COMMENTS

A CASE FOR AN EFFICIENT SYSTEM: HOW RELAXING MIDLEVEL PROVIDER SUPERVISION AND PRESCRIPTIVE AUTHORITY LAWS WILL REDUCE COSTS AND INCREASE ACCESS TO HEALTH CARE IN ALABAMA

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ABSTRACT

Unless a waiver is granted by the Alabama Board of Medical Examiners, physicians are only able to supervise three "full-time equivalent" physician assistants or nurse practitioners (Midlevel Providers) at one time. Most of the non-emergency medical issues in the country—including diagnosis, prescription, and administration of controlled substances—can be handled by midlevel providers. As more patients enroll in health care exchanges with the implementation of the Patient Protection and Affordable Care Act of 2010, Alabama's physician shortage will only be intensified. To provide health care access to areas of Alabama that have a difficult time attracting physicians, midlevel providers are likely the only option. Several states have recently relaxed these rules, and it may be time for Alabama to further relax its rules as well. However, the issue is compounded in light of the statutory limits on prescriptive authority and the scope-of-practice laws in the state. Thus, Alabama must continue to loosen its midlevel provider laws in order to reduce the cost

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of primary health care and enhance the availability of health care to rural and underserved areas.

INTRODUCTION

A. Historical Background

The term "midlevel provider" is often used to describe Physician Assistants (PAs) and Nurse Practitioners (NPs).[2] However, many other health care professionals fall under this descriptive term as well, including Certified Registered Nurse Anesthetists, Certified Nurse Midwives, and Clinical Nurse Specialists.[3] This comment will focus entirely on PAs and NPs.[4]

Physician assistants and nurse practitioners are highly qualified health care professionals who provide an array of medical services to patients. Generally, PAs and NPs practice in primary medical care[5] under the supervision of a physician, although midlevel providers practice in a variety of medical fields and state laws differ over the scope of midlevel practitioner authority.[6] The concept of a "midlevel provider" is not a new one, with its medical tradition dating back decades in the U.S.[7] The development of these practitioners is rooted in the need for access to primary care in rural and underserved areas, and the utility and importance of midlevel providers has increased substantially

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[2] *See* Michael D. Pappas, *Stop Calling Nurse Practitioners Mid-Level Providers*, KEVINMD.COM (July 14, 2014), http://www.kevinmd.com/blog/2014/07/stop-calling-nurse-practitioners-mid-level-providers.html.

[3] *See* OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMIN., MID-LEVEL PRACTITIONERS AUTHORIZATION BY STATE (2015), *available at* http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf.

[4] Unless otherwise noted, I am referring solely to Physician Assistants and Nurse Practitioners when I use the term "midlevel provider."

[5] Primary care is "that care provided by physicians [and other qualified health professionals] specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the 'undifferentiated' patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis." *Primary Care*, AM. ACAD. OF FAMILY PHYSICIANS, http://www.aafp.org/about/policies/all/primary-care.html (last visited Apr. 1, 2015).

[6] *See Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Physician Assistants*, UNIV. OF PITTSBURGH MED. CTR., http://www.upmc.com/patients-visitors/education/miscellaneous/pages/physician-assistants-nurse-practitioners-and-midlevel-providers.aspx (last visited Apr. 1, 2015).

[7] *See* HEALTH RES. & SERVS. ADMIN., A COMPARISON OF CHANGES IN THE PROFESSIONAL PRACTICE OF NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES: 1992 AND 2000, at 7 (2004), *available at* http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/comparechange19922000.pdf.

in recent years.[8]

The idea of the nurse practitioner was developed in the 1960s by Dr. Henry Silver and Loretta Ford, Ph.D. (a nurse educator) at the University of Colorado.[9] Together, the two created a program to educate and train nurses in response to the period's general shortage of primary care physicians in rural areas.[10] The first graduates matriculated in the late 1960s, and some nurse practitioner programs follow this model today.[11] The medical community initially expressed skepticism about the educational process and new role of nurses as practitioners, or "physician-extenders," but over time, many nursing and medical communities have embraced nurse practitioners as valuable and highly qualified health professionals.[12] Nurse practitioners are legally enabled to practice in every state and the District of Columbia.[13] Currently, there are approximately 205,000 nurse practitioners licensed in the U.S.[14]

Much like the development of nurse practitioner programs in the U.S., the physician assistant profession was envisioned to improve and expand health care.[15] In 1965, Eugene A. Stead Jr., M.D., of the Duke University Medical Center assembled the first class of physician assistants in response to the general shortage of primary care physicians in the country.[16] Selecting Navy corpsmen as his students, Dr. Stead based the program's curriculum on his knowledge of the "fast-track" training of physicians during World War II.[17] The first graduates matriculated in 1967, and physician assistants were quickly welcomed by the medical community.[18] Physician assistants are legally allowed to practice in all fifty states and the District of Columbia;[19] there are more

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[8] *See id.*

[9] *See id.*

[10] *Id.* at 7–8.

[11] *Id.* at 8.

[12] *See id.*

[13] HEALTH RES. & SERVS. ADMIN., *supra* note 7, at 8.

[14] *NP Fact Sheet*, AM. ASS'N OF NURSE PRACTITIONERS, http://www.aanp.org/all-about-nps/np-fact-sheet (last updated Mar. 2015).

[15] *See History*, AM. ACAD. OF PHYSICIAN ASSISTANTS, http://www.aapa.org/the_pa_profession/history.aspx (last visited Apr. 1, 2015).

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] *What Is a PA?*, AM. ACAD. OF PHYSICIAN ASSISTANTS, https://www.aapa.org/landingquestion.aspx?id=290 (last visited Apr. 1, 2015).

than 90,000 physician assistants practicing in the U.S. today.[20]

B. Current Issues

Having introduced the historical conception of midlevel providers in the U.S., I next want to frame the current issues that affect physician assistants and nurse practitioners. The current physician shortage, the effects of the Patient Protection and Affordable Care Act of 2010, the issue of insurance reimbursement for midlevel providers, and midlevel provider liability are all relevant topics to consider before examining midlevel provider laws in Alabama.

i. Primary Care Physician Shortage

The U.S. is currently facing a serious shortage of primary care physicians due to several factors. First, medical school debt is astounding, and the cost of education is continuing to rise. According to the Association of American Medical Colleges, the average medical school graduate from the class of 2014 faces nearly $170,000 of debt.[21] Second, according to an article by the American Association of Retired Persons, the starting salary for primary care physicians is in the range of $150,000 to $170,000.[22] Thus, after four years of medical school and three years of residency, physicians have a strong incentive to seek specialty positions with larger salaries, rather than primary care positions.[23] Alternatively, the cost of medical school alone may be enough to keep potential medical school attendees from enrolling in the first place.[24]

A third driving factor behind the physician shortage is the

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[20] *See* NAT'L COMM'N ON CERTIFICATION OF PHYSICIANS ASSISTANTS, 2013 STATISTICAL PROFILE OF CERTIFIED PHYSICIAN ASSISTANTS: AN ANNUAL REPORT OF THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS 8, *available at* http://www.nccpa.net/Upload/PDFs/2013StatisticalProfileofCertifiedPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf.

[21] *Medical Student Education: Debt, Costs, and Loan Repayment Fact Card*, ASS'N OF AM. MED. COLLS. (Oct. 2013), https://www.aamc.org/download/152968/data/debtfactcard.pdf.

[22] Marsha Mercer, *How to Beat the Doctor Shortage*, AARP (Mar. 2013), http://www.aarp.org/health/medicare-insurance/info-03-2013/how-to-beat-doctor-shortage.html.

[23] *See id.* ("[A] radiologist or gastroenterologist can make two to three times that [of a primary care physician] . . . . Only one in five graduating internal medicine residents plans to go into primary care medicine . . . .").

[24] *See id.*

aging demographic of U.S. physicians. Another study by the Association of American Medical Colleges indicates that nearly one-third of all physicians will retire within the next decade.[25] At the same time, the Census Bureau projects "a 36 percent growth in the number of Americans over age 65, the very segment of the population with the greatest health care needs."[26] Thus, holding health reform legislation implications aside, nearly one-third of all U.S. physicians will retire within the next decade, while more than one-third of the population will reach age sixty-five, further straining health care systems.[27]

Finally, according to a 2012 study by the Physicians Foundation, many physicians report that they are either "at capacity or are overworked and overextended," suggesting that patient demand for access to physicians is increasing disproportionately to physician supply.[28] In response, many physicians are cutting back on the number of patients seen or reducing the scope of their services, particularly those rendered to Medicare and Medicaid patients.[29] Such physician measures may intensify the current physician shortage in light of recent health reform legislation that expands the number of insured Americans.

ii. The Patient Protection and Affordable Care Act of 2010 (ACA)

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act[30] (ACA) into law, with more provisions set to roll out in the coming years.[31] The fundamental purposes of the ACA are to expand health care coverage, control and decrease health care costs, and improve the health care delivery system in the U.S.[32] The most obvious implication of the ACA's individual mandate provision—that most

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[25] *Physician Shortages to Worsen Without Increases in Residency Training*, ASS'N OF AM. MED. COLLS., https://www.aamc.org/download/286592/data/ (last visited Apr. 1, 2015).

[26] *Id.*

[27] *See id.*

[28] Merritt Hawkins, *A Survey Of America's Physicians: Practice Patterns and Perspectives*, PHYSICIANS FOUND. 49 (Sept. 2012), http://www.physiciansfoundation.org/uploads/default/Physicians_Foundation_2012_Biennial_Survey.pdf.

[29] *Id.*

[30] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[31] *See id.*

[32] *See* HENRY J. KAISER FAMILY FOUND., SUMMARY OF THE AFFORDABLE CARE ACT 1

U.S. citizens and legal residents obtain health care coverage—is that more Americans will have access to coverage with a limited supply of health care providers.[33] The Association of American Medical Colleges projects that an additional thirty-two million Americans will receive health care coverage.[34] This will only exacerbate the current physician shortage as the ACA becomes fully implemented, especially in light of the aging U.S. population and the limited supply of primary care physicians.[35]

The ACA seeks to retain physicians specializing in primary care. First, the ACA provides a 10% bonus payment to primary care physicians in Medicare from 2011 to 2015.[36] Effectively, this provision is an incentive for physicians to stay in primary care or continue to see Medicare patients.[37] Second, as of 2013, the ACA "[i]ncrease[d] Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014."[38] This set Medicaid rates to match Medicare rates, and allowed states to "receive 100% federal financing for the increased payment rates."[39] Again, this provision aims to ensure that current or new enrollees of Medicaid will have access to primary care physicians, and that those physicians will not cut out Medicaid patients simply on the basis of cost.

Additionally, individuals and small business owners, such as small private practices, have access to the state-run health insurance exchanges contemplated by the ACA.[40] These state-run exchanges allow individuals and small businesses to join together and shop health benefit programs in a competitive marketplace so as to enhance policy-owner bargaining power and to reduce the cost of providing health care coverage for individuals and employees.[41] "States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each

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(Apr. 23, 2013), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf.

[33] *See id.*

[34] *See* ASS'N OF AM. MED. COLLS., *supra* note 25.

[35] *See id.*

[36] HENRY J. KAISER FAMILY FOUND., *supra* note 32, at 10.

[37] *See id.*

[38] *Id.*

[39] *Id.*

[40] *See id.* at 4.

[41] *See id.*

Exchange serves a distinct geographic area."[42] The ACA provided federal funding to states for the establishment of these Exchanges until the start of 2015.[43]

Further, the ACA creates a significant and expanding role for physician assistants and nurse practitioners to supplement the limited supply of primary care physicians. The Bureau of Labor Statistics predicts that employment of physician assistants will grow nearly 38% by 2022,[44] and employment of advanced practice nurses is expected to grow nearly 31% by 2022.[45] Additionally, the ACA seeks to support midlevel provider growth through loan repayments, scholarships, and training programs.[46] Although the ACA intends to support midlevel provider growth and utilization, the effectiveness of midlevel practice is ultimately a state issue.[47] Most states require collaboration agreements between physicians and midlevel providers, so states like Alabama are bound by their own legislation in order to effectively use midlevel providers. Thus, the expansion of collaborative practice between primary care physicians and midlevel providers is paramount to meeting patient demand for primary care as a result of the ACA.

iii. Insurance Reimbursement Rates for Midlevel Providers

Generally, the method of payment for physicians and midlevel providers in the U.S. has contributed to the attrition of primary care professionals.[48] The prevailing system of reimbursement—"fee-for-service"—leans heavily towards compensation

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[42] HENRY J. KAISER FAMILY FOUND., *supra* note 32, at 4.

[43] *Id.*

[44] BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK, 2014–15 EDITION, PHYSICIAN ASSISTANTS (Jan. 8, 2014), http://www.bls.gov/ooh/healthcare/physician-assistants.htm.

[45] BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK, 2014–15 EDITION, NURSE ANESTHETISTS, NURSE MIDWIVES, AND NURSE PRACTITIONERS (Jan. 8, 2014), http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm. An "advanced practice nurse" is a term that encompasses nurse practitioners, nurse anesthetists, and nurse midwives who have earned a master's degree in their respective fields and met certain state and federal licensing and entrance exam requirements. *Id.*

[46] *See* HENRY J. KAISER FAMILY FOUND., *supra* note 32, at 12.

[47] *See id.* at 4, 10.

[48] *See* Melinda Abrams et al., *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers*, COMMONWEALTH FUND 3 (Jan. 2011), http://www.commonwealthfund.org/~/media/files/publications/issue-

for procedures, such as surgeries and X-rays.[49] The fee-for-service system does not adequately compensate practitioners for time spent with a patient, and some core primary care activities are not reimbursed at all.[50] The ACA seeks to remedy primary care reimbursement issues through the 10% Medicare bonus, the mandate that Medicaid reimbursements match those of Medicare, and ancillary benefits for primary care practitioners, such as loan repayment, scholarships, and training programs.[51]

Generally, midlevel providers are reimbursed for services at 85% of the physician's fee schedule.[52] However, reimbursement rates vary by state scope-of-practice requirements[53] and third-party payer terms.[54] For example, Medicare will reimburse the services of midlevel providers at 85% of the physician's fee schedule, but will reimburse midlevel provider services at 100% of the physician's fee schedule if the services are "incident-to" a physician's care.[55] Medicaid, on the other hand, is partially state-funded; indeed, states set the reimbursement rates for midlevel provider services.[56] Likewise, private commercial indemnity insurance companies like Blue Cross Blue Shield set their own rates.

iv. Midlevel Provider Liability

Another implication of the growing demand for health care access is increased exposure to malpractice liability for both physicians and midlevel providers. Under collaborative practice agreements between physicians and midlevel providers, the midlevel provider may be an agent and the physician may be the

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brief/2011/jan/1466_abrams_how_aca_will_strengthen_primary_care_reform_brief_v3.pdf.

[49] *Id.*

[50] *Id.*

[51] *See supra* notes 34–44 and accompanying text.

[52] *See* Alice G. Gosfield, *The Ins and Outs of "Incident-To" Reimbursement*, 8 FAM. PRAC. MGMT. 23, 26 (2001), *available at* http://www.aafp.org/fpm/2001/1100/p23.html.

[53] *See id.* at 24.

[54] Third-party payers are simply the health care entities that provide indemnity payments partially or completely for the patient, such as Medicare, Medicaid, commercial insurance companies, or managed care organizations. *See* 42 U.S.C. § 1396a(a)(25)(A) (2012).

[55] *See* Gosfield, *supra* note 52, at 24, 26.

[56] *Qs and As on the Increased Medicaid Payment for Primary Care: CMS 2370-F (Set II)*, MEDICAID.GOV, http://www.medicaid.gov/affordablecareact/provisions/downloads/qanda-set-ii-increased-payments-for-pcps.pdf (last visited Mar. 8, 2014).

principal of the agent.[57] Further, when a physician uses midlevel providers in collaborative support roles, the physician may be responsible for the acts of the midlevel provider as his or her agent.[58] Therefore, the doctrines of "vicarious liability" and "respondeat superior" are applicable to the physician-midlevel provider relationship.[59]

Black's Law Dictionary defines "respondeat superior" as "[t]he doctrine holding an employer or principal liable for the employee's or agent's wrongful acts committed within the scope of the employment or agency."[60] On the other hand "vicarious liability" is defined as the "[l]iability that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or associate (such as an employee) based on the relationship between the two parties."[61] While respondeat superior is used to connect the negligent acts of the agent to the principal, vicarious liability is used to assign liability to a non-negligent person who maintained a legal relationship with the negligent party.[62] Both theories are frequently used to link the acts of midlevel providers to their collaborating physicians.[63]

However, there are many other causes of action frequently brought against midlevel providers and physicians when liability issues arise. One of the most common allegations against physicians is the "failure to supervise," meaning the supervising physician did not adequately monitor the work of the midlevel provider, resulting in injury to the patient.[64] Midlevel providers are also using this as a defense[65]—depending on the tort theories followed by the jurisdiction where the injury occurred, the midlevel provider could be completely absolved from liability to the patient using this defense.[66]

Other causes of action brought against physicians for the

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[57] *See* Alicia Gallegos, *Mid-Level Providers Bring Different Risk to Practice*, ACS SURGERY NEWS (Oct. 24, 2013), http://www.acssurgerynews.com/index.php?id=15051&type=98&tx_ttnews[tt_news]=217281&cHash=da03e20e36 (last visited April 20, 2015).

[58] *See id.*

[59] *See id.*

[60] BLACK'S LAW DICTIONARY 1426 (9th ed. 2009).

[61] *Id.* at 998.

[62] *See* Gallegos, *supra* note 57.

[63] *See id.*

[64] *See id.*

[65] *Id.*

[66] *See id.*

work of their midlevel providers include: "[f]ailure to have in place a collaborative agreement, . . . [f]ailure to follow the requirements of the collaborative agreement, . . . [a]llowing the [midlevel provider] to practice beyond the scope of his or her collaborative agreement, . . . [and n]egligent hiring of the [midlevel provider]."[67] Usually, such allegations stem from midlevel providers' omissions or delays in diagnoses, physician or specialist referrals, or sufficient communication with the relevant physician.[68]

Clearly, there are many avenues for plaintiffs seeking recovery from physicians for the acts of their collaborating midlevel providers.[69] In other circumstances, midlevel providers may be held responsible for maintaining a standard of care unique to their profession. For example, nurse practitioners may not be seen as an agent of their collaborating physician; rather, they may be seen as licensed practitioners with a professional code of conduct they must follow. In the presence of protocols and collaborative agreement terms, the nurse practitioner, or other licensed midlevel provider, may be held liable for his or her own negligent acts. I will discuss this issue in greater detail below.

ALABAMA'S MIDLEVEL PROVIDER LAWS

A. Nurse Practitioners

i. Prescriptive Authority

Nurse practitioners in collaborative practice with physicians may be granted prescriptive authority upon application to the Alabama Board of Nursing if they have completed an academic course in pharmacology or evidenced experience in pharmacology theory and clinical application in the certified registered nurse practitioner curriculum.[70] Nurse practitioners may prescribe medicines in collaborative practice, but "[t]he drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating

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[67] James W. Saxton & Maggie M. Finkelstein, *Healthcare Reform, Mid-Level Providers, and Liability Risk*, PHYSICIANSNEWS.COM (July 23, 2010, 12:00 AM), http://www.physiciansnews.com/2010/07/23/healthcare-reform-mid-level-providers-and-liability-risk.

[68] *Id.*

[69] *See id.*

[70] ALA. ADMIN. CODE r. 540-X-8-.11(1) (2015).

physician and the certified registered nurse practitioner."[71] Nurse practitioners "may not initiate a call-in prescription in the name of a collaborating physician for any drug . . . which the certified registered nurse practitioner is not authorized to prescribe under the protocol signed by the collaborating physician and certified registered nurse practitioner."[72] However, if "the drug is specifically ordered for the patient by the physician, either in writing or by a verbal order which has been transcribed in writing, and which has been signed by the physician within seven working days or as otherwise specified by the Board of Nursing and the Board of Medical Examiners," then the nurse practitioner may initiate the call-in prescription.[73]

The Alabama Administrative Code provides: "A written prescription for any drug that the certified registered nurse practitioner is authorized to prescribe may be called in to a pharmacy, provided the prescription is entered into the patient's record and signed by the certified registered nurse practitioner."[74] "When prescribing legend drugs a certified registered nurse practitioner shall use a prescription form" meeting several criteria.[75] First, the prescription form must include "[t]he name, medical practice site address and telephone number of the collaborating physician or covering physician," and the nurse practitioner's name must be printed below or next to the physician's name.[76] If the medical practice site address and telephone number of the nurse practitioner is different from that of the collaborating physician, it must be included.[77] "The certified registered nurse practitioner's registered nurse license number and identifying prescriptive authority number assigned by the Board of Nursing" must be included on the form.[78] Next, the form must include the words "'Product Selection Permitted' printed on one side of the prescription form directly beneath a signature line" and "'Dispense as written' printed on one side of the prescription form directly beneath a signature line."[79] Finally, the date on which the prescription is issued must be included on the

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[71] *Id.* r. 540-X-8-.11(2)(a).
[72] *Id.* r. 540-X-8-.11(3).
[73] *Id.*
[74] *Id.* r. 540-X-8-.11(4).
[75] *Id.* r. 540-X-8-.11(7).
[76] ALA. ADMIN. CODE r. 540-X-8-.11(7)(a)–(b).
[77] *Id.* r. 540-X-8-.11(7)(c).
[78] *Id.* r. 540-X-8-.11(7)(d).
[79] *Id.* r. 540-X-8-.11(7)(e)–(f).

prescription form.[80]

The physician in collaborative practice with a certified registered nurse practitioner must have practiced medicine for at least one year, and in some cases, three years.[81] Also, the physician may not collaborate with or supervise any combination of nurse practitioners or other midlevel providers more than "(120) hours per week (three full-time equivalent positions) unless an exemption is granted under [Alabama law]."[82] A "full-time equivalent (FTE)" is the collective unit of people working together in collaborative practice that together sum forty hours of work per week.[83] Finally, within five business days of the commencement or termination of collaborative practice, the physician must deliver signed notice of the practice to the Alabama Board of Medical Examiners.[84]

Additionally, "A physician in collaborative practice may request approval for additional full-time certified registered nurse practitioner positions."[85] An exemption to the 120 hour-per-week rule may be granted in light of several circumstances "to insure that an acceptable standard of care is rendered."[86] Such circumstances include the "availability of the physician," "practice settings and staffing needs for extended hours of service," "risk to patients," "educational preparation, specialty and experience of the parties in the collaborative practice," and "complexity and risk of procedures to be performed."[87]

Once a collaborative practice is legitimately established, the Alabama Board of Medical Examiners requires several elements of continued practice. First, regarding his or her midlevel providers, the collaborating physician must "[p]rovide professional medical oversight and direction . . . [b]e readily available for direct communication or by radio, telephone or telecommunications . . . [and b]e readily available for consultation or referrals

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[80] *Id.* r. 540-X-8-.11(7)(g).
[81] *Id.* r. 540-X-8-.04(1)(b).
[82] ALA. ADMIN. CODE r. 540-X-8-.04(3).
[83] *Id.*
[84] *Id.* r. 540-X-8-.04(4)(a)–(b).
[85] *Id.* r. 540-X-8-.12(3).
[86] *Id.*
[87] *Id.*

of patients."[88] If the collaborating physician is not readily available, then covering physicians may be used.[89] If the nurse practitioner will be practicing at a remote site, then there must be written protocols that specify the circumstances of practice and procedures for physician oversight and availability, including emergency circumstances.[90]

The collaborating physician must be present with the nurse practitioner in an approved collaborative practice site for not less than 10% of the nurse practitioner's scheduled hours in the collaborative practice, and the physician must visit each approved practice site not less than quarterly.[91] However, the "collaborating physicians with the Alabama Department of Public Health and county health departments are exempt from this requirement."[92] Additionally, the "nurse practitioner's scheduled hours in licensed acute care hospitals, licensed skilled nursing facilities, licensed special-care assisted living facilities, and licensed assisted living facilities are not subject to the minimum hours for physician presence."[93]

If the nurse practitioner's scheduled weekly collaborative practice hours are thirty or more hours per week, then the nurse practitioner must be present in the practice site with the collaborating or covering physician for time equal to 10% of the nurse practitioner's scheduled weekly hours.[94] If the nurse practitioner's hours are less than 30 hours per week, then the nurse practitioner shall be present in the practice site with the collaborating or covering physician for time equal to 10% of the nurse practitioner's scheduled weekly hours.[95] Cumulative hours may accrue on a quarterly basis if the nurse practitioner works less than thirty hours per week, and cumulative hours accrue on a monthly basis if the nurse practitioner works more than thirty hours per week.[96] The requirements of written verification of physician availability may be waived "upon documentation of exceptional circumstances."[97]

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[88] ALA. ADMIN. CODE r. 540-X-8-.08(1) (2015).
[89] *See id.* r. 540-X-8-.08(2).
[90] *Id.* r. 540-X-8-.08(3).
[91] *Id.* r. 540-X-8-.08(4).
[92] *Id.*
[93] *Id.* r. 540-X-8-.08(5).
[94] ALA. ADMIN. CODE r. 540-X-8-.08(6) (2015).
[95] *Id.*
[96] *Id.*
[97] *Id.* r. 540-X-8-.08(8).

Due to the collaborating physician's liability for his or her employed and directed nurse practitioners, significant documentation of express responsibilities is required. A written protocol specific to the practice area of the nurse practitioner and the practice area of the collaborating physician, approved and signed by both the collaborating physician and the nurse practitioner, must

> [i]dentify all sites where the [nurse practitioner] will practice[;] . . . [i]dentify the physician's principal practice site . . . [b]e maintained at each practice site . . . [i]nclude a formulary of drugs . . . that may be prescribed[;] . . . [i]nclude a pre-determined plan for emergency services[;] . . . [s]pecify the process by which the certified registered nurse practitioner shall refer a patient to a physician other than the collaborating physician; and . . . [s]pecify a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the certified registered nurse practitioner and include review of no less than 10% of medical records plus all adverse outcomes.[98]

Quality assurance documentation must be readily retrievable, include evaluative summaries, and be reviewed by the physician and nurse practitioner.[99] Clearly, the procedures that nurse practitioners must follow in collaborative practice heavily emphasize quality of care rendered to the patient.

ii. Liability

In Alabama, nurse practitioners must practice, to some degree, in collaboration with a physician. The Alabama Code provides:

> No person shall engage in practice as a certified registered nurse practitioner . . . unless that person is certified by the Board of Nursing as an advanced practice nurse in a category of certified registered nurse practitioner . . . *and is practicing in collaboration with a physician following protocols* which have been approved in accordance with this article or has been exempted from the requirement of practicing in collaboration with a physician following protocols.[100]

Because Alabama's default rule is that nurse practitioners must practice in collaboration with a physician,[101] the physician

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[98] *Id.* r. 540-X-8-.08(9).

[99] *Id.*

[100] ALA. CODE § 34-21-90 (West 2014) (emphasis added).

[101] *See id.*

could be liable, at least in part, for the negligent acts of the nurse practitioner under an agency theory when the physician directs the nurse practitioner to act or not act. However, as described in Alabama Code § 34-21-90, nurse practitioners must practice "in collaboration with a physician following protocols."[102] The fact that nurse practitioners in collaborative practice follow protocols[103] means that a nurse practitioner's failure to follow such protocols may constitute a negligent act. Thus, the failure to follow established protocols may introduce individual liability upon the nurse practitioner. Furthermore, nurse practitioners are licensed health care professionals, regulated by the Alabama Board of Nursing and Alabama statutes and subject to standards of practice unique to their profession.[104]

Nurse practitioners also qualify as "other health care providers" under the Alabama Medical Liability Act (AMLA), where they are defined as "[a]ny professional corporation or any person employed by physicians, dentists, or hospitals who are directly involved in the delivery of health care services."[105] Under the AMLA, to establish liability against a health care provider, a plaintiff holds the burden of "proving by substantial evidence that the health care provider failed to exercise such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice ordinarily have and exercise in a like case."[106] As in other negligence claims, a plaintiff meets this burden by proving the appropriate standard of care for nurse practitioners, the nurse practitioner's deviation from that standard of care, causation, and injury.[107] Additionally, establishing the applicable standard of care and the alleged breach of that standard of care "'ordinarily' requires expert testimony from a 'similarly situated health-care provider,' as that term is defined in [Alabama Code] § 6–5–548."[108] Therefore,

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[102] *Id.*

[103] *See* Michael A. Worel & David G. Wirtes, Jr., *Don't Neglect the Nurse's Duty of Care*, 43 TRIAL, Nov. 2007, at 50–51, 56 (describing protocols as an integral part of a nurse practitioner's duty to advocate on behalf of the patient, especially if an attending physician acts negligently).

[104] *See, e.g.*, ALA. ADMIN. CODE r. 610-X-2-.01 (incorporating the Alabama Board of Nursing's statutory authority).

[105] ALA. CODE § 6-5-481(8).

[106] *Id.* § 6-5-548(a).

[107] *See* Morgan v. Publix Super Mkt., Inc., 138 So.3d 982, 986 (Ala. 2013).

[108] *Id.*

nurse practitioners are largely responsible for their own, independent actions from a professional liability standpoint.

B. Physician Assistants

i. Prescriptive Authority

A physician assistant may prescribe to patients subject to two conditions being met. First, the "drug type, dosage, quantity prescribed, and number of refills [must be] authorized in the job description which is signed by the supervising physician to whom the physician assistant is currently registered and which is approved by the [Alabama] Board [of Medical Examiners]."[109] Second, the drug must be "included in the formulary approved under the guidelines established by the [Alabama] Board [of Medical Examiners] for governing the prescription practices of physician assistants."[110] As of October 1, 2013, physician assistants may prescribe, dispense, and administer schedule III, IV, and V controlled substances after obtaining a "Qualified Alabama Controlled Substances Registration Certificate" (QACSC) pursuant to Act 2013-223.[111]

A physician assistant may not initiate a call-in prescription in the name of the supervising physician for any drug which the PA is not authorized to prescribe, unless the drug is "specifically ordered for the patient by the supervising physician either in writing or by a verbal order reduced to writing and signed by the physician."[112] Otherwise, "a written prescription signed by the physician assistant and entered into the patient's chart may be called-in to a pharmacy," as long as the PA is legally authorized to prescribe the drug.[113] Whenever a physician assistant calls in a prescription to a pharmacy, the physician assistant must identify his or her supervising physician.[114] "Unless prohibited by Federal or state statutes or regulations or by the agency governing a specific form, a physician assistant may sign any form which can be authenticated by the supervising physician's signature, if signing by the physician assistant is authorized by the supervising physician."[115] However, physician assistants are prohibited

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[109] ALA. ADMIN. CODE r. 540-X-7-.28(1)(a).
[110] *Id.* r. 540-X-7-.28(1)(b).
[111] *See* ALA. CODE § 20-2-253(a).
[112] ALA. ADMIN. CODE r. 540-X-7-.28(4).
[113] *Id.* r. 540-X-7-.28(5).
[114] *Id.* r. 540-X-7-.28(6).
[115] *Id.* r. 540-X-7-.31(1).

from signing prescriptions for controlled substances.[116]

When prescribing, a physician assistant must use a prescription form in compliance with several requirements. First, the form must state "[t]he name, medical practice site address and telephone number of the physician supervising the physician assistant."[117] Second, the physician assistant's name must be printed below or to the side of the physician's name.[118] Third, the medical practice site address and telephone number of the physician assistant must be included on the prescription form if they differ from those of the supervising physician.[119] Fourth, when a controlled substance is prescribed, the physician assistant's license number assigned by the Alabama Board of Medical Examiners and the QACSC registration number must be included on the prescription form.[120] Finally, the words "Product Selection Permitted" or "Dispense as Written" must be printed on one side of the prescription form directly underneath a signature line.[121]

ii. Physician Supervision

The Alabama Board of Medical Examiners has expressed that "[t]here shall be no independent, unsupervised practice by physician assistants."[122] Supervising physicians are required to have a "direct, continuing and close supervisory relationship" with the physician assistant registered to practice with them at all times.[123] The supervising physician must be available to communicate directly by telecommunications, and the physician must be available for consultation or referrals from the physician assistant.[124] In the event that the physician is unavailable, a covering physician relationship must be established under the supervisory relationship.[125]

When the primary supervising physician is not immediately available to attend to a patient's needs, the physician assistant

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[116] *Id.* r. 540-X-7-.31(2).
[117] *Id.* r. 540-X-7-.28(8)(a).
[118] ALA. ADMIN. CODE r. 540-X-7-.28(8)(b).
[119] *Id.* r. 540-X-7-.28(8)(c).
[120] *Id.* r. 540-X-7-.28(8)(d)–(f).
[121] *Id.* r. 540-X-7-.28(8)(e)–(f).
[122] *Id.* r. 540-X-7-.23(2).
[123] *Id.* r. 540-X-7-.23(1).
[124] ALA. ADMIN. CODE r. 540-X-7-.23(3)–(4).
[125] *Id.* r. 540-X-7-.23(5).

may not "perform any act or render any treatments unless another qualified physician in the same partnership, group, medical professional corporation or physician practice foundation or with whom the primary supervising physician shares call is on call and is immediately available to supervise the physician assistant."[126] The covering physician must file a letter with the Alabama Board of Medical Examiners stating that he or she assumes all responsibility for the actions of the physician assistant while the physician is covering.[127] Additionally, the covering physician must state in the filing that he or she is familiar with the rules regarding physician assistants and that physician assistant's role, responsible for supervising the physician assistant, and approves of any prescriptions the physician assistant is authorized to administer in his or her duties.[128]

If the physician assistant is to perform duties at a different site than his or her supervising physician, the physician assistant's registration application with the Alabama Board of Medical Examiners must "clearly specify the circumstances and provide written verification of physician availability for consultation and/or referral, and direct medical intervention in emergencies and after hours."[129] This requirement may be waived by the Board under exceptional circumstances similar to those of nurse practitioners.[130] When a physician supervises a physician assistant at a different site, he or she has special duties.[131] First, the supervising physician "receives a daily status report to be made in person, by telephone, or by telecommunications from the assistant on any complications or unusual problems encountered."[132] Second, the supervising physician must personally visit the site at least once per week during normal business hours to observe the physician assistant and provide medical direction and consultation.[133] Third, during the weekly required office visit, the supervising physician must review the case histories of unusual patient situations or complications encountered by the assistant.[134] Finally, the supervising physician must personally

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[126] *Id.* r. 540-X-7.24(1).
[127] *Id.*
[128] *See id.* r. 540-X-7.24(2).
[129] *Id.* r. 540-X-7.23(6).
[130] *See* ALA. ADMIN. CODE r. 540-X-7-.23(6).
[131] *See id.* r. 540-X-7.23(8).
[132] *Id.* r. 540-X-7.23(8)(a).
[133] *Id.* r. 540-X-7.23(8)(b).
[134] *Id.* r. 540-X-7.23(8)(c).

diagnose or treat any patient that requires a follow-up consultation.[135]

iii. Liability

In Alabama, physician assistants may not practice without direct supervision by a physician[136] and are classified as agents of their supervising physician:

> [A]n assistant to a physician shall be conclusively presumed to be the agent, servant, or employee solely of the licensed physician or physicians under whose supervision he or she performs the service, and no other person, firm, corporation, or other organization shall be held liable or responsible for any act or omission of the assistant arising out of the performance of the medical service.[137]

In supervisory delegation circumstances, the physician assistant is an agent and the supervising physician is the principal.[138] Thus, where a physician delegates responsibilities to his or her assistant, the physician at all times "remains responsible for the assistant carrying out those responsibilities in an appropriate manner."[139]

EFFECTIVE LEGISLATIVE SOLUTIONS—ARKANSAS, NEVADA, MASSACHUSETTS, AND TEXAS

A. Arkansas

In Arkansas, like in Alabama, nurse practitioners and physician assistants have prescriptive authority over schedule III, III-N, IV, and V substances.[140] However, midlevel providers in Arkansas have the ability to "Prescribe, Order, and Administer" these substances, while midlevel providers in Alabama may only "Prescribe, Dispense, and Administer" them.[141] Arkansas expanded its nurse practitioners' prescriptive authority in 2013, under Act 604.[142]

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[135] *Id.* r. 540-X-7.23(8)(d).

[136] ALA. ADMIN. CODE r. 540-X-7.23(1).

[137] ALA. CODE § 34-24-292(b) (West 2014).

[138] *See* Cox v. M.A. Primary & Urgent Care Clinic, 313 S.W.3d 240, 254 (Tenn. 2010).

[139] *Id.*

[140] *See* OFFICE OF DIVERSION CONTROL, *supra* note 3, at 1.

[141] *Id.*

[142] Jill Hasley, *Title Changes for Advanced Practice Nurses*, ASBN UPDATE, Oct. 2013, at 18, *available at* http://www.arsbn.arkansas.gov/forms/Documents/October2013.ASBN_ed64 F.pdf.

The Act represents an effort by the Arkansas State Board of Nursing (ASBN) to enact legislative updates to Arkansas' Nurse Practice Act and Chapter 4 of its ASBN Rules.[143] The state's spring 2013 legislative session "passed Act 604, which brought three major changes" to advanced practice nursing in Arkansas.[144] First, "[t]he title of Advanced Practice Nurse (APN) has changed to Advanced Practice Registered Nurse (APRN)."[145] In effect, this change means that "[a]ll four roles of APN licensure (ANP/Nurse Practitioner, CNS, CNM, and CRNA) will now be called APRNs."[146] Second, "the title of Advanced Nurse Practitioner (ANP) has changed to Certified Nurse Practitioner (CNP)."[147] Third, the Prescriptive Authority Advisory Committee of Arkansas now has an additional APRN member that is not required to have prescriptive authority.[148] This will allow advanced practice nurse practitioners that do not have prescriptive authority to sit on the committee, which effectively increases the amount of input that all advanced practice nurses may have on the prescriptive authority policy in the state.[149]

In addition to these three major changes, there were changes to Chapter 4 of the ASBN Rules that became effective January 1, 2013.[150] The first two changes focus on ensuring quality of care in the advanced practice nursing field.[151] The first major change is that "[a]ll four APRN roles (CNP, CRNA, CNM, CNS) require successful completion of a nationally accredited graduate or post-graduate APRN program."[152] While this is not necessarily a new requirement in Arkansas, it serves to clarify the statutory language and emphasize the qualifications of advanced practice nurses in the state.[153] The second major change is that endorsement applicants and individuals who are applying for reinstatement of their APRN license (i.e., those who have been out of practice for more than two years) must take an APRN nursing

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[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] *Id.*
[147] *Id.*
[148] Hasley, *supra* note 142, at 18.
[149] *See id.*
[150] *Id.*
[151] *See id.* at 18–19.
[152] *Id.* at 18.
[153] *See id.*

refresher course or "an extensive orientation, which shall include a minimum of 200 hours of a supervised clinical component with a qualified preceptor."[154] These two changes seek to fortify the quality and experience of advanced practice nurses in Arkansas, which is crucial to state trust in the advanced-practice nursing field.

The next two changes are administrative in nature. First, "[t]he ASBN will notify the appropriate certifying agency when an APRN has disciplinary action taken on their license or privilege to practice."[155] This change seeks to moderate advanced practice nursing and effectively allocate liability for professional misconduct. Matching liability with causation is another way to ensure quality in midlevel provider care. Second, APRNs must notify the ASBN in writing within seven days following the termination of a collaborative practice agreement.[156] This administrative change is intended to prevent midlevel providers from practicing without a collaborative practice agreement, which, as it is in Alabama, is a requirement in Arkansas.[157]

Furthermore, the Act specifies certain requirements for written and electronic prescribing by advanced practice nurses.[158] First, all prescriptions must contain "the name of the patient, the APRN's name, title, address, phone number, and signature with 'APRN.'"[159] Additionally, the prescription must include the information formerly required by Chapter 4, Section 8(d) of the ASBN Rules regarding medication, dosage, and directions.[160] Also, when prescribing controlled substances, the APRN's DEA registration number will continue to be required.[161]

Finally, a new Section IX was added to the Chapter 4 of the ASBN Rules for "Prescribing Guidelines for Anorexiant Drugs."[162] This drug class is a high-abuse class, so the ASBN implemented more regulation on how these drugs are prescribed.[163] While the new section does not place greater restriction on an APRN's ability to prescribe from this drug class,

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[154] Hasley, *supra* note 142, at 18–19.
[155] *Id.* at 19.
[156] *Id.*
[157] ARK. CODE ANN. § 17-87-310(a)(2) (West 2014).
[158] Hasley, *supra* note 142, at 19.
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] *Id.*
[163] *Id.*

it does provide increased procedures that must be followed in order to prescribe these drugs.[164]

While the effective use of midlevel providers requires expanded prescriptive authority and scope-of-practice laws, it also requires strict guidelines for quality underlying the legislative effort to maximize health care access. This Act is a good example of legislative reform for advanced practice nursing and midlevel provider prescriptive authority in general—it represents an emphasis on reforming procedures and protocols in order to ensure the quality of care rendered by midlevel providers.

B. Nevada

In Nevada, nurse practitioners and physician assistants have authority to "Prescribe, Dispense, Administer, [and] Procure" schedule II, II-N, III, III-N, IV, and V substances.[165] Midlevel providers in Nevada have the ability to prescribe schedule II drugs, which presents a different model of expanded authority than those seen in Arkansas and Alabama.[166] Prescriptive authority for schedule II drugs, like morphine and codeine,[167] expands midlevel practice because nurse practitioners and physician assistants in rural and underserved areas can immediately prescribe narcotics to treat traumatic injuries like severely broken bones.

In June of 2013, Assembly Bill 170[168] was signed into law by Nevada's 77th legislature.[169] Assembly Bill 170 is of particular significance to nurse practitioners in Nevada.[170] As amended and passed, Assembly Bill 170 changes three key pieces of legislation affecting Nevada's nurse practitioners.[171] First, the professional title of "Advanced Practice Nurse" (APN) is changed to "Advanced Practice Registered Nurse" (APRN).[172] Like Arkan-

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[164] Hasley, *supra* note 142, at 19.

[165] OFFICE OF DIVERSION CONTROL, *supra* note 3, at 5.

[166] *See id.* at 1, 5.

[167] *Id.* at 1.

[168] *See* NEV. REV. STAT. ANN. § 632.012 (West 2014).

[169] *See* Susan S. VanBeuge & Tomas Walker, *Success for Nurse Practitioners in Nevada: The Story of Assembly Bill 170*, FUTURE OF NURSING: CAMPAIGN FOR ACTION (July 16, 2013), http://campaignforaction.org/community-post/success-nurse-practitioners-nevada-story-assembly-bill-170.

[170] *Id.*

[171] *Id.*

[172] *Id.*

sas', this change is intended to clarify the class of advanced practice nurses in the state and provide independent legal significance and recognition to the class as a whole. Similarly, nurse practitioners will now have a license to practice rather than a "certificate of recognition."[173]

The third change relates to collaborative practice in two ways. First, upon graduation, new APRNs "will be required to complete 2 years, or 2,000 hours, of practice experience prior to prescribing Schedule II medications independently (without a collaborative agreement with a physician)."[174] Thus, a collaborative agreement is no longer required after the practice experience requirement is met.[175] Similarly, no collaborative agreement is required to practice in Nevada for newly graduated APRNs who do not want to prescribe Schedule II medications.[176] Second, for APRNs in Nevada who have been practicing longer than the practice experience minimum, no collaborative agreement is required to practice.[177] According to the Nevada Advanced Practice Nurses Association, "[t]his process of change began with the recognition of Nevada's chronic shortage of primary care providers."[178]

Therefore, in contrast to Alabama and Arkansas, Nevada has implemented a distinct legislative approach to expand its prescriptive authority and scope-of-practice laws.[179] Through a two-year, 2,000-hour practice experience requirement, Nevada established a quality-assurance protocol before midlevel providers, namely nurse practitioners, may use their education fully and receive the broad prescriptive authority and scope-of-practice benefits of Assembly Bill 170.[180] Nevada clearly understands that a health care system is only as efficient as the law allows, and it is certainly a model to be considered for use in Alabama.

C. Massachusetts

In Massachusetts, nurse practitioners and physician assistants have authority to "Administer, Prescribe, and Procure"

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[173] *Id.*

[174] *Id.*

[175] *See* VanBeuge & Walker, *supra* note 169.

[176] *Id.*

[177] *Id.*

[178] *Id.*

[179] *See id.*; *see also* OFFICE OF DIVERSION CONTROL, *supra* note 3, at 1, 5.

[180] *See* VanBeuge & Walker, *supra* note 169.

schedule II, II-N, III, III-N, IV, and V substances.[181] As evidenced by House Bill 2009, Massachusetts is well aware of its need to regulate health care costs and controlled substances through effective use of midlevel providers.[182] House Bill 2009 was presented to the Massachusetts House of Representatives in January 2013,[183] and eventually sent to the Joint Committee of Public Health for review.[184] In order to assess the competitive and economic impact of the proposed Bill, Massachusetts State Representative Kay Khan requested the Federal Trade Commission (FTC) to analyze the Bill.[185] In summary, the FTC staff stated, "as proposed, the elimination of certain supervision requirements for nurse practitioners (NPs) and nurse anesthetists (NAs) would likely benefit consumers and competition in Massachusetts."[186]

According to the FTC staff comment, House Bill 2009 would "permit NPs and NAs to order tests and therapeutics, and issue written prescriptions, without a supervisory agreement with a Massachusetts physician."[187] Additionally, it "would permit them to administer and dispense certain controlled substances without such supervisory agreements."[188] Massachusetts suffers severe physician shortages in some practice areas and geographic regions.[189] The FTC comment focused on this economic aspect of the state's need, noting that excessive supervision requirements for midlevel providers makes provider shortages

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[181] OFFICE OF DIVERSION CONTROL, *supra* note 3, at 4.

[182] *See* H.R. 2009, 188th Gen. Ct. (Mass. 2013) (regulating health care quality and costs by amending existing health care laws to regulate midlevel providers).

[183] *Id.*

[184] *Bill H.2009: Bill History*, MASS. LEGISLATURE, https://malegislature.gov/Bills/188/House/H2009 (follow "https://malegislature.gov/Bills/188/House/H2009" hyperlink; then click "Bill History" tab) (last visited Apr. 1, 2015).

[185] *See* Letter from Andrew I. Gavil, Martin S. Gaynor, & Deborah Feinstein, Dirs., Fed. Trade Comm'n to Rep. Kay Kahn, Mass. H.R. (Jan. 17, 2014), *available at* http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-massachusetts-house-representatives-regarding-house-bill-6-h.2009-concerning-supervisory-requirements-nurse-practitioners-nurse-anesthetists/140123massachusettnursesletter.pdf.

[186] *FTC Staff: Massachusetts Should Consider Removing Physician Supervision Requirements for Nurse Practitioners and Physician Assistants*, FED. TRADE COMM'N (Jan. 23, 2014), http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician.

[187] *Id.*

[188] *Id.*

[189] *Id.*

and access problems even worse, particularly for rural and underserved areas that do not have adequate and cost-effective primary care services.[190] "[W]e encourage the Massachusetts legislature to consider adopting provisions that would permit APRNs . . . to deliver the full range of health care services they are trained and certified to provide."[191]

The staff comment concluded that House Bill 2009 would streamline APRN regulation and permit APRNs "to more fully utilize their education and experience in serving Massachusetts health care consumers."[192] In the FTC's judgment, unless there are sound reasons to keep the existing supervision requirements, removing them could "benefit consumers by improving access to care, containing costs, and expanding innovation in health care delivery."[193] Furthermore, the FTC suggested that "[r]emoving unnecessary and burdensome requirements may benefit Massachusetts consumers by increasing competition among health care providers."[194]

By discussing the competitive environment of health care in Massachusetts, the FTC is acknowledging the efficacy of midlevel providers in delivering quality care. In a proper statutory framework, midlevel providers are more than capable of providing the health care that they are educated and trained to perform. The FTC strives "to promote competition in the health care sector, which benefits consumers through lower costs, better care, and more innovation."[195] As expressed in its comment to the Massachusetts House of Representatives, the FTC conveys the message that efficient health care systems are created through full utilization of health care personnel.[196] Thus, with a federal agency on record supporting the expansion of midlevel provider prescriptive authority and scope of practice laws,[197] Alabama legislature should be responsive to legislative solutions like proposed House Bill 2009 in Massachusetts.

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[190] *See id.*

[191] *Id.*

[192] Fed. TRADE COMM'N, *supra* note 186.

[193] *Id.*

[194] *Id.*

[195] *Id.*

[196] *See id.*

[197] *See id.*

D. Texas:

In Texas, nurse practitioners and physician assistants may "Prescribe and Order" schedule II and II-N substances, but may "Prescribe and Administer" schedule III, III-N, IV, and V substances.[198] Texas' framework represents the next logical step from Alabama's current prescriptive authorizations because Texas midlevel providers have the ability to prescribe schedule II substances, albeit with limited authority.[199] Prescriptive authority and scope-of-practice laws in Texas were revised in 2013 under Senate Bill 406.[200] Senate Bill 406 "amended Chapter 157 of the Texas Occupations Code by removing site-based requirements [of physicians] for the delegation and supervision of prescriptive authority" to midlevel providers.[201] It replaced them with an effective framework that requires "the use of prescriptive authority agreements (PAAs) in most practice settings, the development of a quality assurance plan, and regular quality assurance meetings."[202]

In Texas, independent practice for advanced practice nurses and physician assistants is not allowed.[203] With this in mind, Senate Bill 406 seeks to ensure that the physicians maintain the responsibility and flexibility for delegation and supervision to midlevel providers.[204] Thus, the bill endorses the concept of physician-led health care teams as a way to provide greater access to care,[205] particularly in the rural and underserved areas of the state. Under the bill, prescriptive authority agreements are required in all practice settings for the delegation of prescriptive authority, with the exception of facility-based practice, which is limited to hospitals and long-term care facilities.[206]

In Texas, a prescriptive authority agreement is defined as "an agreement entered into by a physician and an advanced practice registered nurse or physician assistant through which

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[198] OFFICE OF DIVERSION CONTROL, *supra* note 3 at 8.

[199] *See id.* at 1, 8.

[200] S. 406, 83rd Leg., Reg. Sess. (Tex. 2013).

[201] *Background: Prescriptive Authority Agreement*, TEX. MED. ASS'N 1, http://www.texmed.org/uploadedFiles/Current/Advocacy/Scope_of_Practice/Prescriptive%20Authority%20Agreement%20Background%20and%20Sample%20Form.pdf (last visited Apr. 1, 2015).

[202] *Id.*

[203] *Id.*

[204] *Id.*

[205] *Id.*

[206] *See* TEX. OCC. CODE ANN. §§ 157.0512, 157.054 (West 2013).

the physician delegates to the advanced practice registered nurse or physician assistant the act of prescribing or ordering a drug or device."[207] Although prescriptive authority agreements authorize the delegation of prescriptive authority from physician to midlevel provider, the APRN or PA must be under adequate physician supervision—a physician must delegate and supervise in accordance with an appropriate standard of care under Texas law.[208]

Prescriptive authority agreements in Texas may include miscellaneous other provisions agreed to by the physician and midlevel provider, but an agreement must meet several minimum requirements.[209] First, it must "[b]e in writing and signed and dated by the parties to the agreement."[210] Second, it must "[s]tate the name, address, and all professional license numbers of the parties to the agreement."[211] Third, it must "[s]tate the nature of the practice, practice locations, or practice settings."[212] Fourth, it must express schedules of drugs that may be prescribed or not be prescribed.[213] Fifth, it must "[p]rovide a general plan for addressing consultation and referral."[214] Sixth, it must provide protocols for addressing patient emergencies.[215] Seventh, it must "[s]tate the general process for communication and the sharing of information between the physician and the APRN or PA to whom the physician has delegated prescriptive authority."[216] Eighth, if a covering physician is to be used, it must designate one or more covering physicians who may provide adequate supervision on a temporary basis in accordance with the requirements established by the agreement terms.[217] Finally, it must "[d]escribe a prescriptive-authority quality assurance and improvement plan, and specify methods for documenting its implementation that include chart review and periodic

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[207] TEX. OCC. CODE ANN. § 157.051(14) (West 2013).
[208] TEX. MED. ASS'N, *supra* note 201, at 1.
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] *Id.*
[213] *Id.*
[214] TEX. MED. ASS'N, supra note 201, at 1.
[215] *Id.*
[216] *Id.*
[217] *Id.* at 2.

face-to-face meetings."[218]

Texas' prescriptive-authority agreement model is an excellent template for use in a state like Alabama, which has similar laws and health care needs. There are two additional changes Senate Bill 406 made that are worth noting.[219] First, physicians may delegate prescribing authority to up to seven midlevel providers, or seven full-time equivalents.[220] This is an incredibly important feature of Senate Bill 406 because it creates a large network of midlevel providers in one team-based health care unit to treat and diagnose minor or intermediate medical issues. When more midlevel providers are available to treat and diagnose the medical issues that they are educated and trained to handle, physicians have the ability to see more complicated and serious medical issues that they, likewise, are educated and trained to handle. This system both decreases the cost of health care to patients and increases access to physicians systematically.

Second, Senate Bill 406 "replaced the site-based supervision requirements with a requirement that the physician and those to whom a physician delegates prescriptive authority must have regular, documented quality assurance meetings."[221] These meetings generally must occur monthly, at a minimum, but this requirement can be modified to a quarterly basis depending on the length of practice between the physician and midlevel provider.[222] Additionally, a physician can always hold these meetings or other provisions more frequently than the minimum standards provided by Texas statute.[223]

SUGGESTED SOLUTIONS FOR ALABAMA

In light of the legislative solutions created by the previously discussed states, I believe that the best solution for Alabama is to replicate the efforts of Texas and Massachusetts. The issue in Alabama is inefficiency in health care delivery. Alabama must follow in the spirit of the Patient Protection and Affordable Care Act of 2010's focus on decreasing the cost of health care and increasing access to affordable health care, especially primary care.

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[218] *Id.* *See* TEX. OCC. CODE ANN. §157.0512 (West 2013) (providing more information regarding Texas' Prescriptive Authority Agreement requirements).

[219] TEX. MED. ASS'N, supra note 201, at 2.

[220] *Id.*

[221] *Id.*

[222] *Id.*

[223] *Id.* (citing TEX. OCC. CODE ANN. §157.0512 (West 2013)).

Texas, in particular, should serve as an example to Alabama for three reasons.

First, its legislative solution increased the amount of midlevel providers a physician can supervise—seven full-time equivalents, as opposed to three in Alabama.[224] Second, it decreased the collaborating physician's burden of being in direct supervision of the midlevel provider.[225] Third, it afforded the midlevel provider the ability to prescribe schedule II controlled substances in limited circumstances.[226]

These provisions have several effects on the health care market in Texas, especially in primary care. First, a larger network of midlevel providers per each supervising physician increases productivity, especially when effective protocols for referral are in place. Second, services and reimbursement will more accurately reflect the work performed because midlevel providers do "midlevel" work and give physicians more time and ability to perform "physician" work, like treating complex issues instead of prescribing Tamiflu for a typical case of the common flu. Finally, liability will accurately reflect the cause of the harm to the patient. The presence of clearly defined protocols will expose the origin of the medical mistake, as opposed to poorly documented processes that implicate people, like physicians or absent covering physicians, who may have had little or nothing to do with the harm.

The proposed House Bill 2009 in Massachusetts serves as another excellent example for Alabama because of its emphasis on cost reduction and full utilization of qualified health care personnel.[227] Midlevel providers are well-educated and highly trained in their own right, so they should be used accordingly. Relaxing supervision laws governing midlevel provider practice both drives down costs in the health care market and increases access to health care in all areas of the state, especially rural and underserved areas that may have a hard time attracting physicians to practice primary care. Massachusetts understands that an efficient health care system can be facilitated by allowing midlevel providers to fully utilize their skills and education in a flexible regulatory environment.

As it stands, Alabama does not have an efficient health care

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[224] *Id.*

[225] *See* TEX. MED. ASS'N, *supra* note 201, at 2.

[226] OFFICE OF DIVERSION CONTROL, *supra* note 3, at 8.

[227] *See* FED. TRADE COMM'N, *supra* note 186.

provider market because midlevel providers cannot be used as they are intended. They are highly qualified and educated to handle a wide range of primary health issues. However, without statutory authority to prescribe certain drugs or practice in certain areas without physician supervision, midlevel providers will never be able to serve rural or underserved areas adequately, or even effectively streamline health care provision in urban areas like Birmingham. It is set up to be a doctor-dominated market across the board.

The perfect health care system is achieved when midlevel providers see patients and diagnose, prescribe, or refer a patient to the relevant doctor when a certain protocol is triggered. Doctors should handle the complex health issues for which they have been thoroughly trained. The service should match the education and experience of the professional; in such a system, quality will not be a negative consideration because accurate protocols provide quality assurance. Therefore, following in the footsteps of Texas and Massachusetts, Alabama must further relax its midlevel provider scope-of-practice and prescriptive authority laws to reduce the cost of and increase the access to health care in the state.