difficult to alter the downward trajectory of recruitment and retention of primary care physicians, in particular, without significant reforms in reimbursement and care delivery models. Also important is training the next generation of primary care providers within these innovative primary care practice settings, both within and beyond academic health centers. Participants were unanimous in their views that trainees need exposure to effective teams, working within systems that are designed to meet the needs of patients and communities, in order to learn about working in a team-based environment and to appreciate the rich rewards associated with primary care careers.

To ensure these learning environments across the nation, some type of payment reform that

Participants were unanimous in their views that trainees need exposure to effective teams, working within systems that are designed to meet the needs of patients and communities, in order to learn about working in a team-based environment and to appreciate the rich rewards associated with primary care careers.

provides incentives for investment in primary care infrastructures, technologies, and salaries is essential. Frequently, primary care providers are expected to develop the technological and personnel infrastructures necessary to meet the holistic needs of their patients and communities out of their practice incomes.

Participants emphasized repeatedly that a call for greater investment in primary care was not a call for a greater expense in healthcare overall. In numerous studies, the benefits of investments in primary care are clear—overall healthcare costs per capita decline. Without reformed payment structures, however, the frustrations of not being able to meet all expectations become overwhelming, and the inevitable result is a decline in numbers of people choosing primary care careers. The bottom line is this: unless trainees from *all* provider groups witness care being delivered by effective and efficient teams of primary care professionals who have the infrastructures to enable patients, families, and communities to achieve goals for individual and population health, the country will produce fewer and fewer primary care providers and will be unlikely to achieve its goals of reducing overall costs of care while improving healthcare quality and access.

Within this context, participants struggled with whether or not they could address the issues associated with what is referred to broadly as primary healthcare. There was a strong desire to address the broader needs of populations—needs that affect health but derive from a community's access, not only to healthcare, but to systems designed to support other public health, social, and educational needs. The participants considered the possibilities of new forms of primary care, through which society might hold healthcare systems accountable for both individual and population health goals. However, in order to have recommendations of substance that could change outcomes in the foreseeable future, participants decided to focus on the central questions posed to them at the start of the conference: namely, who should deliver primary care and how should the primary care practitioners of the future be trained?

As co-chairs, we were gratified to achieve a remarkable consensus on many issues of substance related to these questions, particularly the idea that *all* health professionals need training that ensures they have the skills to lead and work effectively in teams, to represent the interests of the public in ensuring a strong primary care infrastructure, and to expect, within their careers, to assume their share of accountability for continuously improving access to care, care coordination, costs of care, and quality of outcomes related to individual and population health. Health professionals need to develop attitudes that welcome patients as partners in care, moving beyond the current model of intermittent, facility-based contacts. And they need experience with the use of new tools, such as information technology; online monitoring and assessment; and supports for self care, home-based care, and virtual tele-health interactions, all of which will be part of primary care in the future. These overarching themes led directly to recommendations designed to improve the training of all primary care providers.

We left the conference inspired by the passion and commitment of the participants and with the development of a consensus that would move us toward a preferred future—a future in which our society's needs for primary care would be met effectively. It is our distinct privilege to have co-chaired this important meeting and to share with you the conference conclusions and recommendations.

Conclusions and Recommendations

CONCLUSION I

In order to meet societal needs for primary care and train the right primary care professionals in the right numbers with the right competencies for the most appropriate roles, healthcare systems need incentives to dramatically change the way primary care is valued, delivered, and integrated in evolving healthcare systems. We will not attract and retain sufficient numbers nor achieve the needed geographic distribution of primary care providers unless there is a greater proportional investment in primary care. Our students and trainees must be educated throughout their clinical training in practices that deliver first-contact, comprehensive, integrated, coordinated, high-quality, and affordable care. These practices require teams of professionals who give care that elicits patient and provider satisfaction under conditions of clearly defined roles, effective teamwork, patient engagement, and transparency of outcomes.

Recommendation 1

Create financial and other incentives for the development of innovative models of primary care and the advancement of knowledge about outcomes that allow us to identify best practices in the achievement of high-value primary care. Strategies may include the following:

- A competitive process for the establishment of Centers of Excellence in Primary Care
- Mechanisms that analyze and better define the roles of various health professionals in best- practice, high-value primary care models
- Development and improvement of national metrics for assessment of patient and population health
- Mechanisms for the diffusion of knowledge about best practices, such as the proposed Primary Care Extension Program.

Recommendation 2

Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes.

Recommendation 3

Promote stronger ties between academic health centers and other primary care sites and the communities they serve, setting goals and standards for accountability for primary prevention as well as individual and population health. All health systems, including the primary care practices embedded within them, should be accountable for quality and cost outcomes through well-tested, nationally recognized metrics that address the needs of populations and individuals, with data that are transparent and that can be used for the continuous improvement of models of care.

Recommendation 4

Invest in primary care health information technologies that support data sharing, quality improvement, patient engagement, and clinical care, with the aim of continuously improving the health and productivity of individuals and populations.

Recommendation 5

Recognizing that current payment systems create incentives for underinvesting in primary care services, implement all-payor payment reforms that more appropriately recognize the value contributed by primary care through such mechanisms as global payments linked to patient complexity and accountability for the provision of healthcare services, including preventive services, care coordination across settings, chronic disease management, and 24/7 accessibility. Improved costs and quality of health outcomes for patients and populations should be rewarded. In addition, implement legislation that will standardize insurance reimbursement reporting requirements to reduce administrative costs inherent in a multi-payor system.

CONCLUSION II

In addition to the critical challenges outlined above in the organization and financing of healthcare, current health professional educational models are generally inadequate to attract, nurture, and train the primary care workforce of the future.

Recommendation 1

Create incentives for innovative projects in health professions education, enlisting funding partners from government, industry, philanthropy, and payors in order to develop models of excellent, high-performing, and advanced interprofessional primary care.

Academic health centers, working with teaching community health centers, area health education centers (AHECs), and other training sites are the logical entities to advance such innovations. Strategies could include the development of Primary Care Translational Centers of Excellence that would perform primary care research and evaluation and provide team-based education, with emphasis on the study of new models of primary care and health delivery transformation.

Recommendation 2

Medical schools, nursing schools, and other schools for the health professions, which hold the societal responsibility for the education of health professionals, have an opportunity and obligation to increase the size and strength of the primary care workforce. Leaders of health professional schools should implement actions known to increase the number of students and trainees choosing careers in primary care. These actions include the following:

- Establishing programs to prepare and attract a more socioeconomically, racially, and geographically diverse student body
- Revising admission standards to include more emphasis on social science and humanities and the personal qualities of applicants
- Implementing and expanding scholarship and loan repayment programs in partnership with health systems, governmental agencies, and communities for those pursuing careers in primary care
- Promoting early exposure to primary care practices for all students
- Creating longitudinal immersion clinical experiences in community primary care settings
- Implementing special primary care tracks for students and trainees.
- Establishing and strengthening departments of family medicine within schools of medicine.

Recommendation 3

Interprofessional education should be a required and supported part of all health professional education. This change is especially important for primary care. Regulatory, accreditation, reimbursement, and other barriers that limit members of the healthcare team from learning or working together should be eliminated.

Recommendation 4

The Department of Health and Human Services, through its appropriate agencies and divisions, should be granted additional funding to support interprofessional training, preparation of the primary care workforce, and leadership development programs to produce clinicians to take the lead in new models of primary care. Strategies to accomplish these goals could include the following:

- Expansion of Title VII and Title VIII funding and authority to jointly fund interprofessional programs
- Expansion of Title VII and Title VIII funding to address faculty shortage and educational underinvestment in the development of faculty for primary care
- Increase in AHEC funding to expand its pipeline programs in primary care and to provide community-based, interprofessional educational experiences for all primary care health professions students
- Resumption of the Primary Care Health Policy Fellowship and creation of new programs to prepare clinician-leaders for new models of practice
- Provision of adequate scholarships and loan repayment programs to provide clinicians to underserved areas and to improve diversity
- Expansion and direction of funding for graduate medical, nursing, and physician assistant educational programs (Medicare Graduate Medical Education funding, Title VII, Title VIII) to support trainees and training infrastructure costs in ambulatory settings, including teaching community health centers, AHECs, academic outpatient clinics, and other community-based programs.

CONCLUSION III

Recognizing that the healthcare system is dynamic and will continue to evolve, strong leadership will be needed to advance the science, teaching, practice, and policy development relevant to primary care.

Recommendation 1

Develop leaders with a focus on advancing the curricula and learning opportunities for preparing competent primary care clinicians, scientists, and policymakers of the future.

Medical, nursing, and other health profession school faculties should form partnerships with educators from other disciplines, such as business and law, to develop novel educational opportunities for advancing primary care leadership, research, policy, and advocacy. As a routine part of their education, primary care students should be exposed to mentored opportunities to participate in healthcare improvement and policy development and to function within interprofessional and interdisciplinary leadership teams.

Recommendation 2

Support the further development of science and the scientific leadership necessary to advance the translation of best practices into primary care delivery for the improvement of patient and community health. Initiatives could include the following:

- Funding career development for scientists that can create improved national metrics for assessment of individual and population health
- Providing targeted funding through Clinical Translational Science Awards, National Research Service Awards, and Health Research Services Awards for scientists focused on primary care
- Developing a national healthcare workforce analysis and policy capability for ensuring an adequate and well-prepared primary care workforce over time.

Recommendation 3

Recognize the need to include representatives of all primary care providers in the leadership of delivery systems and in groups that are responsible for developing healthcare policies at the state and federal level.

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Conference Participants

Linda Cronenwett, Ph.D., R.N., FAAN*
University of North Carolina at Chapel Hill
School of Nursing
Co-Chair

Victor J. Dzau, M.D.*
Duke University
Duke University Health System
Co-Chair

Ruth Ballweg, M.P.A., P.A.-C.
MEDEX Northwest Division of Physician Assistant Studies

Richard J. Baron, M.D., FACP
American Board of Internal Medicine Foundation
Greenhouse Internists, PC

Michael S. Barr, M.D., M.B.A., FACP
American College of Physicians

Bobbie Berkowitz, Ph.D., R.N., FAAN
University of Washington
School of Nursing

JudyAnn Bigby, M.D.
Massachusetts Executive Office of Health and Human Services

Robert H. Brook, M.D., Sc.D., FACP
RAND Health

Darwin Brown, P.A.-C., M.P.H.
University of Nebraska Medical Center Physician Assistant Program

Jordan J. Cohen, M.D.
The George Washington University Medical Center

Gerald Cross, M.D.
Department of Veterans Affairs

Susan Dentzer
Health Affairs

F. Daniel Duffy, M.D.
University of Oklahoma College of Medicine, Tulsa

Susan Edgman-Levitan, P.A.
Massachusetts General Hospital

Harvey Fineberg, M.D., Ph.D.
Institute of Medicine

Elliott S. Fisher, M.D., M.P.H.
The Dartmouth Institute for Health Policy and Clinical Practice

John P. Fogarty, M.D.
College of Medicine
Florida State University

David R. Garr, M.D.
South Carolina AHEC
Medical University of South Carolina

Catherine Gilliss, D.N.Sc., R.N., FAAN
Duke University School of Nursing

Marthe Gold, M.D., M.P.H.
Sophie Davis School of Biomedical Education
The City University of New York

Kevin Grumbach, M.D.
Family and Community Medicine
University of California, San Francisco

Paul Grundy, M.D., M.P.H, FACOEM, FACPM
Healthcare Transformation IBM Patient-Centered Primary Care Collaborative

Marc B. Hahn, D.O.
University of New England College of Osteopathic Medicine

Gwen Halaas, M.D., M.B.A.
University of North Dakota School of Medicine and Health Sciences

Jennie Chin Hansen, M.S.N., R.N.
AARP

Susan Hassmiller, Ph.D., R.N., FAAN
Robert Wood Johnson Foundation

Doug Kelling, M.D.
Concord Internal Medicine

Kathleen Klink, M.D.
Columbia University College of Physicians and Surgeons

Richard D. Krugman, M.D.
School of Medicine
University of Colorado Denver

Joseph Martin, M.D., Ph.D.*
Harvard Medical School

David Meyers, M.D.
Center for Primary Care, Prevention, and Clinical Partnerships
Agency for Healthcare Research and Quality

J. Lloyd Michener, M.D.
Community and Family Medicine
Duke University Medical Center

Fitzhugh Mullan, M.D.
The George Washington University Department of Health Policy

Mary D. Naylor, Ph.D., R.N., FAAN
NewCourtland Center for Transitions & Health
University of Pennsylvania

Marc A. Nivet, Ed.D.*
Josiah Macy, Jr. Foundation

Luis Padilla, M.D.
Upper Cardozo Health Center

Herbert Pardes, M.D.
New York Presbyterian Hospital

Robert L. Phillips, Jr., M.D., MSPH*
The Robert Graham Center

Joanne M. Pohl, Ph.D., ANP-BC, FAAN*
University of Michigan School of Nursing

David Satcher, M.D.
Morehouse School of Medicine

Steve Schoenbaum, M.D., M.P.H.
The Commonwealth Fund

Stephen C. Shannon, D.O., M.P.H.
American Association of Colleges of Osteopathic Medicine

Joan Shaver, Ph.D., R.N., FAAN
The University of Arizona College of Nursing

Kurt C. Stange, M.D., Ph.D.
Annals of Family Medicine
Case Western Reserve University

Barbara Starfield, M.D., M.P.H.
The Johns Hopkins Primary Care Policy Center

Valerie E. Stone, M.D., M.P.H.
Massachusetts General Hospital
Harvard Medical School

George E. Thibault, M.D.*
Josiah Macy, Jr. Foundation

Reed V. Tuckson, M.D., FACP
UnitedHealth Group

Kenneth Veit, D.O.
Philadelphia College of Osteopathic Medicine

Macy Foundation
George E. Thibault, M.D.*
Marc A. Nivet, Ed.D.*
Karen Butler
Barbara J. Culliton
Nicholas R. Romano, M.A.

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**Planning Committee Member*

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The Future of Nursing
Leading Change, Advancing Health

With more than 3 million members, the nursing profession is the largest segment of the nation's health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act, legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs. A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

A number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing.

Nurses practice in many settings, including hospitals, schools, homes, retail health clinics, long-term care facilities, battlefields, and community and public health centers. They have varying levels of education and competencies—from licensed practical nurses, who greatly contribute to direct patient care in nursing homes, to nurse scientists, who research and evaluate more effective ways of caring for patients and promoting health. The committee considered nurses across roles, settings, and education levels in its effort to envision the future of the profession. Through its deliberations, the committee developed four key messages that structure the recommendations presented in this report:

1) Nurses should practice to the full extent of their education and training.

While most nurses are registered nurses (RNs), more than a quarter million nurses are advanced practice registered nurses (APRNs), who have master's or doctoral degrees and pass national certification exams. Nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives all are licensed as APRNs.

Because licensing and practice rules vary across states, the regulations regarding scope-of-practice—which defines the activities that a qualified nurse may perform—have varying effects on different types of nurses in different parts of the country. For example, while some states have regulations that allow nurse practitioners to see patients and prescribe medications without a physician's supervision, a majority of states do not. Consequently, the tasks nurse practitioners are allowed to perform are determined not by their education and training but by the unique state laws under which they work.

The report offers recommendations for a variety of stakeholders—from state legislators to the Centers for Medicare & Medicaid Services to the Congress—to ensure that nurses can practice to the full extent of their education and training. The federal government is particularly well suited to promote reform of states' scope-of-practice laws by sharing and providing incentives for the adoption of best practices. One sub-recommendation is directed to the Federal Trade Commission, which has long targeted anti-competitive conduct in the health care market, including restrictions on the business practices of health care providers, as well as policies that could act as a barrier to entry for new competitors in the market.

High turnover rates among new nurses underscore the importance of transition-to-practice residency programs, which help manage the transition from nursing school to practice and help new graduates further develop the skills needed to deliver safe, quality care. While nurse residency programs sometimes are supported in hospitals and large health systems, they focus primarily on acute care. However, residency programs need to be developed and evaluated in community settings.

2) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be improved. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care. These competencies include leadership, health policy, system improvement, research and evidence-based practice, and teamwork and collaboration, as well as competency in specific content areas including community and public health and geriatrics. Nurses also are being called upon to fill expanding roles and to master technological tools and information management systems while collaborating and coordinating care across teams of health professionals.

Nurses must achieve higher levels of education and training to respond to these increasing demands. Education should include opportunities for seamless transition into higher degree programs—from licensed practical nurse (LPN)/licensed vocational nurse (LVN) diplomas; to the associate's (ADN) and bachelor's (BSN) degrees; to master's, PhD, and doctor of nursing practice (DNP) degrees. Nurses also should be educated with physicians and other health professionals both as students and throughout their careers in lifelong learning opportunities. And to improve the quality of patient care, a greater emphasis must be placed on making the nursing workforce more diverse, particularly in the areas of gender and race/ethnicity.

To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be improved. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care.

3) Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Efforts to cultivate and promote leaders within the nursing profession—from the front lines of care to the boardroom—will prepare nurses with the skills needed to help improve health care and advance their profession. As leaders, nurses must act as full partners in redesign efforts, be accountable for their own contributions to delivering high-quality care, and work collaboratively with leaders from other health professions.

Being a full partner involves taking responsibility for identifying problems and areas of system waste, devising and implementing improvement plans, tracking improvement over time, and making necessary adjustments to realize established goals. In the health policy arena, nurses should participate in, and sometimes lead, decision making and be engaged in health care reform-related implementation efforts. Nurses also should serve actively on advisory boards on which policy decisions are made to advance health systems and improve patient care.

In order to ensure that nurses are ready to assume leadership roles, nursing education programs need to embed leadership-related competencies throughout. In addition, leadership development and mentoring programs need to be made available for nurses at all levels, and a culture that promotes and values leadership needs to be fostered. All nurses must take responsibility for their personal and professional growth by developing leadership competencies and exercising these competencies across all care settings.

4) Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Planning for fundamental, wide-ranging changes in the education and deployment of the nursing workforce will require comprehensive data on the numbers and types of health professionals—including nurses—currently available and required to meet future needs. Once an improved infrastructure for collecting and analyzing workforce data is in place, systematic assessment and projection of workforce requirements by role, skill mix, region, and demographics will be needed to inform changes in nursing practice and education.

The 2010 Affordable Care Act mandates the creation of both a National Health Care Workforce Commission to help gauge the demand for health care workers and a National Center for Workforce Analysis to support workforce data collection and analysis. These programs should place a priority on systematic monitoring of the supply of health care workers across professions, review of the data and methods needed to develop

accurate predictions of workforce needs, and coordination of the collection of data on the health care workforce at the state and regional levels. All data collected must be timely and publicly accessible.

Conclusion

The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role.

The recommendations presented in this report are directed to individual policy makers; national, state, and local government leaders; payers; and health care researchers, executives, and professionals—including nurses and others—as well as to larger groups such as licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health.

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500 Fifth Street, NW
Washington, DC 20001
TEL 202.334.2352
FAX 202.334.1412

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The NEW ENGLAND JOURNAL of MEDICINE

Broadening the Scope of Nursing Practice

Julie A. Fairman, Ph.D., R.N., John W. Rowe, M.D., Susan Hassmiller, Ph.D., R.N., and Donna E. Shalala, Ph.D.

The Affordable Care Act promises to add 32 million Americans to the rolls of the insured at a time when there is a shortage of primary care providers. [illegible]

phase of reform must slow the growth of health care costs and improve value through payment reforms, including bundling of payments and payments for episodes of care. Some savings will derive from implementation of innovative models of care, such as accountable care organizations, medical homes, transitional care, and community-based care. We believe that if we are to bridge the gap in primary care and establish new approaches to care delivery, all health care providers must be permitted to practice to the fullest extent of their knowledge and competence. This will require establishing a standardized and broadened scope of practice for advanced-practice registered nurses — in particular, nurse practitioners — for all states.

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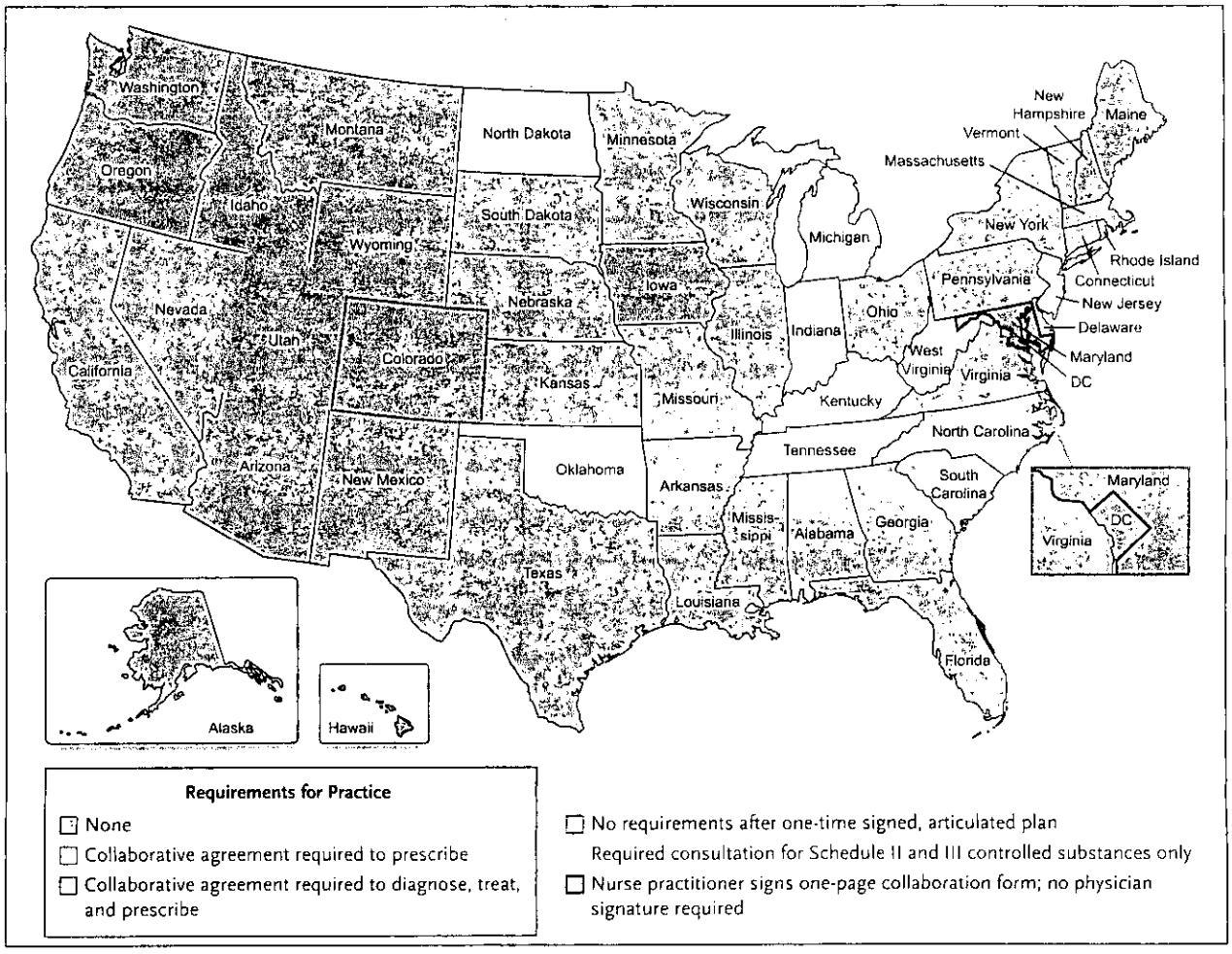
Nurses' role in primary care has recently received substantial scrutiny, as demand for primary care has increased and nurse practitioners have gained traction with the public. Evidence from many studies indicates that primary care services, such as wellness and prevention services, diagnosis and management of many common uncomplicated acute illnesses, and management of chronic diseases such as diabetes can be provided by nurse practitioners at least as safely and effectively as by physicians.[1] After reviewing the issue, an Institute of Medicine (IOM) panel recently reiterated this conclusion and called for expansion of nurses' scope of practice in primary care.[2]

Some physicians' organizations argue that physicians' longer, more intensive training means that nurse practitioners cannot deliver primary care services that are as high-quality or safe as those of physicians. But physicians' additional training has not been shown to result in a measurable difference from that of nurse practitioners in the quality of basic primary care services.[1,2] We are not arguing that nurse practitioners are substitutes for these physicians, but rather that we should consider how primary care services can be more effec-



Scope-of-Practice Regulations for Nurse Practitioners, According to State.
Data are from the AARP (http://championnursing.org/aprnmap).

tively provided to more people with the use of the full primary care workforce.

The critical factors limiting nurse practitioners' capacity to practice to the full extent of their education, training, and competence are state-based regulatory barriers. States vary in terms of what they allow nurse practitioners to do, and this variance appears not to be correlated with performance on any measure of quality or safety. There are no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of physicians in less restrictive states has changed or deteriorated.

There is variation in several aspects of practice, including requirements for prescribing privileges, oversight and chart reviews, and the maximum "collaboration ratios" for nurse practitioners working with physicians. In some states, nurses cannot certify home health care visits or stays in skilled nursing facilities or hospice, order durable equipment, admit patients to hospitals without a physician's supervision or collaborative agreements, or prescribe medications without physician oversight. Nurses tend to move from more restrictive to less restrictive states, and from primary to specialist care, with a resulting loss of access to care for patients. Credentialing and payment are also linked to state regulations: more restrictive states are less likely than those allowing independent practice to credential nurse practitioners as primary care providers.[2,3]

Sixteen states plus the District of Columbia have already

liberalized and standardized their scope-of-practice regulations and allow nurse practitioners to practice and prescribe independently (see map). Several other states are reconsidering their laws to allow independent practice and to adopt the Advance Practice Nurse (APRN) Model Act generated by the National Council of State Boards of Nursing. Under such laws, nurse practitioners may practice independently and be accountable "for recognizing limits of knowledge and experience, planning for the management of situations beyond [their] expertise; and for consulting with or referring patients to other health care providers as appropriate."[4]

The trend toward easing restrictions is propelled by recent reports from several blue-ribbon panels. In addition to the IOM report, which specifically targets regulatory barriers, several policy briefs from other organizations, including the Macy Foundation, support broader scope-of-practice boundaries. One of the largest consumer groups, the AARP (formerly the American Association of Retired Persons), also supports an expanded role for nurse practitioners in primary care.

In addition to the data on the quality of care, the expected dramatic increase in demand for primary care services from Americans with insurance, and the impending shortage of primary care providers, there are several other reasons to relax state regulations. Effective implementation of new delivery models, such as medical homes and accountable care organizations, which would provide chronic disease management and transitional care, requires the establishment of interdisciplinary teams in which nurses provide a range of services, from case management to health and illness management. Such an expanded scope of practice and team-based approaches including nurse practitioners have been shown to improve quality and patient satisfaction and reduce costs at the Veterans Administration Health System, Geisinger Health System, and Kaiser Permanente.[2]

Reductions in cost associated with broadening nurse practitioners' scope of practice can be seen elsewhere as well. In U.S. retail clinics, where cost savings have been documented, nurse practitioners provide most of the care. But retail clinics have been slow to expand in states with more restrictive scope-of-practice regulations. Research in Massachusetts shows that using nurse practitioners or physician assistants to their full capacity could save the state $4.2 billion to $8.4 billion over 10 years and that greater use of retail clinics staffed primarily by nurse practitioners could save an additional $6 billion.[3]

Since nurse practitioners' education is supported by federal and state funding, we are underutilizing a valuable government investment. Moreover, nurse practitioner training is the fastest and least expensive way to address the primary care shortage. Between 3 and 12 nurse practitioners can be educated for the price of educating 1 physician, and more quickly.[5]

Despite the robust rationale for broadening nurse practitioners' scope of practice, key medical organizations oppose the idea. The American Medical Association, the American Osteopathic Association, the American Academy of Pediatrics, and the American Academy of Family Physicians all support requiring direct supervision of nurse practitioners by physicians. As health care reform advances, implementation of payment reforms — including global or bundled team-based payments and medical home–based payments — may ease professional tensions and fears of substitution while enhancing support for an increased scope of nursing practice.

Legal considerations also seem to favor such a trend. The Federal Trade Commission recently evaluated proposed laws in three states and found several whose stringent requirements for physician supervision of nurses might be considered anticompetitive. The agency has also investigated proposed state policies that would protect professional interests rather than consumers.[2]

This is a critical time to support an expanded, standardized scope of practice for nurses. Economic forces, demographics, the gap between supply and demand, and the promised expansion of care necessitate changes in primary care delivery. A growing shortage of primary care providers seems to ensure that nurses will ultimately be required to practice to their fullest capacity. Fighting the expansion of nurse practitioners' scope of practice is no longer a defensible strategy. The challenge will be for all health care professionals to embrace these changes and come together to improve U.S. health care.

The views expressed in this article are those of the authors and do not necessarily represent those of their institutions.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania School of Nursing, Philadelphia (J.A.F.); the Robert Wood Johnson Foundation Initiative on the Future of Nursing, Institute of Medicine, Washington, DC (J.A.F., J.W.R., S.H., D.E.S.); the Department of Health Policy and Management, Mailman School of Public Health, Columbia University, New York (J.W.R.); and the University of Miami, Miami (D.E.S.).

See also related letters to the Editor (10.1056/NEJMc1013895).

This article (10.1056/NEJMp1012121) was published on December 15, 2010, at NEJM.org.

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EDITORIAL

Jeff Susman, MD
Editor-in-Chief

It's time to collaborate—not compete—with NPs

It is time—time to abandon our damagingly divisive, politically Pyrrhic, and ultimately unsustainable struggle with advanced practice nurses (APNs). I urge my fellow family physicians to accept—actually, to *embrace*—a full partnership with APNs.

Why do I call for such a fundamental change in policy? First, because it's the reality. In 16 states, nurse practitioners already practice independently. And in many more states, there is a clear indication that both the public and politicians favor further erosion of barriers to independent nursing practice. Indeed, such independence is outlined in "The Future of Nursing: Leading Change, Advancing Health," published by the Institute of Medicine (IOM) in October 2010. Among the IOM's conclusions:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Second, I believe our arguments against such a shift in policy don't hold up. Despite the endless arguments about outcomes, training, and patient preferences, I honestly believe that most nursing professionals—just like most physicians—practice within the bounds of their experience and training.

> Arguments FPs make against APNs sound like specialists' arguments against us

Indeed, the arguments family physicians make against APNs sound suspiciously like specialists' arguments against us. (Surely, the gastroenterologists assert, their greater experience and expertise should favor colonoscopy privileges only for physicians within their specialty, not for lowly primary care practitioners.) Rather than repeating the cycle of oppression that we in family medicine battle as the oppressed, let's celebrate differences in practice, explore opportunities for collaboration, and develop diverse models of care.

Third, I call for a fundamental shift in policy because I fear that, from a political perspective, we have much to lose by continuing to do battle on this front. Fighting fractures our support and reduces our effectiveness with our legislative, business, and consumer advocates.

Finally, I'm convinced that joining forces with APNs to develop innovative models of team care will lead to the best health outcomes. In a world of accountable health care organizations, health innovation zones, and medical "neighborhoods," we gain far more from collaboration than from competition.

As we ring in the new year, let's stop clinging to the past—and redirect our energies toward envisioning the future of health care.

Jeff Susman, MD

Clinical Outcomes: The Yardstick of Educational Effectiveness

American Academy of Nurse Practitioners

The safety and quality of nurse practitioner (NP) competency-based education has consistently been demonstrated through 40 years of patient care research. The yardstick of educational effectiveness should be based on patient outcomes. Educational preparation for physicians and nurse practitioners does differ. Although different, there is no evidence to suggest one is superior to the other in terms of patient outcomes, safety and quality of care provided. There are numerous studies that demonstrate nurse practitioners consistently provided high quality and safe care. In the over 100 studies on care provided by both nurse practitioners and physicians, not a single study has found that nurse practitioners provide inferior services.[1] In fact, these studies have shown NPs have the same or better patient outcomes when compared to physicians.

Three differences in education models between the professions make clinical outcomes a more effective determinant for safety.

1. NP students have formal academic preparation in healthcare before graduate school.

Prior healthcare education is a significant difference and deserves to be weighted in this discussion of education. NP students have had education and clinical experience in evaluating and managing patients even before they attend their first day of an NP program. This prior education included physical assessment skills, interpreting diagnostic test results, evaluating the appropriateness of medications and patients response to treatments in both hospital and community settings. The undergraduate platform of knowledge allows NP education to start at a more advanced level than other graduate health professional programs. Additionally, many nurse practitioner students have experience working as registered nurses prior to beginning their NP programs. During this time they have spent numerous hours caring for patients. This care has involved administering medications and required cautious consideration of pharmacological agents, as well as utilizing all the skills listed above.

2. NP students determine their patient population at the time of entry to an NP program.

Population focus from the beginning of educational preparation allows NP to education match the knowledge and skills to the needs of patients, and to concentrate the program of academic and clinical education study on the patients for whom the NP will be caring. For example, consider a primary care Pediatric NP. The entire time in didactic and clinical education is dedicated to the issues related to the development and healthcare needs of the pediatric client. While medical students and residents spend time learning how to manage adult clients and complete surgery rotations, a primary care pediatric nurse practitioner student's educational time is 100% concentrated on the clinical area where the NP clinician will actually be practicing.

3. NP education is competency-based, not time-based.

NP students must demonstrate that they have integrated the knowledge and skill to provide safe patient care. NP students do not progress or graduate based on the hours spend in a rotation or by the number of times they have seen a particular ailment; Instead, NP students progress only when knowledge and skill competency is achieved. While competency-based education has been the standard in nursing for decades, the concept is transitioning to other health professions. Medicine has recently begun to re-examine their time-based approach. After the 2010 Carnegie Report called for just such an innovation in medical education, Dr. William Hueston, a member of the American Academy of Family Physicians Commission on Education commented, "Both in medical student education and residency, we have clung to the belief that if you spend a certain amount of time learning about something, then you must know it." he told *AAFP News Now*. "That's as ridiculous as thinking that a teenager should be given a (driver's) license just because he or she spent a set number of hours behind the wheel of a car.[2]

Head to head comparison of educational models is not the appropriate measure of clinical success or patient safety. The appropriate measure is patient outcomes. Forty years of patient outcomes and clinical research demonstrates that nurse practitioners consistently provide high quality and safe care.

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

[2] Bein, B. (2010, June 26). Carnegie Report Calls for Key Innovations in Medical Education: Better Integration of Formal Knowledge, Clinical Experience Needed. *AAFP News Now*. Retrieved from http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-issues/20100629carnegiereport.html

National Administrative Office:
PO Box 12846
Austin, TX 78711
Phone 512 442-4262
Fax 512 442-6469
Email admin@aanp.org
Website www.aanp.org

Office of Health Policy:
[redacted]0130
[redacted]ton, DC 20016
Phone 202 966-6414
Fax 202 966-2856
Email dcoffice@aanp.org

#4

TESTIMONY

TO

HOUSE HUMAN SERVICES COMMITTEE

62ND NORTH DAKOTA LEGISLATIVE ASSEMBLY

BY

Kris Todd-Reisnour, FNP

MARCH 9, 2011

Madame Chairman Lee and Committee Members

My name is Kris Todd-Reisnour. I am a Family Nurse Practitioner (FNP) and I am here to testify in favor of SB 2148. I am one of the 4 Nurse Practitioners (NPs) in the state who are self-employed. I own and operate Dakota Osteoporosis in Bismarck. In this clinic I diagnose, educate and treat patients for osteoporosis and orthopaedic problems. Patient referrals come to me from physicians, other NPs, chiropractors, therapists as well as others.

My collaborating physician for prescriptive authority is Dr. Biron Baker at Medcenter One. My license requires that I contact Dr. Baker once every two months to discuss medication questions. Many prescriptions are written between those conversations. NPs must attain 15 contact hours pertaining

to pharmacology to renew my ND license. We must also work at least 1,000 hours every two years in patient care to be relicensed. We write our Scope of Practice (SOP) according to the job we have. NPs must also pass a certification test administered by a national agency. Every five years we must have 150 contact hours to be recertified.

When we work for an organization, a credentialing board determines what skills we can use in their facility depending on our previous training. After working in orthopaedics for many years I am allowed to perform joint injections and manage fractures. Someone who works in pulmonology may be allowed to perform thoracenteses if they have had the proper training and experience.

I am also a contract employee for a local medical facility seeing residents in long term care facilities for health problems. Often I contact other health care providers regarding medications and treatment recommendations. The health care provider I choose to contact may be a Family Practice physician, the NP who manages the dialysis unit, the surgeon when you find a mass or your favorite pharmacist depending on the patient's need. All NPs collaborate with the appropriate health care provider when practice and prescriptive issues arise. That is part of our training.

Our NDNPA members have gathered a significant number of signatures from physicians, hospital board members, pharmacists and county commissioners in support of SB 2148. The Ashley Hospital Board of Directors have all signed in support. We have received letters of support from many organizations: Community HealthCare Association of the Dakotas, AARP, American Academy of NPs, American College of NPs, National Council of State Boards of Nursing and many others listed for you.

As Secretary of NDNPA I receive emails from recruiting agencies and organizations at least monthly. They ask me to send out information to our membership regarding job openings for NPs in North Dakota communities. In the last two months there have been requests from Towner, New Town, Oakes, Grand Forks and Dickinson to name a few. It is difficult to recruit NPs from out of state if they have no connection with a ND physician and cannot find one willing to collaborate with them.

I worked with Lee Boyles, Administer of Oakes Community Hospital when he was looking for a NP. He sent a note I would like to share with you. "Good morning. I wanted to let you know that Oakes Community Hospital is in favor of this bill to remove the requirement of nurse practitioners (NPs) to have a formal collaborative agreement with a physician for prescribing medication. We have several nurse practitioners

employed by our hospital providing high quality and safe patient care in every department of our facility - outpatient clinic, inpatients, and emergency room patients. They provide all aspects of patient care, within their scopes of practice, without collaboration from a physician with the exception of prescription authority only. They do collaborate with whatever healthcare provider is appropriate for each patient on a more frequent basis than the every 2 months that the NP licensing requires. Eliminating the collaborative signature will not stop collaboration as our NPs know it takes a team approach to deliver healthcare in our rural settings.

Our mid-level providers, such as NPs, are a vital part of healthcare delivery in Oakes and rural communities in the state. The use of mid-level providers continues to grow and is the future of primary care by helping bridge the gap of the existing physician shortages. We have also found it is much easier to recruit quality mid-level providers to our rural communities (we've hired 5 mid-levels in the past 18-months vs. 1-physician), thus improving access to primary care for our region's patients. Through the use of new technology, ePharmacy and eEmergency, our mid-levels have another entire level of collaboration to provider quality, safe care, when the need consulting a physician or pharmacist does arise.

In summary, we are in favor of the bill to remove the collaborative agreement for nurse practitioners. Please let me know if you have any questions. Thank you for your time on this bill, we really appreciate it. Sincerely, Lee Boyles, Administrator Oakes Community Hospital"

In closing I would like to leave you with a question. One of our members is a NP who practices in Westhope with a 76 year-old collaborating physician. When he is no longer practicing will she be able to find a new collaborating physician outside the community to sign on? Or will the community lose two health care providers?

I urge you to support Senate Bill 2148. Thank you for allowing me to share my thoughts with you today. This Bill is not only important to me but also to healthcare access in North Dakota.

If you have any questions please feel free to contact me.

Kris Todd-Reisnour, FNP
Secretary NDNPA
ktodd@bis.midco.net
471-3813

AARP North Dakota
107 W. Main Avenue
Suite 125
Bismarck, ND 58501

T 1-866-554-5383
F 701-255-2242
TTY 1-877-434-7598
www.aarp.org/nd

Cheryl Rising
North Dakota Nurse Practitioner Association
8300 Burnt Creek Island Road
Bismarck, ND 58503

Dear Ms. Rising,

North Dakota residents need access to high quality health care offered by primary care providers, especially in our underserved rural and urban communities. Along with the rest of the country, our state is facing a shortage of primary care providers who can care for people of all ages, but particularly those with multiple chronic conditions. Consider the numbers, according to a 2010 study by the University of North Dakota, 89% of North Dakota's counties are partially for fully designated as Primary Care Health Professional Shortage Areas.

Nurse practitioners are part of the solution; North Dakota has 350 nurse practitioners. But state laws limit our ability to access the care they provide.

North Dakota state legislators and the Governor have an opportunity to bring much needed primary care to tens of thousands of North Dakota residents with the bill introduced by Senator Lee, which would amend and re-enact Section 43-12. 1-18 of the North Dakota century code relating to the prescriptive standards for advanced practice registered nurses (APRNs). Such a legislative change would make fundamental and necessary changes to how nurse practitioners can provide the health care services for which they are trained, skilled and licensed.

Nurse practitioners and other APRNs provide primary care and women's health services, and help patients manage chronic conditions such as diabetes, among other important health services. Yet, North Dakota laws limit the consumer's ability to access these services by requiring nurse practitioners and other APRNs to practice under physician supervision, through a collaborative agreement. This is particularly troubling for our residents who live in rural areas, where a severe shortage of physicians is prevalent, making it a challenge for nurse practitioners to find physicians for oversight. If enacted, this bill would eliminate waiting periods of up to six months for nurse practitioners to provide care. These waiting periods delay APRNs' ability to write prescriptions, diagnose problems, refer patients to specialists and perform diagnostic testing. As a result, North Dakota residents struggle with undiagnosed ailments, go without medication, and their health declines.

That is why AARP North Dakota urges the State Legislature and the Governor to remove barriers that prevent APRNs from providing the health care services we need.

APRNs are registered nurses with advanced training in preventing, diagnosing, and treating illness, licensed to write prescriptions. These health care professionals hold two nursing degrees (an undergraduate and Master's degree), and must complete supervised clinical training and testing by national accrediting bodies in nursing. Similar to other health care professionals, once certified by the state, APRNs broaden their skill-base through continuing education and experience. APRNs

are educated and trained to do what we need them to do – care for those who need primary, preventive, and chronic care.

Studies demonstrate that APRNs deliver safe and effective health care to all populations, across settings, and in many specialties. In fact, research shows no difference in outcomes of primary care delivered by APRNs and physicians, including patient health status, number of prescriptions written, return visits requested, or referrals to other providers. A recent review of the quality and effectiveness of care provided by APRNs from 1990 to 2008 found that APRNs provide as high a quality of care as physicians.

North Dakota already faces a severe shortage of health care providers. We will benefit by removing barriers that prevent APRNs from practicing to their full level of education, expertise and licensure.

Janis S Cheney, Senior State Director

AARP North Dakota

Altru
Health System

P.O. Box 6002
Grand Forks, ND
58206-6002
(701) 780-5000 *phone*
altru.org *web*

October 19, 2010

Cheryl Rising
President of NDAPN
905 Dodge Circle
Bismarck, North Dakota 58501

Cheryl,

I am sending this letter to you, offering our support for the legislative change – so Nurse Practitioners would no longer need a collaborative letter with a physician for prescriptive practices. As president of the North Dakota Organization of Nurse Execs, I give you the support of our organization for this legislation. Good luck.

Sincerely,

Margaret Reed RN

Margaret Reed, RN
Chief Nurse Executive
Altru Health System

South Dakota

1400 West 22nd Street
Sioux Falls, SD 57105-1570

phone: (605) 357-1515
fax: (605) 357-1510

25th Anniversary

CHAD

Community HealthCare Association of the Dakotas

North Dakota

1003 East Interstate Avenue
Suite 1
Bismarck, ND 58503

phone: (701) 221-9824
fax: (701) 221-0615

January 11, 2011

To Members of the 62nd Legislative Assembly:

On behalf of the member Community Health Centers in North Dakota, I am writing in support of the proposed legislation to modernize and update the requirements of their advance practice registered nurse standards found in SB 2148.

In reviewing the rationale and the literature put forward by the American Academy of Nurse Practitioners, our North Dakota Health Center members support the ability of Nurse Practitioners to meet the intent of their scope of practice with the changes proposed in the legislation. Nurse Practitioners have proven to be valuable also providers of health care, particularly primary health care, in North Dakota. The Practice Act governing their work and standards should be allowed to stand on their own and to reflect the quality of their preparation and competencies.

Sincerely,

Karen E. Larson

Karen E. Larson, Deputy Director

C: Scot Graff, CEO
Sharon Ericson, Valley Community Health Centers
Patricia Patron, Family HealthCare Center
Joan Altenbernd, Migrant Health Services
Faye Hagen, Northland Community Health Center
Dawn Berg, Coal Country Community Health Center

Cavalier County, North Dakota
Office of Auditor

901 Third Street - Suite 15
Langdon, ND 58249
(701) 256-2229
(701) 256-2546 (fax)

Dawn Roppel - Auditor
Lisa Gellner - Deputy Auditor
Pam Lafrenz - Office Clerk

Honorable Senator Judy Lee

We, the Cavalier County Commissioners, voted at our December 21, 2010, meeting to support the elimination of the requirement for a physician signature on Nurse Practitioner prescriptive privilege licensure. We believe it is an unnecessary formality which does not improve quality or safety of NP practice. We believe, also, NP's assess, diagnose, and treat acute and chronic diseases. The passage of this bill eliminating the signature requirement will improve access to healthcare and position North Dakota to improve the recruiting of NP's into this fine state. We believe this will help eliminate the primary care provider shortage in North Dakota. We want to take this opportunity to thank you for sponsoring this bill, and again, reiterate our support for it. We appreciate the endless hours and dedication our NP's do in our community and county.

Cavalier County Commissioners

COLLEGE AND UNIVERSITY NURSING EDUCATION ADMINISTRATORS

Dakota Nursing Program

Dickinson State University
Department of Nursing

Jamestown College
Department of Nursing

Medcenter One
College of Nursing

Minot State University
Department of Nursing

Sitting Bull College
Department of Nursing

[redacted] Dakota State
[redacted]ge of Science
Department of Nursing

North Dakota State University
Department of Nursing

United Tribes Technical College
Department of Nursing

University of Mary
Division of Nursing

University of North Dakota
College of Nursing

November 29, 2010

To NDNPA:

The College and University Nursing Education Administrators (CUNEA) has voted to support the legislative bill to eliminate the required signature for prescriptive privileges for advanced practice registered nurses.

Respectfully,

Kelly Buettner-Schmidt, Co-Chair

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881
Telephone: (701) 328-9777 Fax: (701) 328-9785
Web Site Address: http://www.ndbon.org

Workplace Impairment Program: (701) 328-9783

To: **ND Nurse Practitioners Association**
Cheryl Rising APRN, FNP, President

From: **ND Board of Nursing**
Buzz Benson RN, President

Re: **Support of proposed legislation to amend the NDCC 43-12.1 -18. Nursing Practice Standards**

Date: **September 28, 2010**

The North Dakota Board of Nursing met on September 16, 2010 and discussed the request for NDBON support for the legislative proposal to amend NDCC 43-12.1-18 Nursing Practice Standards. The NDBON reviewed the Nurse Practices Act as it relates to the submission of a collaborative agreement for granting prescriptive authority for APRNS. Brian Bergeson, SAAG, reviewed applicable law related to the collaborative agreement and determined that this was a requirement in the NDCC 43-12.1-18 Nursing Practice Standards.

Therefore the Board made the following motion:

Motion: Rustvang, seconded by Traynor to:

SUPPORT A LEGISLATIVE PROPOSAL TO AMEND NDCC 43-12.1-18 NURSING PRACTICE STANDARDS THAT WOULD ELIMINATE THE REQUIREMENT OF A COLLABORATIVE AGREEMENT WITH A LICENSED PHYSICIAN FOR PRESCRIPTIVE AUTHORITY.

Roll call vote: Anderson, yes; Benson, yes; Christianson, yes; Frank, yes; LaLonde, yes; Levi, yes; Rustvang, yes; Smith, yes; Traynor, yes;
9 yes, 0 no, 0 absent. Motion carried.

Thank you for this opportunity to provide support for the APRNs to practice to their full scope of practice.

NDANA
North Dakota Association of Nurse Anesthetists
P.O. Box 1755 • Bismarck, ND 58502-1755 • Phone 701-221-7797 • Fax 701-224-9824 • ndana@aptnd.com • www.ndana.org

Chery Rising
North Dakota Nurse Practitioner Association
905 Dodge Circle
Bismarck, ND 58503

November 4, 2010

Ms. Rising:

The North Dakota Association of Nurse Anesthetists supports the NDNPA proposal to remove the requirement for collaborative agreements from the regulation of nurse practitioners.

The North Dakota Association of Nurse Anesthetists represents more than 200 advanced practice, Certified Registered Nurse Anesthetists, practicing in all settings across the state. From urban to rural facilities, sole provider and in a team approach, CRNAs provide safe, quality care, administering anesthesia to the vast majority of North Dakota patients. This care allows surgical, obstetrical, and trauma stabilization services in hospitals and clinics, increasing access to health care throughout our state.

NDANA supports CRNAs practicing to the fullest extent of the scope of practice. ND law does not, and never has required physician supervision of the CRNA or any collaborative arrangement with a physician for the administration of anesthesia. It has been our position that any such requirement is not in the best interest of the health care of ND citizens as it would create barriers to access. Additionally, national studies have shown no difference in outcomes where the CRNA practices with or without physician supervision.

The NDANA board received your information proposing to "Update the regulation requirements of nurse practitioners to improve healthcare workforce utilization in North Dakota while maintaining safety." Your proposal to remove the requirement for collaborative agreements is consistent with the NDANA position to improve access to safe, quality healthcare throughout ND. Additionally, NDANA agrees with your position that such requirements "...do not assure patient safety, improve quality of care, or lead to meaningful intra-disciplinary or integrated practice." In fact, often such requirements, especially in a rural state like ND, limit access to meet the healthcare needs of the citizens.

Sincerely,

Jody Slominski, CRNA, MSN

Jody Slominski, CRNA, MSN
President

NDNA

PO Box 292 ✧ Mandan, ND ✧ 58554
701-223-1385

The Nursing Scope and Standards of Practice, 2nd Ed. published in 2010 by the American Nurses Association lists the standards of practice for all nurses. These standards include assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The standards of coordination of care, health teaching and promotion, consultation and prescriptive authority and treatment further define the standard of implementation. Consultation and prescriptive authority and treatment are specifically aimed at the advanced practice nurse. To complete the list of standards, the standards of professional performance include: ethics, education, evidence-based practice, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health. These standards are foundational in practice descriptions for the Registered Nurse and subsequently the APRN, thus being the basis for state law and regulation which further define criteria for the licensure and description of the scope of practice.

The APRN scope of practice already mandates the APRNs use a process that ensures patient safety by following well accepted national standards of practice. It is expected that all nurses as well as advanced practice nurses fulfill their contract with society by being accountable to the public by meeting the Scope and Standards of Practice and the Code of Ethics. The Nurse Practices Act and Rules and Regulations further promote safety through self regulation and individuals are further overseen by institutional policy and procedures, credentialing and reviews all based upon these Codes and Standards.

Based on the solid foundation upon which the APRN scope of practice has been developed, and the fundamental belief that practice is self-governing and that the standards describe accountabilities to society, NDNA fully supports removal of the regulatory requirement for collaborative agreement for prescriptive privileges as presently written in the ND Nurse Practices Act.

Shanda Rose PhD, RNBC
NDNA President

ACNP

AMERICAN COLLEGE OF NURSE PRACTITIONERS

December 14, 2010

To whom it may concern,

This letter is being sent in support of the North Dakota Nurse Practitioner Association's legislative efforts to change the Nurse Practice Act, Chapter 43-12.1-18 Nursing Practice Standards. Currently the standard reads that in order to have prescriptive authority NPs must "include evidence of a collaborative agreement with a licensed physician." The NDNPA is seeking to remove this barrier to full, appropriate NP practice.

There are currently fifteen states that do NOT require NPs to have any type of relationship with a licensed physician to prescribe medications, with many of them having prescriptive "independence" for over 20 years.

In July of 2008, the National Council of State Boards of Nursing released its document "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education." In this document, the definition of an APRN "includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and **prescription of pharmacologic** and non-pharmacologic interventions" (p.7). (www.ncsbn.org/170.htm) Removal of the clause "include evidence of a collaborative agreement with a licensed physician" will bring the North Dakota Nurse Practice Act into alignment with the recommendations and direction of the National Council of State Boards of Nursing, and remove barriers to full and appropriate practice for Nurse Practitioners and their patients.

Should you want any further information regarding Nurse Practitioners having independent prescribing privileges, please feel free to contact me at President@ACNPweb.org.

Regards,

Marsha Siegl

Marsha Siegel, EdD, FNP-BC
President
ACNP Board of Directors

ACNP ❖ 1501 Wilson Boulevard, Suite 509 ❖ Arlington, VA 22209
Tel: 703/740-2529 ❖ Fax: 703/740-2533 ❖ Email: ACNP@acnpweb.org ❖ www.acnpweb.org

AMERICAN ACADEMY OF NURSE PRACTITIONERS

Incorporated 1985

Administration: PO Box 12846 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: admin@aanp.org · Web Site: www.aanp.org

Office of Health Policy: PO Box 40130 · Washington, DC 20016 · 202-966-6414 · Fax: 202-966-2856 · E-mail: dcoffice@aanp.org

Journal (JAANP): PO Box 12965 · Austin, TX 78711 · 512-442-4262 · Fax: 512-442-6469 · E-mail: journal@aanp.org

December 1, 2010

Senator Lee
North Dakota State Capitol
600 East Boulevard
Bismarck, North Dakota 58505

Re: Updating the Regulatory Statutes for Nurse Practitioner Prescribing (ND Century Code 43-12.1-18)

Dear Senator Lee,

On behalf of the American Academy of Nurse Practitioners (AANP), our North Dakota nurse practitioners members and the patients served by the North Dakota nurse practitioner community, I am writing to express support for the proposed updates to nurse practitioner prescribing section of 43-12.1-18 of the North Dakota Century Code.

Nurse practitioners are primary care providers who evaluate, diagnose, order and interpret diagnostic tests, and initiate and monitor treatments—including writing prescriptions. For nearly half a century, nurse practitioners have cultivated a track record for providing high quality, safe and cost effective care across all care settings. Today, North Dakota is in a situation where we have well equipped clinicians that are restricted from providing care at the top of their education and abilities because of outdated legislative and regulatory language. Discussions with our North Dakota nurse practitioner members have made it clear that the outdated requirement for a collaborative agreement with a physician for nurse practitioner prescribing is failing to add safety, quality, integrated communication, or coordination to patient care. Instead, it has become an unnecessary formality that has set up barriers to practice, decreased access to care, and clouded the public transparency around prescribing accountability.

The AANP recommends the removal of the outdated requirement for a collaborative agreement for prescribing. In fact, AANP is not alone in recommending that outdated legislative barriers to practice be removed.

- The Institute of Medicine, "The Future of Nursing: Leading Change, Advancing Health," publication released October 2010 recommends that "advanced practice registered nurses should be able to practice to the full extent of their education and

training." To achieve this goal, the IOM committee recommends that state legislatures "reform the scope-of-practice regulations to confirm to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules"

- The Josiah Macy Foundation's 2010 "Who will provide primary care and how will they be trained?" summary recommends that "policies be changed to remove barriers that make it difficult for nurse practitioners and physicians assistants to serve as primary care providers and leaders of the patient-centered medical home of other models of primary care delivery."
- Consumer groups are additionally supporting updating practice regulation to provide for greater access. In March 2010, the AARP released the following policy statement, "Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification."

- 14 states and the District of Columbia have already adopted similar updates that no longer require links to a physician for practice and prescribing—some states have had these updates for over a decade.

The proposed language update to 43-12.1-18 is consistent with these national recommendations and with the national trends in regulating nursing practice. This language update will help address the healthcare workforce challenges facing North Dakota, and maintain the strong commitment to public safety and quality of nurse prescribing under the direct authority of the Board of Nursing. This change to the regulation of nurse practitioner prescribing will not alter the scope of practice.

The American Academy of Nurse Practitioners, along with our North Dakota membership, respectfully asks the Legislature to ensure that North Dakota effectively utilizes the healthcare workforce by updating 43-12.1-18 to align with the National Council of State Boards of Nursing (NCSBN) regulatory framework for advanced practice nurses. We appreciate the opportunity to provide comment to this legislative process and its implication to care delivery. If there are any questions regarding the AANPs comments, please contact our health policy office at (202) 966-6414.

Sincerely,

Tay Kopanos, DNP, NP
Director of Health Policy, State Government Affairs

February 28, 2011

Via Email to: rweisz@nd.gov

Robin Weisz, Chairman
House Human Services Committee
State Capitol 600 East Boulevard
Bismarck, ND 58505-0360

RE: **S. 2148**

Dear Chairman Weisz:

I am writing on behalf of the American College of Nurse-Midwives, the national professional organization representing the interests of certified nurse-midwives (CNMs) and certified midwives (CMs). ACNM, along with its North Dakota affiliate, strongly supports Senate Bill 2148.

The bill, which passed the Senate earlier this year, is slated for consideration by your committee in early March. This critical legislation will eliminate the onerous, unnecessary requirement for a **collaborative prescriptive agreement** between an advanced practice registered nurse (APRN) and a physician practicing in North Dakota.

Certified nurse-midwives are licensed in North Dakota as a category of APRN. CNMs serve as primary care providers for women throughout the lifespan; they receive stringent education and are fully trained to exercise plenary prescriptive authority without any formal contractual relationship with a physician. Core competencies included in all nationally accredited midwifery education programs feature in-depth pharmacology components that support full prescribing privileges.

CNMs have a rich tradition of providing health services to rural areas and underserved populations. Retention of this archaic requirement impedes timely care to women and their families. The administrative burden on the midwife, collaborating physician and health care facility brings frustration, delay and potentially even vicarious or direct liability to the physician.

By way of example, a midwife duly licensed to practice in North Dakota may need to prescribe and quickly have the prescription filled for certain drugs or medications; under current law, these may be held up in order that the collaborative agreement physician approve the prescription. Yet in neighboring jurisdictions, identical prescription-writing is seamlessly facilitated. Under North Dakota law, not only may the provision of direly needed drugs be delayed without justification, the collaborating physician who is party to the contractual arrangement with the midwife, and who may never have met or examined the midwife's patient, could face liability to the midwife's patient if there is an untoward reaction to the medication or if the delay in approving, filling and taking the prescription occasions additional harm.

8403 Colesville Road, Suite 1550, Silver Spring, MD 20910-6374 240.485.1800 fax: 240.485.1818 www.midwife.org

North Dakota bases the scope of practice of an APRN "upon an understanding that a broad range of health care services can be appropriately and competently provided by a registered nurse with validated knowledge, skills, and abilities in specific practice areas. The health care needs of citizens of North Dakota require that nurses in advanced practice roles provide care to the fullest extent of their scope of practice. The [APRN] retains the responsibility and accountability for that scope of practice and is ultimately accountable to the patient within the nurse Practice Act." [*See* N.D.A.C. §54-05-03.1.01]

Additionally, APRNs must demonstrate education in pharmacotherapy related to their scope of advanced practice, which must include "pharmacokinetic principles and their clinical application and the use of pharmacological agents in the prevention of illness, restoration, and maintenance of health," and must have been obtained either from a formal advanced education program or accredited continuing education. Renewal of prescriptive authority every two years requires completion of additional continuing education. [*See* N.D.A.C. §§54-05-03.1-09 through 54-05-03.1-11]

Legislation to ensure certified nurse-midwives may practice to the full extent of their training and education is widely-recommended. The Pew Health Professions Commission in its 1999 report *"The Future of Midwifery"*[1] addresses the need for legislative and regulatory entities to imbue midwives with the rights and responsibilities regarding scope of practice authority and accountability that all independent professionals share. The Robert Wood Johnson Foundation and the Institute of Medicine's 2010 report likewise supports elimination of such restrictions on practice.[2] The National Council of State Boards of Nursing (NCSBN) *Consensus Model for APRN Regulation* is also supportive and addresses the change this bill would make.[3] The Consensus Model seeks to ensure uniformity in licensure, accreditation, certification, and education to facilitate the regulation of safe and competent advanced practice registered nurses (APRNs).

ACNM urges swift approval of this vital, overdue legislation. To reiterate by way of emphasis a portion of the North Dakota's Administrative Code cited above: "The health care needs of citizens of North Dakota require that nurses in advanced practice roles provide care to the fullest extent of their scope of practice." Enactment of SB 2148 will help North Dakota meet this essential stated policy goal. Thank you.

Sincerely,

Joanna M. King
Director, Government Relations

---

[1] Dower, C., Miller, J., O'neil, E., & the Taskforce on Midwifery. (1999). *Charting a Course for the 21st Century: The Future of Midwifery.* San Francisco, CA: Pew Health Professions Commission and the UCSF Center for the Health Professions.

[2] Institute of Medicine (2010). The Future of Nursing: Leading Change, Advancing Health. http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf

[3] National Council of State Boards of Nursing. (2008) *Consensus Model for APRN Regulation.* www.ncsbn.org/aprn.htm

8403 Colesville Road, Suite 1550, Silver Spring, MD 20910-6374 240.485.1800 fax: 240.485.1818 www.midwife.org

SIGNATURES of SUPPORTING PHYSICIANS

Corey Arcelay, MD

Biron Baker, MD

Robert Bathurst III, MD

Gretchen Belzer Curl, MD

Paula Bercier, MD

Paul Beauclair, MD

Jan Bexell-Gierke, MD

Michael Cassidy, MD

Anthony Chu, MD

Kurt Datz, DO

Kent Diehl, MD

Jon Dickson, MD

Russell Emery, MD

Napoleon Espejo, MD

Siri Fibiger, MD

Kevin Folkers, MD

Greg Glasner, MD

Michael Grandison, DO

Doug Grissom, MD

Larry Halvorson, MD

Thomas Hardis, MD

David Hartfield, MD

Mary Holm, MD

Anthony Johnson, MD

Richa Kaushik, MD

Kenneth Kihle, MD

John Kim, MD

Darwin Lange, MD

Gordon Leingang, DO

Keith Lesterburg, MD

Lara Lunde, MD

Tracie Mallberg, MD

Candelaria Martin, MD

Kent Martin, MD

Tracy Martin, MD

Robert Martino, MD

Steve Mattson, MD

Thomas Matzke, MD

John Mickelson, MD

Kristi Midgarden, MD

Niral Patel, MD

Suresh Patel, MD

David Pengilly, MD

Mark Peterson, MD

William Pryatel, MD

Sandra Robinson, DO

Jamie Roed, MD

Ben Roller, MD

Kinsey Schultz Piatz, MD

Fauna Shruji, MD

Philip Sondrol, MD

Jerry Smith, DO

Stuart Smith, MD

Sherry Stein, MD

Eric Thompson, MD

Tom Thorson, MD

Michael Tilus, MD

Michelle Tincher, MD

Udom Tinsa, MD

Matthew Viscito, MD

Karin Willis, MD

Terry Wolf, DO

Marcel Young, MD

#5

Family Nurse Practitioner Scope of Practice
With Prescriptive Authority

Location Optional: I plan to practice as a Family Nurse Practitioner at Dakota Osteoporosis Inc., long term care facilities and in other clinics.

My scope of practice will include:

1). FOCUS OF CARE:

A. Primary care includes identification and/or referral of health problems as well as promotion of health maintaining behaviors and prevention of illness.

B. Providing care in the rural health care clinic, home, long-term and acute care settings.

C. Coordination of care and advocating for the client in the health-care settings.

D. Comprehensive assessment and decision making about the care needs of individuals, families and groups.

E. Working interdependently with other health care providers, including physicians, in responding to the health care needs of the rural areas in which the clinics are located.

F. Collaboration and oversight for medical grade skin care treatments.

2). ELEMENTS OF CARE:

A. Assessing the health status, illness conditions, responses to illness and health risks through history taking, physical examination, laboratory data;

B. Diagnosing the actual or potential health problems or needs based on analysis of the data collected;

C. Planning therapeutic interventions with the client or family;

D. Intervening to assist the client's participation to the fullest extent. Intervention includes measures to promote health, manage chronic illness or treat illness in its' earliest stages to prevent disability. Intervention may include but is not limited to direct nursing care, transmittal of physician orders for medications and consultation or referral to other health care providers; and

E, Evaluation of the effectiveness of care individually or over-all through regular care review of the client health status or participation in the institutional quality assurance activities.

3). TYPE OF CLIENT:

Provide primary health care services to individuals, families and groups throughout the life span in a predominantly rural setting and acutely ill clients in the hospital.

4). CONSULTATION PATTERNS:

These consults will be in the form of direct on-site, telephonic, facsimile communication or interactive video consultation with other health-care providers. Consultation and collaboration will be documented in the health care record. For problems outside the scope of practice clients are to the appropriate provider.

Family Nurse Practitioner Scope of Practice
With Prescriptive Authority
(continued)

5.) COLLABORATION FOR PRESCRIPTIVE PRACTICE:

A. Broad Classification of Drugs or Devices: Medical agreement with Biron Baker, MD provides mutual agreement on medications commonly prescribed and renewed for patients in the clinic or acute care setting. Medications include but are not limited to: bisphosphonates, analgesics, antibiotics, anti-inflammatory agents, diabetic agents, hormones, laxatives, muscle relaxants, respiratory drugs, sedatives, urinary tract agents, cardiovascular agents and vaginal preparations.

B. Methods and Frequency of Collaboration: Collaboration and consultation occurs by telephone, face to face meetings or in writing as client need dictates on a daily or weekly basis. Each means of communication is initiated by either party.

C. Documentation of Collaboration: Documentation of collaboration and consultation are kept in the patient's record which is confidential.

D. Alternative Arrangements for Collaboration: a physician from Family Medical North Clinic will serve as a collaborating physician in the temporary absence of Biron Baker, MD.

COLLABORATIVE PRACTICE AFFIDAVIT
PHYSICIAN AGREEMENT - PRESCRIPTIVE AUTHORITY
NORTH DAKOTA BOARD OF NURSING

NDAC 54-05-03.1-09 (4)
Submit an affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice.

Physician Name: Biron Baker	APRN Name: Kristie Todd
Physician's Medical Specialty or Practice: Family Practice	APRN Scope of Prescriptive Practice: Family Nurse Practitioner

I, the above named physician, have agreed to a collaborative practice arrangement with the above named advanced practice registered nurse for purposes of prescriptive authority.

Collaboration means the process in which an authorized registered nurse (licensed by the Board of Nursing as an Advanced Practice Registered Nurse) functions with a licensed physician for review and approval of planned prescriptive practices. Collaboration includes systematic formal planning and evaluation between the professionals involved in the collaborative practice arrangements.

NOW, THEREFORE, APRN and PHYSICIAN certify and agree to the following:

1. This agreement is valid for the same period of time as the advanced practice registered nurse licensure period unless terminated by either party.

2. This agreement may not be assigned by either APRN or PHYSICIAN and does not establish an employee/employer relationship.

3. APRN certifies that he/she has never been excluded from participating in any federal health care program, as defined under 42 U.S.C. § 1320a-7b and, to APRN's knowledge there are no pending government investigations that may lead to such exclusion. APRN shall notify PHYSICIAN of a commencement of any such exclusion or investigation against the APRN within seven (7) days of APRN first learning of such investigation. PHYSICIAN may terminate this agreement immediately upon notification of such exclusion or investigation.

4. PHYSICIAN certifies that he/she has never been excluded from participating in any federal health care program, as defined under 42 U.S.C. §1320a-7b and, to PHYSICIAN'S knowledge there are no pending government investigations that may lead to such exclusion. PHYSICIAN shall notify APRN of a commencement of any such exclusion or investigation against the physician within seven (7) days of PHYSICIAN first learning of such investigation. APRN may terminate this agreement immediately upon notification of such exclusion or investigation.

5. This agreement is automatically terminated if adverse disciplinary action is ordered against PHYSICIAN by the North Dakota Board of Medical Examiners, or if adverse disciplinary action is ordered against APRN by the North Dakota Board of Nursing. Under such circumstances a new agreement may be executed between the APRN and the PHYSICIAN provided that all conditions resulting from disciplinary action have been reflected in such new agreement.

6. APRN may prescribe and renew classification of drugs or devices, which shall be limited to the scope of practice of the APRN and the PHYSICIAN. List below exclusions, if any. None

7. APRN scope of practice is attached to this agreement and is made a part thereof by reference. Classifications or medications include but are not limited to the following:
bisphosphonates, analgesics, antibiotics, anti-inflammatory agents, diabetic agents, hormone therapy, laxatives, muscle relaxants, respiratory drugs, sedatives, urinary tract agents, cardiovascular agents and vaginal preparations.

8. The prescribing practices shall be periodically reviewed (at least once every two months) by the APRN and collaborating physician to assure that the prescribing is within the identified scope of practice. Methods and frequency of consultations under NDAC 54-05-03.1-09(4) and NDAC 54-05-03.1-11(6) between PHYSICIAN and APRN shall be as follows:
Telephone, face to face meetings or in writing as client need dictates on a weekly or daily basis. Each means of communication can be initiated by either party

9. PHYSICIAN shall notify APRN in writing of the name, address, and telephone numbers of the physician who shall be available to the APRN to provide immediate consultation for any medical issue that may arise which APRN believes should be addressed by a licensed physician when PHYSICIAN is absent or unable to consult with APRN.

10. If any term or provision of this agreement is declared by a court having jurisdiction to be illegal or unenforceable, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties are to be construed and enforced as if the contract did not contain that term or provision.

11. This agreement is governed by the laws of the state of North Dakota.

12. This agreement may not be waived, altered, modified, supplemented or amended, in any manner, except by written agreement signed by both parties.

APRN Name (please print or type) Kristie Todd		Telephone Number 701-222-0707	
Address 8300 Burnt Creek Island Road	City Bismarck	State ND	Zip Code 58503
Specialty/Area of Practice Family Nurse Practitioner		License Registration Number R25050	

APRN AFFIDAVIT

STATE OF North Dakota)

COUNTY OF Burleigh)

I, being duly sworn, state that I am the APRN who is referred to in the foregoing Collaborative Practice Affidavit Physician Agreement- Prescriptive Authority, that the statements contained herein are strictly true in every respect, and that I have read and understand this affidavit.

Kristie Todd
Signature of APRN

Subscribed and sworn to before me on 2/19/09
(Date)

Candy M. Riffey
Notary Public

My Commission expires August 15, 2013

NOTARY SEAL

CANDY M. RIFFEY
Notary Public
State of North Dakota
My Commission Expires Aug. 15, 2013

Physician's Name (please print or type) Biron Baker		Telephone Number 701-323-6400	
Address 2830 N Washington St	City Bismarck	State ND	Zip code 58501
Specialty/Area of Practice Family Practice		License Registration Number	

PHYSICIAN AFFIDAVIT

STATE OF North Dakota)

COUNTY OF Burleigh)

I, being duly sworn, state that I am the physician who is referred to in the foregoing Collaborative Practice Affidavit Physician Agreement- Prescriptive Authority, that the statements contained herein are strictly true in every respect, and that I have read and understand this affidavit.

Signature of Physician

Subscribed and sworn to before me on 2/19/09
(Date)

Candy M Riffey
Notary Public

My Commission expires August 15, 2013

NOTARY SEAL

CANDY M. RIFFEY
Notary Public
State of North Dakota
My Commission Expires Aug. 15, 2013

NORTH DAKOTA BOARD OF NURSING
919 S 7th STREET, SUITE 504
BISMARCK, ND 58504-5881
(701) 328-9777
Web Site www.ndbon.org

MEDCENTER ONE
BISMARCK, NORTH DAKOTA 58501

APPLICATION FOR CLINICAL PRIVILEGES - NURSE PRACTITIONER

Your Name: Kristie Todd Reisnour Supervising Physician: B. Baker

Nurse Practitioner	Graduate Nurse Practitioner program RN/NP licensure North Dakota Board of Nursing Prescriptive Authority ND Board of Nursing Current DEA registration

General practice includes:

Performance of history and physical examination
Admission and Discharge summaries
Diagnosis, treatment, management of common, acute or chronic, emergent conditions in hospital/clinic settings
Order and review laboratory tests, radiological studies
Prescribe treatment modalities including prescriptive medications

Initial Clinical privileges:

- ✓ Local anesthetic, regional blocks
- ✓ Incision/drainage infected or noninfected cysts and abscesses
- ✓ Incision/removal of foreign body
- ✓ Drainage of hematoma
- ✓ Avulsion, nail (partial or complete)
- ✓ Nail debridement
- ✓ Initial treatment, first degree burns (no more than local treatment necessary)
- ✓ First degree burns, less than 50%, without consultation
- ✓ Second degree burns (consultation required for greater than 10% or involving the face)
- ✓ Electro/surgical destruction (with or without surgical currettement) leukoplakia, actinic or senile keratosis, keratoacanthomas, to include anesthesia.
- ✓ Drainage of onychia or paranychia
- ✓ Biopsy of skin, subcutaneous tissue, mucous membranes with/without suturing
- ✓ Repair of lacerations
- ✓ Electro/surgical destruction of multiple fibrocutaneous tags
- ____ Electro/surgical/chemical destruction of flat (plantar/juvenile) warts

✓ Simple fracture, no reduction

✓ Bursae aspiration

_____ Endotracheal intubation, emergency procedure
_____ Control of epistaxis
_____by nasal packing
_____by distal cautery
_____ Nasal fracture, simple, no reduction
_____ Enucleation or excision of external thrombotic hemorrhoid
_____ Destruction of condyloma
✓ Incision and drainage of Bartholin's gland abscess, unilateral

_____ Removal of foreign body from surface of cornea
_____ Use of slit lamp for diagnosis and treatment
_____ Removal of foreign body from surface of conjunctiva
_____ Tonometry

_____ Pap smear, conventional or Thin Prep

✓ Determination of death
_____ Injection of medication for pharmacologic testing
_____ Access AV fistula/graph
_____ Port-a-cath access

Other :
Joint injections.

DATE: 2-25-11 SIGNATURE OF APPLICANT: Kristi Todd Bishop

DATE: 2-28-11 SIGNATURE OF COLLABORATING PHYSICIAN: [signature]

DATE: _____ SIGNATURE OF SERVICE LINE CHAIR: _____

#6

TESTIMONY

TO

HOUSE HUMAN SERVICE COMMITTEE

62ND ND LEGISLATIVE ASSEMBLY

BY

GWEN WITZEL NP, FAMILY NURSE PRACTITIONER,

AMERICAN ACADEMY OF NURSE PRACTITIONERS (AANP)

BOARD OR DIRECTORS REGION 8

March 9, 2011

Mr. Chairman and Members of the Committee

My name is Gwen Witzel, Family Nurse Practitioner (FNP) and a primary care provider in a rural community in ND, and I am here to testify in support of Senate Bill 2148. I practice in a critical access hospital covering the clinic, emergency room and have hospital admitting privileges. I was selected as ND 2009 Rural Health Provider of the Year, which is an award presented by the Center for Rural Health, UND, and the UND School of Medicine and Health Sciences. I

mention this to demonstrate that my practice is busy and recognized as providing high quality health care.

My collaborating physician for prescriptive privileges is Dr Tracie Mallberg who is a Family Practice Physician and owner of Lilycare Clinic in Fargo which is 180 miles from my practice location. Dr Mallberg and I do not practice together, nor is she responsible for my practice, and is not responsible for reviewing my medical records. I had requested Dr Mallberg to sign the affidavit when she was doing locum coverage at the facility I work. During that time my community did not have any regular physician on staff. Her signature on my license meets the requirement of the law but does not provide for any direct oversight of my practice or my prescriptive writing. I was lucky to find Dr Mallberg to sign the required, affidavit for prescriptive privileges. If I had not found an MD to sign this form I would not have been able to continue working as a primary care provider in my community.

Having a physician signature on file at the ND Board of Nursing for an APRN (Advanced Practice Registered Nurse) prescriptive license is an unnecessary formality. As a Nurse Practitioner (NP) I diagnose, and treat acute and chronic health conditions, order lab and x-ray tests, interpret results and prescribe medication. NPs have been recognized as primary care providers in ND since 1992. As a NP I collaborate with other health care providers on a daily basis.

The person with whom I consult is based on the need of the patient. Most often the physician consulted is not the physician who has her signature on my license at the Board of Nursing.

As you have heard the testimony of my colleagues the requirement to have a physician signature on my license at the Board of Nursing is a formality that does not improve quality or safety of practice. There have been a number of studies and all have shown NP practice is safe and of high quality. (American Academy of Nurse Practitioners (AANP) Quality of Nurse Practitioner document) The nation is moving forward to eliminate barriers to NP practice. This will improve access to healthcare and address the issue of the increasing numbers of people who will be needing primary care services under the new Federal Healthcare initiative.

The collaborative agreement states that the NP is required to consult with a collaborative physician or another physician in her absence once every two months in regard to some prescriptive practice. You may hear testimony from some physicians who have the opinion that this requirement will ensure safe prescribing practice. I argue that having a physician signature on file at the Board of Nursing does not make me "Safe". What improves safety and quality of practice is the requirement of national certification, periodic peer review, clinical outcome evaluations, a code of ethical practice and evidence of continuing professional development and maintenance of clinical skills. All of these are included in my

Scope of Practice. Nurse Practitioners maintain licensure with the Federal DEA (drug enforcement administration) for prescribing of controlled substances and participate in ND Drug Utilization Program to help ensure appropriate and safe prescribing of controlled substances. During my graduate education I sat side by side the medical students and took the same pharmacology course that was provided through UND medical school. I have visited with a number of physicians who are in support of this change and have signatures from a number of physicians and communities encouraging a "Yes" vote for SB2148.

There are communities in ND that do not have any healthcare provider. By eliminating the requirement for physician signature will open doors for NPs to practice in areas that may not currently have providers. Also we are working toward making the Nurse Practice Act similar from state to state to allow NP practice across state lines. This will help to decrease the shortage of primary care providers particularly in rural ND.

Eliminating the physician signature requirement for my prescriptive practice will not change my scope of practice. (American Academy of Nurse Practitioners (AANP) Scope of Nurse Practitioner Practice document) Also it will not change the quality review process that is already established in most practices to assure quality of care. All that will change is the unnecessary paper on file at the Board of Nursing.

I am requesting your support of Bill 2148 to move ND forward to be consistent with recommendations from the National Council of State Boards of Nursing and a host of other national and state organizations and to improve access to healthcare in ND.

Thank you for your support

Gwen Witzel FNP
Family Nurse Practitioner, Langdon ND
American Academy of Nurse Practitioner Board of Director- Region 8 (ND, SD, UT, MO, WY, CO)
gtwitzel@utma.com

Scope of Practice for Nurse Practitioners

American Academy of Nurse Practitioners

PROFESSIONAL ROLE

Nurse Practitioners are licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. According to their practice specialty they provide nursing and medical services to individuals, families and groups. In addition to diagnosing and managing acute episodic and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention. Services include, but are not limited to ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, and prescription of pharmacologic agents and non pharmacologic therapies. Teaching and counseling individuals, families and groups are a major part of nurse practitioner practice.

As licensed independent practitioners, nurse practitioners practice autonomously and in collaboration with health care professionals and other individuals to assess, diagnose, treat and manage the patient's health problems\needs. They serve as health care researchers, interdisciplinary consultants and patient advocates.

EDUCATION

Entry level preparation for nurse practitioner practice is at the master's, post master's or doctoral level. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long term health care settings. Self-directed continued learning and professional development beyond the formal advanced education is essential to maintain clinical competency.

ACCOUNTABILITY

The autonomous nature of the nurse practitioner's advanced clinical practice requires accountability for health care outcomes. Insuring the highest quality of care requires national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continuing professional development and maintenance of clinical skills. Nurse practitioners are committed to seeking and sharing knowledge that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research, and applying findings to clinical practice.

RESPONSIBILITY

The role of the nurse practitioner continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, nurse practitioners combine the roles of provider, mentor, educator, researcher and administrator. Members of the profession are responsible for advancing the role of the nurse practitioner and insuring that the standards of the profession are maintained. This is accomplished through involvement in professional organizations and participation in health policy activities at the local, state, national, and international levels.

Administration
P.O. Box 12846
Austin, TX 78711
p 512.442.4262
f 512.442.6469
www.aanp.org

[redacted] of Health Policy
P[redacted]ox 40130
Washington, DC 20016
p 202.966.6414
f 202.966.2856

Position Statement on Nurse Practitioner Prescriptive Privilege

American Academy of Nurse Practitioners

The American Academy of Nurse Practitioners (AANP) advocates that nurse practitioners have unlimited prescriptive authority (this includes dispensing privileges) in their scope of practice.

Nurse practitioners are licensed independent advanced practice nurses who have completed a formal educational program beyond that of the registered nurse. Nurse practitioners have advanced education in pathophysiology, pharmacology and clinical diagnosis and treatment that prepares them to diagnose and prescribe medications and treatments in their specialty area. Nurse practitioners make independent and collaborative decisions about the health care needs of individuals, families, and groups across the life span.

Over four decades of research conclude that nurse practitioners provide safe, cost-effective, high-quality health care. Prescribing medications and devices is essential to the nurse practitioner's practice. Restrictions on prescriptive authority limit the ability of nurse practitioners to provide comprehensive health care services.

Nurse practitioners are regulated by state boards of nursing or other state designated agencies. Nurse practitioners serve as members of state boards of nursing and advisory councils for advanced practice nurses. This process promotes public safety and competent nurse practitioner practice.

AANP recommends that state boards of nursing regulate nurse practitioner practice and prescriptive authority. AANP also advocates that nurse practitioners be nationally certified and obtain annual continuing education credits in pharmacology.

The ability of nurse practitioners to prescribe, without limitation, legend and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies is essential to provide cost-effective, quality health care for the diverse populations they serve across the life span.

Administration
P.O. Box 12846
Austin, TX 78711
p 512.442.4262
f 512.442.6469
www.aanp.org

Health Policy
[redacted]40130
Washington, DC 20016
p 202.966.6414
f 202.966.2856

American Academy of Nurse Practitioners

Quality of Nurse Practitioner Practice

Administration
Box 12846 • Austin, TX 78711
2.442.4262 • *f* 512.442.6469
www.aanp.org

Office of Health Policy
P.O. Box 40130 • Washington, DC 20016
p 202.966.6414 • *f* 202.966.2856

Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965, and for 45 years, research has consistently demonstrated the high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. ***Archives of Internal Medicine, 151*****(4), 694-698.**
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

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.**
Bakerjian conducted and extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. ***Nursing Research, 44*****(6), 332-9.**
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office. (1979). ***Physician extenders: Their current and future role in medical care delivery.*** **Washington, D.C.: US Government Printing Office.**
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. ***Journal of Advanced Nursing, 40*****(6), 771-730.**
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. ***Medical Decision Making, 26*****, 9-17.**
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. ***British Medical Journal, 324,*** **819-823.**
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. ***Cochrane Database of Systematic Reviews.*** **2006, Issue 1.**
This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (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.**
The outcomes of care in the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. ***Nursing Economics, 20*****(4), 174-179.**
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast , PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. ***Journal of the American Medical Association, 283*****(1), 59-68.**
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

Office of Technology Assessment. (1986). ***Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis.*** **Washington D.C.: US Government Printing Office.**
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have." (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

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

The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lips, and microalbumin levels and were more likely to be at target for lipid levels.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner, 1*(1), 28-32.

The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

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

A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sacket, D.L., Spitzer, W. O., 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.

A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

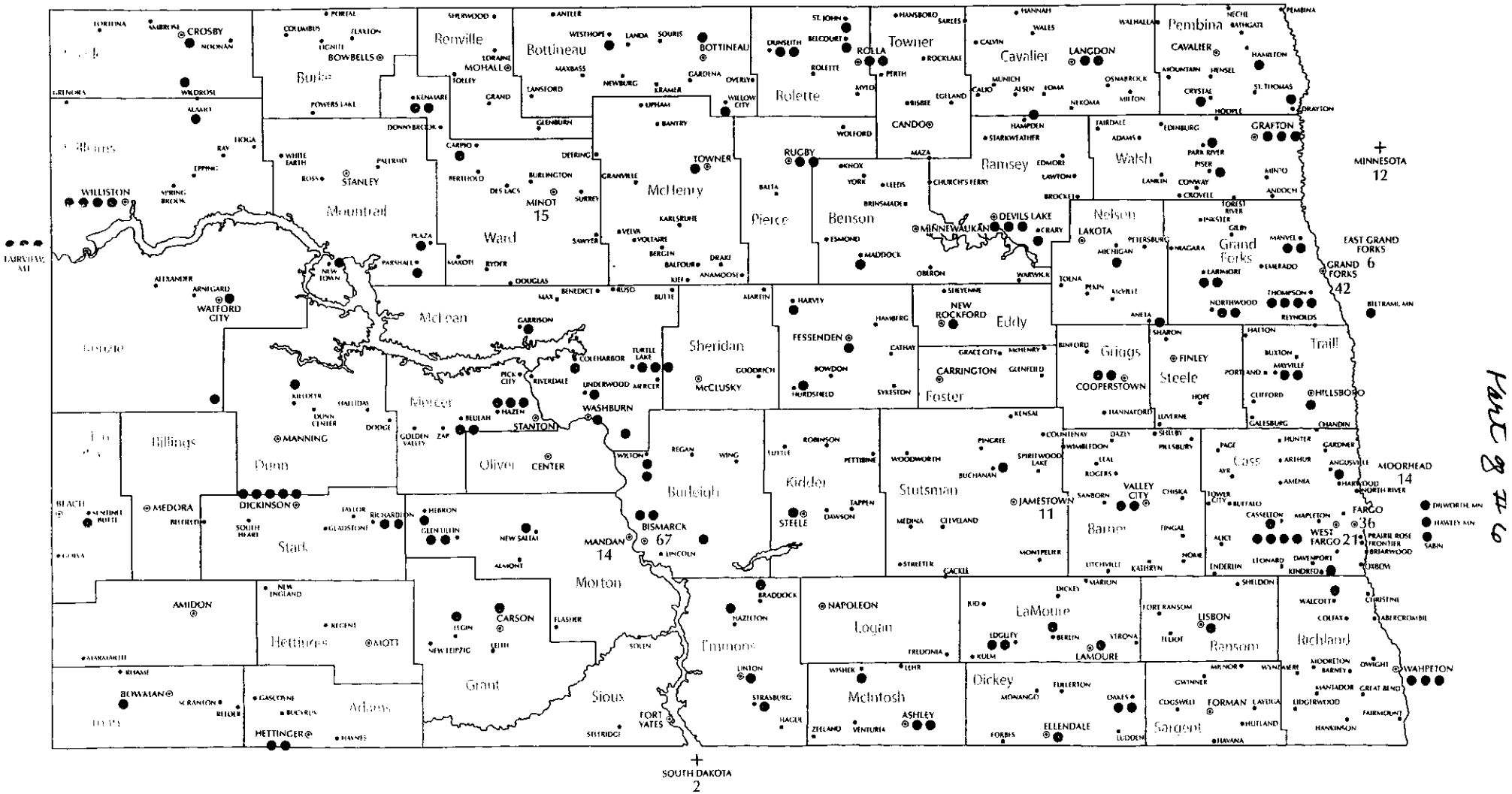
Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation, 9*(2).

The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

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

This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

North Dakota Nurse Practitioner Locations



#7

House Human Services Committee

Nelson (Buzz) Benson CRNA, MMGT
Board Member
President
North Dakota Board of Nursing

Chairman Weisz and members of the Committee, thank you for the opportunity to provide information regarding the SB 2148 related to prescriptive practice standards for advanced practice registered nurses.

I am Buzz Benson CRNA and President of the Board of Nursing. The Board currently licenses approximately: RNs 10,736; LPN 3,611; APRN 753; UAPs and Medication Assistants 4,591. The Board of Nursing is currently a nine member board appointed by the governor. Three of the Board Members are masters prepared RNs, two of which are APRNs; one is a nurse anesthetist and the other is a nurse practitioner. The third masters prepared RN is director of the Dakota Nurse Program. See the attached list of members. We are currently short a public member due to the recent resignation of the public member. Notably the NDBON has been designated a High Performing Board by the NCSBN Commitment to Ongoing Regulatory Excellence (CORE) Project. A designation made by comparing the regulatory processes of all boards of nursing. Lastly, the Board is a member of the Nurse Licensure Compact which encompasses 24 states.

The NDBON has taken action on the licensees of APRNs swiftly and expeditiously as the case warrants. In the past ten years, there have been thirteen APRNs sanctioned by the Board. Three of the individuals were monitored for specific practice issues which included prescriptive authority.

APRNs have advanced education, knowledge and skills to care for a specific population of patients, including adults, families, children or neonates. APRNs can also provide gender specific health care (such as women's health) or provide psychiatric/mental health services. They are educationally prepared to assess, diagnose and manage patient problems, which includes ordering tests and prescribing medication. APRNs work in a variety of settings, including hospitals, clinics and private offices. They can provide care in places where there is a shortage of physicians and health care is badly needed.

Rural areas remain underserved. 61.3 percent of the population (2009) resides in rural communities. Seventy-three (73) percent of the physicians (2010) reside within the urban cities of ND and 23% are located in rural areas. Thirty-nine percent (39) of all APRNs are practice in rural areas (2010). There is a need for practitioners to meet the primary care needs of this population. APRNs are qualified to provide much needed health care to people of all ages.

<u>THE BASIC REQUIREMENTS FOR EVERY APRN INCLUDES THE FOLLOWING:</u>

- Registered nurse with a bachelors degree;
- Graduate education, either masters or doctorate; original transcript from program;

- Certification by a national nursing certification body;
- Submission of an application which includes a written scope of practice;
- Approval for licensure by the NDBON;
- Regulation by the ND Board of Nursing;
- Use of a APRN title followed by the specific role; and
- National accreditation of all APRN programs by an accrediting organization that is accrediting organization that is recognized by the U.S. Department of Education and/or the Council for Higher Education Accreditation (CHEA).

HOW WILL THE REMOVAL OF THIS REQUIREMENT AFFECT PRACTICE IN ND?

APRN practice will be affected in a POSITIVE way by allowing APRNs to practice to the full extent of their education and experience. APRN regulation, which is within the oversight of the Board of Nursing, is consistent with independent practice. APRNs are taught to be independent practitioners.

They are able to diagnose, prescribe medication and can treat a variety of illnesses. They can provide the much needed care in many parts of our state. Collaboration between healthcare providers should be the professional norm and not legally required for only one or two different professions. The overarching theme to provide safe and effective care should guide legal authority; Overlap of scope of practice among professions is necessary. No one profession actually owns a skill or activity in and of itself—and so with the authority to write prescriptions.

I have attached an example of a scope of practice used by the applicants for Nurse Practitioner license. Please note the example and all applications for APRN licensure must include a scope of practice which includes all the components. The Board will continue to require the scope of practice to include consultation and collaboration information.

In closing, removing the requirement for a collaborative agreement should have NO bearing on quality and safety of the APRN's practice because they collaborate regularly now as may be needed for each patient, just as a physician should do, including collaborating with pharmacists on an as needed basis, not because any law or policy may require it.

Thank you for your time. I am now open to questions.

EXAMPLE NURSE PRACTITIONER
SCOPE OF PRACTICE WITH PRESCRIPTIVE AUTHORITY

I[redacted]TION OPTIONAL: I plan to practice as a Family Nurse Practitioner at _____ clinic and [redacted]liated satellite clinics.

My Scope of Practice will include:

1) FOCUS OF CARE:

A. Primary care includes identification, management and/or referral of health problems as well as promotion of health-maintaining behaviors and prevention of illness.
B. Providing care in the rural health clinic, home, long-term and acute-care settings.
C. Coordination of care and advocating for the client in the health-care setting.
D. Comprehensive assessment and decision-making about care needs of individuals,, families, and groups.
E. Working interdependently with other health care providers including physicians in responding to the health care needs of the rural areas in which the clinics are located. Until I receive prescriptive authority from the Board of Nursing, I will consult with physicians regarding my pharmacotherapy and transmit their orders for medications to the pharmacist, patient, or care-setting.

2) ELEMENTS OF CARE:

A. Assessing the health status, illness conditions, responses to illness and health risks through history-taking, physical examination, and laboratory data;
B. Diagnosing the actual or potential health problems or needs based on analysis of the data collected;
C. Planning therapeutic interventions with the client or family;
D. Intervening to assist the client's participation to the fullest extent. Intervention includes measures to promote health, manage chronic illness, or treat illness in its' earliest stages to limit disability. Intervention may include but is not limited to direct nursing care, transmittal of MD orders for medications, and consultation or referral to other health care providers; and
E. Evaluation of the effectiveness of care individually or over-all through regular care review of the client health status, or participation in institutional quality assurance activities.

3) TYPE OF CLIENT: Provide primary health care services to individuals, families, and groups throughout the life span in a predominantly rural setting through federally certified rural health clinics.

4) CONSULTATION PATTERNS: Will be in the form of direct on-site, telephonic, facsimile communication, or interactive video consultation with other health care providers. Consultation and collaboration will be documented in the health care record.

NORTH DAKOTA BOARD OF NURSING
919 SOUTH SEVENTH STREET, SUITE 504
BISMARCK, ND 58504-5881
(701) 328-9777

NAME AND ADDRESS	PHONE	E-MAIL
President		
Nelson (Buzz) Benson, CRNA, MMGT 215 Laredo Dr Bismarck, ND 58504-7210	222-2973(H) 323-6262(W) 202-5972 (C)	bbenson42@bis.midco.net
Vice President		
Julie Traynor, MSN, RN PO Box 838 Devils Lake, ND 58201-8811	662-7212(H) 662-1492(W) 230-1739(C)	julie.traynor@lrsc.edu
Treasurer		
Charlene Christianson BSN, RN Box 37 Glenfield, ND 58443-0037	785-2809(H) 652-3117(W)	ccrndon@daktel.com
Elizabeth Anderson LPN 501 20th Ave N Fargo, ND 58102	237-5792(H) 232-3241(W)	Elizabeth.Anderson6@va.gov - W garyliz.anderson@msn.com - H
Melisa Frank AASPN, LPN 1055 Lincoln St Dickinson, ND 58601	483-7997(H) 456-7387(W) 260-4974 (C)	mfrank@northlandhealth.com
Daniel Rustvang APRN, FNP 3324 Primrose Court Grand Forks, ND 58201	795-1047(H) 780-6941(W) 740-5954(C)	drustvang@altru.org
Deborah Smith BSN, RN 3111 Bay Shore Bend SE Mandan ND 58554	530-6252(W) 258-0466(H) 391-0849(C)	dasmith@primecare.org
Angela Levi LPN 817 2nd Street North PO Box 108 Hettinger, ND 58639	567-4711(H) 567-4561(W)	raklevi@ndsupernet.com
Public Member Vacancy		

2/11

NORTH DAKOTA BOARD OF NURSING

99.9% OF THE NURSES PRACTICE SAFELY.

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- ***LICENSES 10,736 RNS AND 3661 LPNS; REGISTERED 4591 UNLICENSED ASSISTIVE PERSONS.***
- ***LICENSURE APPLICANTS COMPETENCE ASSESSED THROUGH REQUIRED 400 HOURS OF PRACTICE AND 12 CONTACT HOURS OF CONTINUING EDUCATION.***
- ***LICENSES 753 APRNS; 405 HAVE PRESCRIPTIVE AUTHORITY.***
- ***APPROVES 10 RN, 5 PN AND 3 GRADUATE NURSING PROGRAMS WITH AN ENROLLMENT OF 2141.***
- ***AVERAGE PASS RATE RN PROGRAMS IS 89%; LPN PROGRAMS IS 94.3%.***
- ***NURSING EDUCATION LOAN PROGRAM DISPERSED $71,350.***
- ***FUNDS THE NURSING NEEDS STUDY – SEE http://ruralhealth.und.edu/publications/22.***
- ***MEMBER NURSE LICENSURE COMPACT ALONG WITH 24 OTHER STATES.***
- ***ONLINE RENEWAL FOR RNS, LPNS, UAP, MA AND APRNS.***
- ***ONLINE VERIFICATION OF LICENSURE/REGISTRATION OF ALL NURSES AND UNLICENSED ASSISTIVE PERSONS.***
- ***TURN AROUND TIME FOR LICENSURE APPLICATIONS IS RAPID, LESS THAN 2 DAYS.***
- ***INVESTIGATIONS COMPLETED IN AN AVERAGE OF 77 DAYS.***
- ***100% COMPLIANCE REPORTING TO HIPDB/NPDB & OFFICE OF INSPECTOR GENERAL (OIG)***
- ***MAINTAINS WORKPLACE IMPAIRMENT PROGRAM.***
- ***IMPLEMENTED CRIMINAL HISTORY RECORD CHECKS.***
- ***RESPONDS TO QUESTIONS ON PRACTICE, LICENSURE AND EDUCATION.***
- ***PROVIDES ANNUAL REPORT TO THE GOVERNOR AND AVAILABLE ON WEBSITE.***

The mission of the North Dakota Board of Nursing is to assure North Dakota citizens quality nursing care through the regulation of standards for nursing education, licensure and practice.

Updated 1/11

#8
7-1 and In Testimo

TESTIMONY TO

HOUSE HUMAN SERVICE COMMITTEE

62ND ND LEGISLATIVE ASSEMBLY

BY

Tracie M. Mallberg, M.D.

Owner and physician at

LILYCARE CLINIC,

West Fargo, ND

Mr. Chairman and members of the committee;

My name is Dr. Tracie Mallberg. I am a family practice physician and I practice in my own facility; LilyCare Clinic in West Fargo, ND. I opened my clinic in June of 2008. Prior to that time I was a partner in a locum tenens firm and I provided services to many of the rural communities and Emergency Departments around the state. The rural communities that I worked with were typically staffed by Nurse Practitioners as the primary healthcare providers.

I have had the opportunity to work closely with many of the Nurse Practitioners across ND. In my experience, the quality of care, the dedication to community and adherence to scope of practice has been exemplary. While I was

providing physician services in Langdon, ND I became very familiar with the practice of Gwen Witzel, FNP. I have a great respect for Ms. Witzel and her dedication to the community in which she practices. After several return visits to Langdon I was approached by Ms. Witzel with regard to acting as her collaborating physician for prescriptive privileges. At that point, I was completely unaware of the requirement and when I was approached I needed to research this to try and understand the requirements that this signature encompassed. I was surprised by the frivolity of the requirement. The signature requires that Gwen is required to consult with myself or another physician once every two months with regard to some prescriptive practice. As a provider in ND; Physician, Nurse Practitioner or otherwise, collaboration regarding patient issues takes place on a near daily basis.

This requirement has no effect on patient care, chart review or practice methods. Nurse Practitioners of North Dakota have proven to have a high quality of practice and deserve the respect of those in a lawmaking positions to recognize formalities and rules of practice that improve quality of patient care.

Thank you for your time and consideration in this matter.

Tracie M. Mallberg M.D. Family Practice

#9

Testimony in Opposition
Senate Bill 2148
Senator Spencer Berry, MD
House Human Services Committee
Rep. Robin Weisz, Chairman
March 9, 2011

Mr. Chairman and members of the House Human Services Committee. For the record, I am Senator Spencer Berry, representing district 27, and have been a practicing physician for nearly 25 years, board certified in family practice.

At the core of my position on this bill is my true and honest belief that it is in the best interest of all North Dakotans, as it relates to the healthcare they receive, that the practice of medicine in this state have some form of oversight by individuals with a license to practice medicine.

The proponents of this legislation minimize the collaborative agreement requirement in section 43-12.1-18 as simply a ministerial "signature" requirement. It is much more than that. The collaborative agreement requirement is a very important provision that ensures that advanced practice registered nurses are providing care consistent with their level of training and skills. It underscores the value of all healthcare professionals working together in a coordinated, team based fashion, which is recognized as an optimal approach to providing quality, patient-centered care. The collaborative agreement requirement does not prevent nurse practitioners from practicing to the full extent of their training and experience as part of a collaborative team. It is simply a tool used by 39 states as oversight for the public.

Let's be clear. Yes, the collaborative agreement provision requires the signature of a physician. What that signature represents is a collaborative, prescriptive agreement that sets forth the manner of review and approval of the nurse practitioner's planned prescriptive practices. The plan identifies the broad classifications of drugs or devices to be commonly prescribed by the nurse practitioner, identifies the methods and frequency of the collaboration for prescriptive practices, "which must occur as client needs dictate, but no less than once every 2 months." It also identifies methods of documentation of the collaborative process regarding prescriptive practices

and identifies arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

That is what this signature represents-a tool that provides assurance that there is collaboration. It formalizes an ongoing relationship between a physician and Nurse Practitioner that allows for consistency and continuity of care. It does not prevent nurse practitioners from practicing to the full extent of their training and experience.

Currently, as it stands in North Dakota, the NDBME has regulatory and oversight authority as it pertains to medical doctors and physician assistants. The North Dakota Board of Nursing has the regulatory and oversight authority as it relates to nurse practitioners. Therefore, licensure of medical doctors and PAs is handled by the board of medical examiners, and licensure of nurse practitioners is handled by the Board of Nursing.

The educational, clinical training, and testing requirements for medical doctors to receive licensure in the state are determined by the Board of Medical Examiners. The educational, clinical training, and testing requirements to receive licensure for Nurse Practitioners are determined by the Board of Nursing.

These are 2 very separate and distinct paths of education, experience and training. One path is formulated and designed to confer a medical degree and the opportunity to apply for a license to practice medicine The other path is formulated and designed to confer a nursing degree and the opportunity to apply for a license to practice nursing. Individuals are free to pursue whichever path they prefer. I believe both paths are noble endeavors and I have great respect for both professions. The fact remains, however, that these are 2 separate professions. Physicians and nurse practitioners complete training with different levels of knowledge, skills, and abilities that while not equivalent are complementary.

Nurses are critical to the healthcare team; however, there is no substitute for a physician's education and training. Physicians have 7 or more years of postgraduate education and more than 10,000 hours of clinical experience. Nurse practitioners possess a registered nursing degree and usually 2 years of additional education. This difference in education and training matters. It matters in primary care situations when seemingly "simple" conditions actually mask underlying, complex medical problems. It also matters, as

these additional years of physician education and training are vital to optimal patient care in the event of a complication.

As it relates to prescriptive authority, physicians receive extensive education in the use of prescriptive medications and controlled substances. They spend an additional 3-5 years in a residency training program developing clinical expertise in the utilization and management of these prescriptive medicines and controlled substances.

The scope of practice and autonomy for nurse practitioners has greatly expanded in recent years. North Dakota already has in place extremely liberal laws regarding medical oversight for nurse practitioners. There is no geographical physical proximity requirement in the collaborative agreement and there is no restriction on the number of nurse practitioners that a physician may have a collaborative agreement with. The collaborative agreement, therefore, is not an onerous obstacle. If this bill is enacted into law, it would remove the last and only vestige of oversight of nurse practitioners by an individual with a medical license.

On a broader level, actual or perceived shortages in securing access to qualified medical care in rural or underserved areas provides, at first glance, what seems to be a legitimate rationale upon which to lobby for an expanded scope of practice for nurse practitioners. AMA geographical maps showing nurse practitioners dispersed around the state, even in communities in which there is no physician, reveals no access issues related strictly to the collaborative agreement requirement. As previously demonstrated, and contrary to statements by some, the required collaborative agreement does not affect access to healthcare in our state.

Much of the testimony and the general thrust of this legislation is that the removal of all physician oversight of Nurse Practitioners will increase North Dakotan's access to healthcare. This premise, however, does not hold up to scrutiny with the facts. The oversight provided has in the past, and will continue in the future, to help maintain and assure that ALL North Dakotans- rural and urban-receive the best healthcare we have to offer.

Thank you for your consideration of this matter, and I would respectfully request a "DO NOT PASS" recommendation from this committee.

#10

March 9, 2011

Testimony in Opposition to SB 2148
Jeff Hostetter, MD speaking for the Board of the ND Academy of Family Physicians (NDAFP)

Chairman Weisz and Committee Members,

I am Doctor Jeff Hostetter. I am the Program Director of the UND Center for Family Medicine Residency in Bismarck, an Assistant Professor of the UND School of Medicine and Health Sciences in the Dept. of Family and Community Medicine, and the secretary/treasurer of the ND AFP. I was the chief of staff at the Standing Rock HIS hospital in Fort Yates, ND.

In my many roles, I have had the privilege to work with many ANP's and other mid-level providers. In Fort Yates, I became acutely aware of the physician shortage that has spurred the presentation of SB 2148. Indeed, even though I no longer work at Fort Yates, I am currently the collaborating physician for the mid-level providers in the Fort Yates hospital, because they have been unable to hire any new physicians who could take over for me.

Let me start by acknowledging that this is a bill that elicits strong emotional responses from both sides of the issue.

I am here to state the position of the board of directors of the NDAFP, and hopefully my remarks will be interpreted not as personal or professional attacks on ANP's who we respect, but as our well-considered opinion on the issue.

We oppose SB2148 for the following reasons.
1) It is a solution without a problem. Currently consultation with a supervising physician is a mere phone call away for any ANP in ND. There are no places where access to health care can be blamed on this issue, because there are phones throughout the state.

2) There are likely to be many unintended consequences if this bill is passed. Namely,

a) ANP's with current collaborative agreements who desire to keep them may be unable to do so, because if a physician has an agreement with an ANP, they are accepting additional liability. Malpractice carriers and some health systems will likely force physicians to jettison these agreements in they are not required. In my personal case, I had to apply for special dispensation from the UND's malpractice carrier in order for me to sign collaborative agreements with mid-level providers.

b) ANP's will find it increasingly difficult to find physicians to cover for or back them up when they are on call, and to find physicians who will accept patients in transfer again due to increased liability issues. We feel this will actually worsen access to safe and necessary care of patients in rural areas.

c) The Patient Centered Medical Home (PCMH), under which all future Medicare reimbursement will occur, has been articulated and is currently codified with physicians as team leaders. Although studies utilizing physician-extenders are ongoing, none have published results showing similar beneficial outcomes that physician-led medical home have done. With less incentive to get physicians into rural communities, patients and medical facilities in rural areas risk once again being left behind in the wave of medical reform that is currently occurring due to being unable to qualify as a CMH. This will negatively effect both patient care and financial viability of rural clinics and hospitals.

Due to these reasons as well as those articulated by previous presenters, we must respectfully oppose SB 2148. I would be happy to answer any questions.

#11

HOUSE HUMAN SERVICES COMMITTEE

S.B. 2148

March 9, 2011

Testimony of Duane Houdek
North Dakota State Board of Medical Examiners

Mr. Chairman, members of the House Human Services Committee, my name is Duane Houdek, Executive Secretary of the North Dakota State Board of Medical Examiners. On behalf of the Board, I testify in opposition to Senate Bill 2148.

At the Medical Board, we investigate and discipline physicians and physician assistants. We respond to complaints filed with the Board by patients, law enforcement, other physicians and health care institutions. From that experience, I can tell you that prescribing cases–especially the prescribing of pain medications–are among the most complex cases we review. The correct prescription of opioids is an extremely difficult and nuanced matter. It is really hard to get it right.

The importance of correctly prescribing pain medications and other controlled substances is especially elevated today, as we know that prescription drugs have become the drug of choice for many and prescription drug abuse is a most serious societal problem. Nationally, prescription opioids are now responsible for more overdose deaths and emergency room visits than heroin and cocaine combined.

This is an area where the need for public protection is especially acute. I understand that your job, as policy makers, is oftentimes to balance competing interests. In this case, at this time, I suggest to you that prescribing of controlled substances by everyone, nurse practitioners included, needs more collaboration, not less. Oversight of such prescribing needs to be enhanced, not diminished.

In balance, it does not appear to me that passage of this bill will do anything to increase access or benefit the public in any other way, but it will remove some of that oversight.

I was sorry to hear, when this bill was heard in the Senate, that some physicians and some nurse practitioners don't think the collaboration requirement in current law is very meaningful. At the Medical Board, we think it is. We have investigated physicians and disciplined physicians

based on a violation of their duty to collaborate meaningfully with nurse practitioners and to make as sure as we can that opioid prescribing is done in a way that properly treats the patient and protects the rest of society. That is really the only message I wanted to give you today.

Thank you. I will try to answer any questions you may have.

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NORTH DAKOTA MEDICAL ASSOCIATION

1622 East Interstate Avenue
Post Office Box 1198
Bismarck, North Dakota
58502-1198

(701) 223-9475
Fax (701) 223-9476
www.ndmed.org

Kimberly T. Krohn, MD
Minot
President

A. Michael Booth, MD
Bismarck
Vice President
Council Chair

Steven P. Strinden, MD
Fargo
[redacted]tary-Treasurer

Debra A Geier, MD
Jamestown
Speaker of the House

Robert A. Thompson, MD
Immediate Past President

Gaylord J. Kavlie, MD
Bismarck
AMA Delegate

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Grand Forks
AMA Alternate Delegate

Bruce Levi
Executive Director and
General Counsel

Courtney Koebele, JD
Director of Advocacy

Leann Benson
Director of Membership
Office Manager

[redacted]nette Weigel
[redacted]istrative Assistant

Testimony in Opposition to SB 2148
House Human Services Committee
March 9, 2011

Chairman Weisz and Committee Members, I'm Courtney Koebele and I am the Director of Advocacy for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

The North Dakota Medical Association initially reviewed SB 2148 through an ad hoc committee comprised of the following physicians, who reaffirmed existing NDMA policy:

Steven P. Strinden, MD, Fargo

Kimberly T. Krohn, MD, Minot

A Michael Booth, MD, Bismarck

Fadel Nammour, MD, Fargo

Catherine E. Houle, MD, Hettinger

Shelly A. Seifert, MD, Bismarck

While the North Dakota Medical Association recognizes the critical roles performed by advanced practice registered nurses as part of the multidisciplinary team that provides high quality and efficiently delivered health care, the Association opposes SB 2148 for the following reasons:

1. The collaborative prescriptive agreement required by NDCC 43-12.1-18 is a very important and necessary patient safety tool that ensures that advanced practice registered nurses are exercising prescriptive authority consistent with their level of training and skills.

2. The proposed removal of the collaborative prescriptive agreement will change nurse practitioner scope of practice; state law should continue to recognize the limits of the clinical and pharmacotherapy training of advanced practice registered nurses and continue to recognize the need for physician collaboration in prescriptive practice.

3. The proposed removal of the collaborative prescriptive agreement will not increase access to care for patients; the collaborative prescriptive agreement is not a barrier in the sense that it limits advanced practice registered nurses from practicing to the full level of their training and clinical skills.

4. The proposed removal of the collaborative prescriptive agreement will result in independent practice that equates to the practice of medicine; while advanced practice registered nurses provide many core primary care services, they are not interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The collaborative prescriptive agreement appropriately recognizes the differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care.

---

1. The collaborative prescriptive agreement required by NDCC 43-12.1-18 is a very important and necessary patient safety tool that ensures that advanced practice registered nurses are exercising prescriptive authority consistent with their level of training and skills.

The proponents of this legislation minimize the collaborative prescriptive agreement requirement in section 43-12.1-18 as a ministerial "signature" requirement. It is much more than that. The collaborative prescriptive agreement is a very important patient safety provision that ensures that advanced practice registered nurses are providing care consistent with their level of training and skills. It underscores the value of all health care professionals working together in a coordinated, team-based fashion which is recognized as an optimal approach to providing quality, patient-centered care.

The collaborative prescriptive agreement does not prevent advanced practice registered nurses from practicing to the full extent of their training and experience as part of a collaborative team. It is simply a tool used by the vast majority of states to protect the public, including many states in our region - Minnesota, South Dakota, Nebraska, Kansas and Wisconsin which require a collaborative or supervisory agreement not just for prescriptive

authority but for diagnostic and treatment practice as well. North Dakota is one of about eight "hybrid" states that require only a collaborative prescriptive agreement and do not require a collaborative or supervisory agreement for diagnosis and treatment. Yet overall, 35 states still recognize the importance of collaboration or supervision by a physician in the prescriptive practice of advanced practice registered nurses.

As asserted, the collaborative prescriptive agreement does require the signature of a physician. What that signature represents is a collaborative prescriptive agreement that sets forth the manner of review and approval of the planned prescriptive practices for the advanced practice registered nurse. The plan identifies the broad classifications of drugs or devices to be commonly prescribed by the nurse practitioner, identifies the methods and frequency of the collaboration for prescriptive practices, "which must occur as client needs dictate, but no less than once every two months," identifies methods of documentation of the collaborative process regarding prescriptive practices, and identifies arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician [NDAC 54-05-03.1-09(4)]. The administrative rules of the North Dakota Board of Nursing relating to the collaborative prescriptive agreement are attached.

That is what the signature represents – a tool that provides assurance that there is collaboration to ensure that the prescriptive authority is consistent with the nurse practitioner's training and experience. It is not onerous. It does not prevent nurse practitioners from practicing to the full extent of their training and experience.

Legislation enacted in 1995 provides the backdrop for the collaborative prescriptive agreement. Representatives of the ND Board of Nursing, nurse practitioners, the ND Board of Nursing, the ND Board of Medical Examiners, the ND Medical Association and others all agreed in 1995, through a process mediated by the ND Consensus Council, that the collaborative prescriptive agreement was appropriate and consistent with collaborative principles agreed upon at that time [Legislative History, Ch. 403, ND Session Laws, 1995]. Nothing has changed to deviate from those principles today.

In the 2009 legislative session, the North Dakota Nurse Practitioners Association argued successfully to the legislature for status as Medicaid primary care case managers. In their

testimony it was argued that primary care case manager status "will not change or affect our collaborative agreement." [Testimony of Cheryl Rising, RN, MS, CNRN, FNP, January 20, 2009, Sen. Human Services Committee]. Clearly, the collaborative agreement may be an inconvenience to some nurse practitioners, but the inconvenience of the collaborative prescriptive agreement does not affect the ability of a nurse practitioner from practicing to the full extent of their education and training, whether it be as a primary care case manager with Medicaid or in general prescriptive practice.

With a shortage of both physicians and nurses and millions more insured Americans, health care professionals will need to continue working together to meet the surge in demand for health care. A collaborative team approach to care - with each member of the team playing the role he or she has been educated and trained to play - has a proven track record of success and helps to ensure that patients get safe, high-quality care and value for their health care spending.

2. The proposed removal of the collaborative prescriptive agreement will change nurse practitioner scope of practice; state law should continue to recognize the limits of the clinical and pharmacotherapy training of advanced practice registered nurses and continue to recognize the need for physician collaboration in prescriptive practice.

Although nurses are critical to the health care team, there is no substitute for a physician's education and training. Physicians come with seven or more years of postgraduate education and more than 10,000 hours of clinical experience. We believe this difference in education and training matters. It matters during times of medical emergencies. It matters in primary care situations when seemingly "simple" conditions actually mask underlying, complex conditions. And it matters to ensure that the right diagnosis and treatment plan, including the right prescription if necessary, is made from the beginning to help save patients money on unnecessary prescriptions, tests and referrals.

Nurse practitioner groups nationally in their literature belabor the general notion that collaboration is not the same as "supervision," especially if compared to the use of the term "supervision" in the administrative rules of the North Dakota Board of Medical Examiners in the regulation of physician assistants who "provide patient services under the supervision and responsibility of a physician who is responsible for the performance of that assistant" [NDAC 50-03-01-01]. If collaboration means to "*work jointly with others*," it certainly is in the best

interests of patients that nurse practitioners and physicians work together, particularly in prescribing controlled substances. The collaborative prescriptive agreement recognizes differences in the training and skills between the medical and nursing professions, and simply places the physician and nurse practitioner in the position of working together in prescriptive practice to ensure that patients receive prescriptions that are medically necessary and appropriate to the diagnosis.

3. The proposed removal of the collaborative prescriptive agreement will not increase access to care for patients; the collaborative prescriptive agreement is not a barrier in the sense that it limits advanced practice registered nurses from practicing to the full level of their training and clinical skills.

NDMA recognizes that difficulties in securing access to qualified physicians in rural or underserved areas provide at first glance what seems to be a legitimate rationale on which to lobby for expanded scope of practice. However, NDMA has always looked first to what's best for patients. It has always argued that solutions to actual or perceived shortages or barriers simply do not justify expansions in scope of practice of any non-physician that expose patients to unnecessary or unintended health risks due to limitations in the education and training of any non-physicians.

The collaborative prescriptive agreement has not diminished access to care for North Dakota patients. There currently are no restrictions on the diagnostic and treatment services provided by an advanced practice registered nurse, which allows the nurse practitioner to practice across the state with only a collaborative prescriptive agreement in place with a physician. The map of North Dakota provided as part of our NDMA testimony, prepared by the American Medical Association in 2008 shows that advanced practice registered nurses in North Dakota practice in many rural communities in which physicians do not. Certainly, the existence of the collaborative prescriptive agreement has not stopped nurse practitioners from practicing in rural areas across the state.

The collaborative prescriptive agreement has been used in North Dakota for many years. It was not perceived as a problem by nurse practitioners in the 2009 session when Medicaid primary care case manager status was sought. It should not be eliminated now simply for the purported purpose of making it more convenient for out-of-state nurse practitioners to gain a license in our state, or eliminated to pursue a license compact with states west of North

Dakota that have public policies in place that are not consistent with North Dakota or states south and east of North Dakota. The collaborative prescriptive agreement serves an important purpose in protecting the public. Its proposed elimination is simply a solution to a problem that does not exist.

4. The proposed removal of the collaborative prescriptive agreement will result in independent practice that equates to the practice of medicine; while advanced practice registered nurses provide many core primary care services, they are not interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The collaborative prescriptive agreement appropriately recognizes the differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care.

The history of the nurse practitioner profession began in the late 1960s as a way to provide basic primary care services and advice to people in regions where physicians were scarce, and has become today a profession that seeks to be allowed to deliver the same medical care that physicians do under the auspice of advanced practice nursing [AMA Scope of Practice Data Series: *Nurse Practitioners*, October 2009].

A frequently-heard comment from physicians discussing "scope of practice" issues of other health care professionals is: "If they want to practice medicine, they ought to go to medical school." Certainly, over the years physician organizations have taken positions on issues relating to the independent practice by advanced practice registered nurses. The American Medical Association opposes enactment of any legislation to authorize the independent practice of medicine by any individual who is not licensed to practice medicine. The position of the American Academy of Family Physicians is that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician, and should not function as an independent health practitioner.

The American College of Physicians recently made the following observations in response to the recent Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, which advocates reliance on collaborative, multidisciplinary, team-based care to improve the quality and delivery of care in a transformed health care system. The

observations capture many of the underlying concerns of physicians and the blurring of differences in training and skills between the medical and nursing professions, yet recognize the importance of our professions working together, rather than apart, in the delivery of care:

> The American College of Physicians strongly supports this [collaborative, multidisciplinary, team-based care] model. Nurses, physician assistants, physicians, and other health care professionals should practice to the full level of their training and clinical skills, working as part of a collaborative team, and inappropriate barriers that stand in their way should be examined and revised accordingly.
>
> We agree that certified nurse practitioners can provide many core primary care services, but it is important that this not be misunderstood as suggesting that nurses are interchangeable with physicians in providing the full depth and breadth of services that primary care physicians provide. The two professions are complementary but not equivalent. For diagnostic evaluation of clinical presentations that are not straightforward and for ongoing management of complex or interacting medical problems, the most appropriate clinician is a physician who has received in-depth training in the diagnosis and treatment of conditions affecting all organ systems and who can effectively integrate current and evolving scientific knowledge with the delivery of clinical care. Any examination of state licensing laws, as the IOM recommends, should therefore distinguish between inappropriate restrictions on nurses or other licensed health care professionals that prevent them from practicing to the full level of their training and experience as part of a collaborative team and laws designed to ensure that licensed health care professionals are providing care consistent with their level of training and skills.
>
> The IOM has done a great service by providing a comprehensive set of recommendations that, although focusing on the nursing profession, appropriately emphasize the importance of physicians, nurses, physician assistants, and other health care professionals working together to provide high-quality, patient-centered care, through delivery systems (such as the patient-centered medical home) that use everyone's skills and training optimally. It is essential, however, that further discussions of and communications relating to the IOM report provide sufficient clarity on the issues to prevent misunderstanding. Care should be taken by everyone involved in the implementation of the IOM recommendations to ensure that they are not misconstrued as blurring the important differences in training and skills between the medical and nursing professions and in their respective contributions to team-based and patient-centered care. [J. Fred Ralston, Jr., MD, Steven E. Weinberger, MD, American College of Physicians, *Nurses' Scope of Practice,* New England Journal of Medicine, Dec. 2010].

As previously stated, NDMA's position is that the collaborative prescriptive agreement, rather than placing a barrier to advanced practice registered nurses practicing to the full level of their training and clinical skills, instead promotes patient safety and physicians and advanced practice registered nurses *working together* in a collaborative, multidisciplinary, team-based approach to care that benefits North Dakota patients.

Thank you for the opportunity to present the views of the North Dakota Medical Association. NDMA urges the Committee to vote a "DO NOT PASS" on SB 2148.

54-05-03.1-09. Requirements for prescriptive authority. Applicants for prescriptive authority shall:

1. Be currently licensed as an advanced practice registered nurse in North Dakota.

2. Submit a complete, notarized prescriptive authority application and pay the fee of fifty dollars.

3. Provide evidence of completion of thirty contact hours of education or equivalent in pharmacotherapy related to the applicant's scope of advanced practice that:

   a. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority; or

   b. Other methods that may be approved by the board.

4. Submit an affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice. The affidavit must address all of the following areas:

   a. Broad classifications of drugs or devices to be commonly prescribed by the advanced practice registered nurse;

   b. Methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate, but no less than once every two months;

   c. Methods of documentation of the collaboration process regarding prescriptive practices; and

d. Alternative arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997; April 1, 2004; March 24, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-02(7), 43-12.1-09(2)(c)(d)

54-05-03.1-10. Authority to prescribe.

1. A permanent advanced practice registered nurse license with the addition of prescriptive authority shall be issued following review and approval of the completed application by the board.

2. Between meetings of the board, board staff may review the prescriptive authority application and grant a temporary permit to prescribe if all the requirements are met.

3. The advanced practice registered nurse with prescriptive authority may prescribe drugs as defined by chapter 43-15-01 pursuant to applicable state and federal laws. Notice of the prescriptive authority granted will be forwarded to the board of pharmacy.

4. A prescriptive authority license does not include drug enforcement administration authority for prescribing controlled substances. Each licensee must apply for and receive a drug enforcement administration number before writing prescriptions for scheduled drugs.

5. The licensee may prescribe, administer, sign for, dispense, and procure pharmaceutical samples following state and federal regulations.

6. The signature on documents related to prescriptive practices must clearly indicate that the licensee is an advanced practice registered nurse.

7. The advanced practice registered nurse with prescriptive authority may not prescribe, sell, administer, distribute, or give to oneself or to one's spouse or child any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug.

8. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient's sexual partner or partners, without

there having been an examination of that patient's sexual partner or partners.

History: Effective March 1, 1992; amended effective November 1, 1996; April 1, 2004; January 1, 2009.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-05-03.1-11. Prescriptive authority renewal. Prescriptive authority is valid for the same period of time as the applicant's advanced practice registered nurse and registered nurse license. The applicant for renewal must:

1. Renew the applicant's registered nurse license.

2. Submit verification of current certification by a national nursing certification body in the specific area of nursing practice.

3. Submit a completed advanced practice registered nurse with prescriptive authority renewal application.

4. Pay the advanced practice registered nurse renewal fee of forty dollars and the fifty dollar renewal fee for prescriptive authority.

5. Provide evidence of completion of fifteen contact hours of education during the previous two years in pharmacotherapy related to the scope of practice. These contact hours may fulfill the registered nurse renewal continuing education requirement. The education or its equivalent as approved by the board may include academic credits, attendance at approved seminars and courses, or participation in approved correspondence or home study continuing education courses.

6. Submit a verification of affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice. The affidavit must address all of the following areas:

   a. Broad classifications of drugs or devices to be commonly prescribed by the advanced practice registered nurse;

   b. Methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate, but no less than once every two months;

   c. Methods of documentation of the collaboration process regarding prescriptive practices; and

d. Alternative arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

History: Effective March 1, 1992; amended effective November 1, 1996; June 1, 2001; April 1, 2004; March 24, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-12. Change in physician collaboration regarding prescriptive authority. The advanced practice registered nurse or the collaborating physician may terminate the relationship at any time. The advanced practice registered nurse must notify the board in writing within five working days of the termination. An affidavit of collaboration with another licensed physician must be submitted when there is a change in the licensed physician providing the collaboration. The affidavit and a revised scope of practice statement must be submitted within sixty days of the change in collaboration with a licensed physician.

History: Effective March 1, 1992; amended effective November 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

54-05-03.1-13. Suspension or enjoining of prescriptive authority. The prescriptive authority granted to an advanced practice registered nurse may be temporarily suspended or enjoined according to provisions of North Dakota Century Code chapters 28-32 and 32-06, when the advanced practice registered nurse has:

1. Failed to maintain current licensure as an advanced practice registered nurse or failed to meet prescriptive authority requirements;

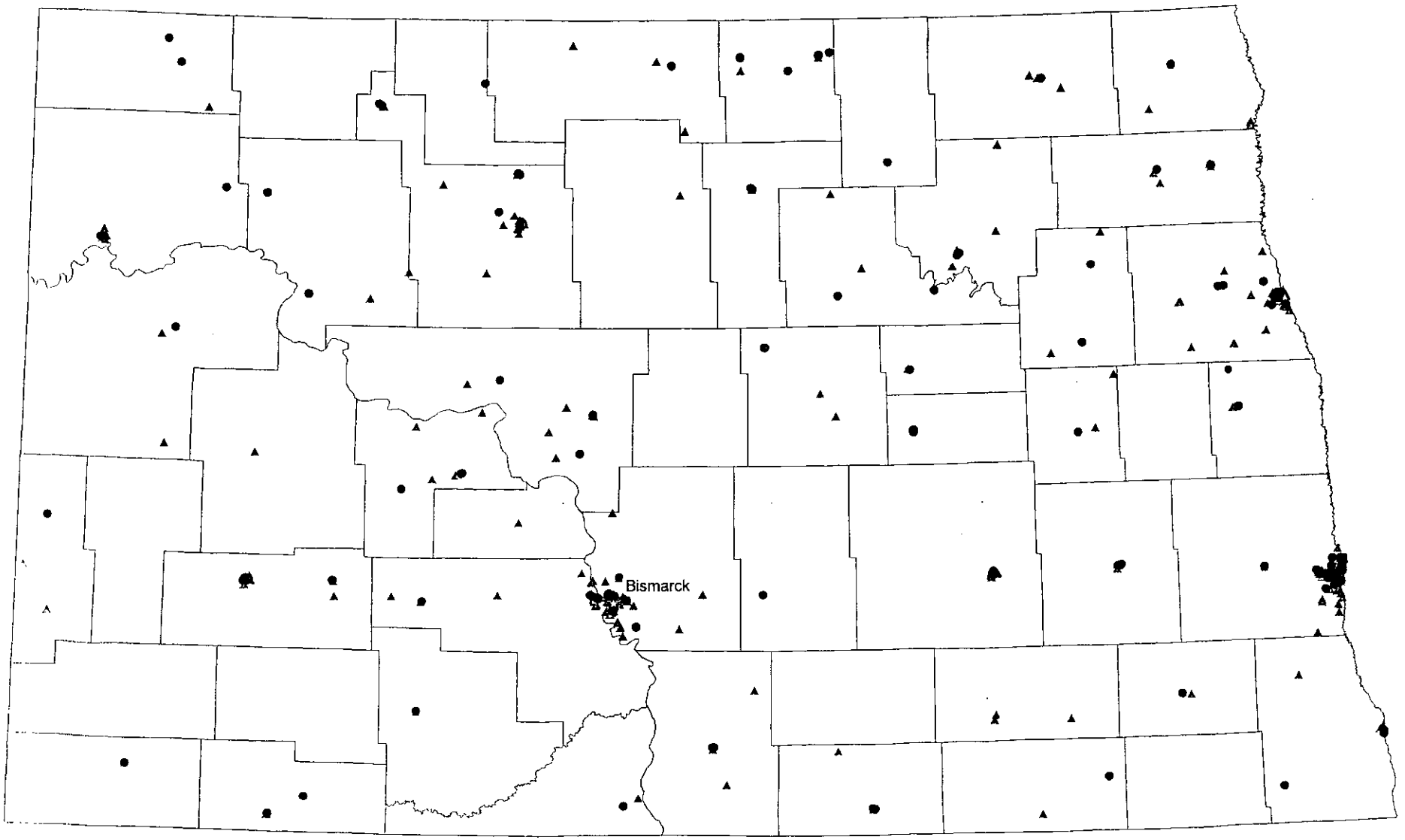
2. Prescribed outside the scope of practice or for other than therapeutic purposes;

3. Violated any state or federal law or regulation applicable to prescriptions; or

Following final board action notice of suspension or injunctive action regarding prescriptive authority will be forwarded to the board of pharmacy and the collaborating physician.

History: Effective March 1, 1992; amended effective November 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(1)

North Dakota Primary Care Physician to Advanced Practice Registered Nurse Distribution Comparison



● = the location of one or more actively practicing Primary Care Physicians (n = 555)

▲ = the location of one of more actively practicing Advanced Practice Registered Nurses (n = 286)

Data Source: American Medical Association, American Osteopathic Association (2008) and the North Dakota Board of Nursing (June 2008)

National Center for the Analysis of Healthcare Data (2008)

Senator Spencer Berry

PROPOSED AMENDMENT TO SB NO. 2148

Page 1, line seven, remove the overstrike over "~~The board shall~~"

Page 1, line 8, remove the overstrike

Page 1, line 9, remove the overstrike over "~~advanced practice registered nurses.~~"

Page 1, line 10, remove the overstrike over "~~and include evidence of a collaborative~~"

Page 1, line 11, remove the overstrike over "~~agreement with a licensed physician~~" and insert immediately thereafter "for schedule II through V controlled substances"

Renumber accordingly