FREQUENTLY ASKED QUESTIONS REGARDING THE NEW LAW ON APRN PRACTICE (as of July 3, 2018)

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

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

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

No. While the new law incorporates the contents required for protocols, it sets out additional requirements for the new practice agreements. For example, the practice agreement must authorize the prescriptive authority for Schedule II drugs allowed by the new law for APRNs. There is also a new requirement for the physician to set out in the practice agreement the mechanisms the physician will utilize to ensure that quality of clinical care and patient safety is maintained.

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

No. The process is the same as it currently is for protocols. There is no prior approval, but either Board may request a copy of a practice agreement, which must be submitted within 72 hours of the request.

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

The physician must hold a permanent, active, and unrestricted authorization to practice medicine in South Carolina and must be actively practicing within the geographic boundaries of South Carolina. Another important requirement of the new law is that a physician cannot enter into a practice agreement with an APRN performing a medical act, task, or function that is outside the usual practice of the physician or outside of the physician's training or experience. This provision was included in the new law in light of certain instances in which some APRNs were performing procedures that the supervising physician did not perform in his or her practice or have training regarding the procedure. The Medical Board can approve exceptions to this requirement.

5. If a physician is employed by a hospital or other entity, is it the responsibility of the physician or the employer to develop and execute a practice agreement with an APRN?

The physician is responsible for developing and executing the practice agreement with the APRN with whom the physician will be working. The practice agreement is a clinical document, not an employment contract. It is intended to be individualized for each APRN based on the APRN's education, training, and experience and on the type of practice and

practice setting. Thus, there is no "one size fits all" standard document that can be used. If a template is provided by an employer, the document must be tailored to fit the specifics of the physician's practice with the APRN.

6. Does the Medical Board plan to audit practice agreements?

The new law authorizes the Medical Board to audit practice agreements if it chooses to do so. The extent to which the Medical Board will audit practice agreements has not yet been addressed by the Medical Board. The Board of Nursing, however, is required by law to conduct random audits biennially. If the Board of Nursing determines through its audit that a compliance problem exists, it will likely refer the physician to the Medical Board. Also, both Boards have the authority to request a copy of a practice agreement, and the practice agreement must be submitted to the requesting Board within 72 hours.

7. What will the Medical Board be looking for if it audits a practice agreement?

The Medical Board will be looking to determine whether the practice agreement complies with all statutory requirements. Auditors performing this function for the Board would compare the contents of the practice agreement under audit to the contents required by the new law. Auditors will also look to make sure that the practice agreement has been executed by all parties and is in effect for the current year.

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

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

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

The new law does not use the terms "supervise" or "collaborate" for physician-APRN practice. The new law uses the terms "work with" and "support" the APRN as it pertains to the physician. It is up to the individual physician and APRN to specify in the practice agreement whether their relationship is "supervisory" or "collaborative" in nature or whether some other descriptive term is appropriate.

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

The key responsibility of the physician is to ensure that the quality of clinical care and patient safety is maintained in compliance with State and federal law and Board regulations. The physician must include in the practice agreement the specific mechanisms the physician will utilize to meet that responsibility. The practice agreements must also set out when direct evaluation by or referral to the physician is necessary and how backup consultation will be provided. Finally, the physician must be "readily available" to the

APRN which means that the physician must be able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice.

11. Will the Medical Examiners be posting any educational information on the new law or guidance on how to comply with the new law?

The Medical Board will meet in August and could discuss whether educational information or guidance would be helpful. A document entitled "Sample Collaborative Written Practice Agreement" is currently posted on the Medical Board website, as well as on the Board of Nursing website. This document was approved by the Board of Nursing. While this document may provide some guidance, it does not encompass all requirements of the new law.

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

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

13. Is there a list of specific medical acts that new law authorizes an APRN to perform?

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

There have been questions whether signing DNRs or prescribing DME is on the statutory list. They are not on the list in the new law. Whether these medical acts can be authorized through a practice agreement will depend on the requirements of other applicable State and federal laws and regulations.

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

The new law eliminates the 45-mile geographic radius. The physician, however, must be actively practicing within the geographic boundaries of South Carolina. There has been some confusion based on the language in Section 40-47-195(C) of the Medical Practice Act whether off-site practice by an APRN might require prior approval by the Medical

Board. It is anticipated that LLR will interpret this section in a manner consistent with the intent of new law and not require such approval.

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

The new law expands the physician-to-APRN ratio from one physician to three (3) full-time equivalent ("FTE") APRNs to one physician to six (6) FTE APRNs. Thus, a physician could enter into practice agreements with more than six APRNs if one or more APRNs work part-time. Agreeing to sign a practice agreement as a backup physician does not count toward the number of practice agreements that a physician may enter into as the primary physician.

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

There have been questions about how to comply with the requirement to work with only six (6) APRNs and/or PAs at a given time. The use of a calendaring system or equivalent system could be a means to document compliance. Also, establishing a mechanism for notifying the backup physician when he or she will be working with a particular APRN is important.

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

Section 40-33-34(I) of the Nurse Practice Act, which is part of the new law, provides that APRNs may perform medical acts via telemedicine pursuant to a practice agreement. Thus, if an APRN plans to practice though telemedicine, the practice agreement must address that practice, including prescriptive authority. If the APRN will be establishing a nurse-patient relationship solely by means of telemedicine, there are specific statutory requirements and limitations that should be incorporated into the practice agreement. Most important are the requirements for prescribing medications if the relationship is established solely via telemedicine. For example, an APRN may not prescribe medication via telemedicine if an in-person exam is necessary for diagnosis. Also, the APRN must adhere to the same standard of care as a licensee employing more traditional in-person care. If the practice agreement authorizes the APRN to prescribe medications in Schedules II and III or lifestyle medications, that prescriptive authority must also be approved by a joint committee of the Board of Nursing and the Medical Board prior to prescribing.

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