Hawai`i State Center for Nursing

HSCFN APRN Subcommittee

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THE HAWAI'I STATE CENTER FOR NURSING ADVANCED PRACTICE REGISTERED NURSES SUBCOMMITTEE

2011 Report

The Hawai`i State Center for Nursing's APRN Subcommittee (Subcommittee) was convened to:

- identify barriers which preclude APRNs from practicing to the full extent of their education and training in Hawai`i
- to improve understanding and communication among health care providers, regulatory agencies and legislators to eliminate barriers.

Legal Barriers Identified

Despite barrier-breaking legislation[1] in recent years, many provisions of these Acts have not been implemented. Decades old, obsolete and restrictive statutes, rules and regulations exist which, if repealed or properly amended, will provide access to care as well as, improvement in the quality of health care that will benefit Hawai'i consumers. The continued existence of these rules, regulations and laws and the failure to timely implement new laws may be due to the lack of manpower and expertise among existing personnel, as well as, the need for the regulating agencies to make access to APRN care a high priority.

To identify the barriers to APRN practice in Hawai'i, the Subcommittee obtained information from different sources including, but not limited to, discussion groups,

[1] **Act 169, SLH 2009** required insurers/HMOs/benefit societies to recognize APRNs as PCPs; authorized APRNs to sign, certify, or endorse all documents relating to health care within their scope of practice provided for their patients including workers' compensation, verification documents, verification and evaluation forms the DHS and DOE, verification and authorization forms of the DOH and physical examination forms.
Act 57, SLH 2010 the adoption of the National Council of State Boards of Nursing's Model Nurse Practice Act and Model Nursing Administrative Rules.
Act 110, SLH 2011 required:

- Each hospital in the State licensed under Hawai`i Revised Statutes (HRS), § 321-14.5 is required to allow[1] APRNs [1] and qualified APRNs granted prescriptive authority to practice within the full scope of practice including as a primary care provider.
- APRNs granted prescriptive authority to prescribe controlled drugs (Schedule II-V) within formulary appropriate to the APRN's specialty. Able to prescribe drugs without working relationship agreement with a licensed physician

surveys[2], health journals, research of federal, state and county laws; and concerns expressed by individual Hawaii APRNs and consumers in various settings.

The Subcommittee intends to continue its effort to solicit input from various sources to identify any additional barriers to APRN practice through surveys[3] and other means.

The Subcommittee's grid (attached) lists all of the barriers which it has identified to date. Areas in which APRN practice barriers exist include, but are not limited to:

- Health Care settings such as: Broad Service Hospitals; Nursing Facilitities (Skilled Nursing/Intermediate Care Facilities); Home Care or Private Duty services; Freestanding Adult Day Health Centers; Home Health Agencies; Adult Day Health Centers
- Community based Foster Homes for children, adults and the developmentally disabled/mentally retarded
- Therapeutic services: Physical Therapy-Medicare Part A; Medicaid/Quest Physical and Occupational Therapy
- Mental Health (MH4) designation for admission to hospitals;
- Incapacity Determination for designation of surrogate;
- Pharmacist Orders;
- Physician Orders for Life Sustaining Treatment; Compassionate Care Only Bracelet application
- Medicare Nutrition Therapy
- Exemption from Childhood Immunizations
- Death Certificates
- Life Jackets for the blind, partially blind, physically handicapped;
- Handicap Parking Passes (certificate of disability); Motor Vehicle Insurance
- Worker's Compensation
- Juror Exclusion

Communication among parties

In 2011, the Subcommittee:

- Drafted (6/2011) a point paper for the Hawai'i Congressional Delegation regarding parts of the Code of Federal Regulations which greatly restrict patient access to Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) care

[2] Dianne Okumura, with the assistance of Sister Alicia Lau, surveyed the health care facilities in Hawai'i to ask how the use of APRNs has benefitted their residents. The results indicated that APRNs provided greater access to effective health care.

[3] Yvonne Geesey, with the assistance of Lenora Lorenzo, will survey nursing organizations in Hawai'i for additional barriers to APRN practice.

in Medicare participating Skilled Nursing Facilities(SNFs). Specifically, these parts are in the U.S. Code Title 42: Public Health Part 424, Subpart B, Section 424.20 and Part 483, Subpart B., Section 483.40.

- Apprised the National Council of State Boards of Nursing and the Hawaii Workforce Development Council of its work to identify APRN barriers to practice
- Drafted a point paper on Action 110, Session Laws of Hawaii 2011 and worked with the Hawaii State Board of Nursing in a collaborative effort to apprise APRNs in Hawaii of the legislative changes
- Developed a grid of federal and state statutory and regulatory barriers to APRN practice in Hawaii

Breaking Down Barriers

The Subcommittee:

- will continue to work with the regulatory agencies that are responsible for implementing the laws which impede or restrict APRNs from practicing to the full extent of their education and training
- wishes to encourage a collaborative/synergistic relationship among the Center for Nursing, the regulatory agencies and other stakeholders so new laws can be properly and timely implemented; and obsolete or restrictive laws can be repealed or made procompetitive
- remains open and receptive to all who can help to remove these barriers to APRN practice
- continues to seek venues through which information relating to APRNs can be timely and cost effectively shared with APRNs and other stakeholders

HSCFN APRN COMMITTEE

LAWS EXCLUDING APRNS

State Law impacted	Federal law In conflict	Other state law In conflict	Problem	Plan of Action	Result
DOH State Licensing Section – State regulations only					
Chapter 89			**Developmental Diabilities Domicilliary Homes(DDDOM) –** 5 or less residents who are Developmentally Disabled and the operator does not require any medical background; service plans are developed by resident Case Manager;	Request review of all regulations and update to be commensurate with current regulations relating to authority of APRNs	
Chapter 90			**Assisted Living Facilities (ALF)–** individual units for individuals to age in place, who are independent initially and then may require additional care services. requires nursing assessment and development of service plans and in some instances care plans, medication administration done through nursing delegation		
Chapter 92			**Therapeutic Living Programs (TLP**)– new rules in process, however, there are facilities currently licensed (many for children/youth) – for settings from 8 or more residents with mental health issues; medications may be administered to residents through delegation or by "making meds available" (staff observations of residents taking meds on own)		
Chapter 98			**Special Treatment Facilities (STF)–** new rules in process, however facilities are currently licensed for some children/youth but majority for adults with mental health issues; again meds administered similar to Chap 92		

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DOH Medicare Section: State and Federal regulations apply					
Chapter 91	CMS Hospice		New rules in process for State Licensure. However there are Hospice Agencies who are operating and are Certified to receive Medicare/Medicaid reimbursement (and need to adhere to federal requirements) – so there are at home or in-patient hospice settings.		
Chapter 93	CMS Hospital		**Broad Service Hospitals (also includes Freestanding Birthing Facilities) –** this is State Licensure only for the Acute hospitals. Hospitals are able to receive M/M reimbursement if they are accredited and meet all CMS requirements – so they need to meet federal as well as State Licensing requirements. As Chap 93 is old – there is no reference to APRN as this time. the following is language from the regs : 11-93-31	Amend: **"**All patients admitted to a hospital shall be under the general care of a physician member of the medical staff. Individuals admitted by a nonphysician member of the medical staff who has been granted admitting privileges will have a qualified physician who is a member of the medical staff designated to be responsible for the general medical evaluation and medical care of the patient in accordance with requirements of the governing board. (d) The hospital shall not permit interns, residents, fellows, graduates of foreign medical schools or medical students in an approved	

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				training program to perform a service for which a license is required by the State of Hawaii unless they are at the time licensed or under the direct control and direct supervision of a licensed physician or a medical staff member of the same profession."	
11-93-1			"Drug Dispensing", no mention of APRN No definition of APRN, including Midwife		
11-93-4			Anesthesia: No mention of CRNA		
11-93-14			No mention of APRN		
11-93-22 (3)			Revise wording. "Review and evaluate clinical activities" equals physician supervision of practice.		
11-93-22 (C):			No APRNs have admitting and PCP rights under Act 169		
11-93-24			No mention of APRN		
11-93-28 C			No wording for APRN prescriptive authority		
11-93-29 (D): (3), (6)			No APRN		
Chapter 94(94.1)	Yes, conflicts and supercedes state law CFR 42		**Skilled Nursing/Intermediate Care Facilities (Nursing Facilities) –** does reference APRN however, Valisa would like the wording to be consistent with federal language – both S/F requirements apply Reimbursement issue at Kaiser only?	Lobby CMS; Senator Grassley; Pat DeLeon Facility can request a waiver for now. Provision in the rules: "With respect to a particular facility, a specific rule may be waived for a period of one year at	

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				the discretion of the director."	
Chapter 96	CMS Ambulatory Surgical Centers		**Freestanding Adult Day Health Centers (ADHC)** apply to those ADHC that stand alone and not part of 94(94.1) do not reference APRN – all orders shall be signed by physician. State licensure only**.**		
Chapter 97	CMS Home Health Agencies		**Home Health Agencies (HHA) –** APRN is not referenced in rules. Establishment and review plan of treatment	Amend: (1) A home health agency shall establish policies and procedures for assuring that services and items to be provided are specified under the plan of treatment established and regularly reviewed by the physician who is responsible for the use of the patient. (2) The original plan of treatment shall be signed by the physician responsible for the patient and incorporated into the patient's medical record. (3) The total plan shall be reviewed by the attending physician, in consultation with the agency's professional personnel at such intervals as the severity of the patient's condition may require, but not less than once every two months.	

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				(4) The professional staff shall bring to the attention of the patient's physician changes in the patient's condition which may indicate the need for altering the treatment plan or for the termination of service. (5) Only the attending physician shall terminate services. Upon termination of services, the physician shall prepare a discharge summary which includes reasons for termination of services, condition upon discharge and a summary of the course of the patient's illness. (6) Original orders of a physician and all changes in orders for the administration of dangerous drugs and narcotics shall be signed by the attending physician and incorporated into the patient's medical record. (7) All other changes in orders shall be either signed by the physician or by the professional nurse of the home health agency, if such changes are received verbally by the nurse.	

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				(8) When verbal orders are received by the professional nurse or other professional disciplines they shall be signed by the physician within a reasonable period of time.	
HRS, Chapter 321.14.8			**Home Care Agency, licensing –** "establishes home care agencies" however no rules have been promulgated as yet**.**	HAH working on the rules, so there's time to work with them to insert APRN role and appropriate language	
Chapter 99	CMS Intermediate Care Facility for the Mentally Retarded Community		**Intermediate Care Facilities for the Mentally Retarded –** S/F requirements apply. As the State requirements are old – does not reference APRN role.		

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DCCA HRS 431:10C-103.5,			**Motor Vehicle Insurance** (ambiguous) (a) Personal injury protection benefits, with respect to any accidental harm, means all appropriate and reasonable treatment and expenses necessarily incurred as a result of the accidental harm and which are substantially comparable to the requirements for prepaid health care plans, including medical, hospital, surgical, professional, nursing, advanced practice nursing recognized pursuant to chapter 457, dental, optometric, naturopathic medicine, chiropractic, ambulance, prosthetic services, medical equipment and supplies, products and accommodations furnished, x-ray, psychiatric, physical therapy pursuant to prescription by a medical doctor, occupational therapy, rehabilitation, and therapeutic massage by a licensed massage therapist when prescribed by a medical doctor.		
Dept of Labor HRS 386-21			**Work Comp** (b) Whenever medical care is needed, the injured employee may select any physician or surgeon who is practicing on the island where the injury was incurred to render medical care. If the services of a specialist are indicated, the employee may select any physician or surgeon practicing in the State. The director may authorize the selection of a specialist practicing outside the State where no comparable medical attendance within the State is available. Upon procuring the services of a physician or surgeon, the injured employee shall give proper notice of the employee's selection to the employer within a reasonable time after the beginning of the treatment. If for any reason during the period when medical care is needed, the employee wishes to change to another physician or		

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			surgeon, the employee may do so in accordance with rules prescribed by the director. If the employee is unable to select a physician or surgeon and the emergency nature of the injury requires immediate medical attendance, or if the employee does not desire to select a physician or surgeon and so advises the employer, the employer shall select the physician or surgeon. The selection, however, shall not deprive the employee of the employee's right of subsequently selecting a physician or surgeon for continuance of needed medical care.		
DOH HRS 338-9			**Death Certificates** (a) The person in charge of the disposition of the body shall file with the department of health in Honolulu or with the local agent of the department of health in the district in which the death or fetal death occurred, or a dead body was found, a certificate of death or fetal death within three days after the occurrence, except that reports of intentional terminations of pregnancy performed in accordance with section 453-16 may be deferred for up to one month. (b) In preparing a certificate of death or fetal death the person in charge of the disposition of the body shall: (1) Obtain and enter on the certificate the personal data and other information pertaining to the deceased person required by the department from the person best qualified to supply them; (2) Present the certificate of death to the physician last in attendance upon the deceased, or to the coroner's physician, who shall thereupon certify the cause of death to the physician's best knowledge and belief, or present the certificate of fetal death to the physician, midwife, or other person in attendance at the fetal death, who shall		

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			certify the fetal death and such medical data pertaining thereto as can be furnished; provided that fetal deaths of less than twenty-four weeks or intentional terminations of pregnancy performed in accordance with section 453-16 may be certified by a nurse or other employee based upon the physician's records; and (3) Notify immediately the appropriate local agent, if the death occurred without medical attendance, or if the physician last in attendance fails to sign the death certificate.		
DCCA HAR 16-11-3			**Physical Therapy (this may have been amended)** §16-110-3 When referrals required. (a) Treatment of a person by alicensed physical therapist is prohibited unless the person has been referred to the licensed physical therapist for treatment by a *physician licensed pursuant to chapter 453, HRS; osteopathic physician licensed pursuant to chapter 460, HRS;dentist licensed pursuant to chapter 448, HRS; chiropractor licensed pursuant tochapter 442, HRS; naturopath licensed pursuant to chapter 455, HRS; optometrist licensed pursuant to chapter 459, HRS; or podiatrist licensed pursuant to chapter 463E, HRS.*		
DCCA HRS 461-1			**Pharmacist Orders** (2) Performing the following procedures or functions as part of the care provided by and in concurrence with a "health care facility" and "health care service" as defined in section 323D-2, or a "pharmacy" or a licensed physician, or a "managed care plan" as defined in section 432E-1, in accordance with policies, procedures, or protocols developed collaboratively by health professionals, including physicians and surgeons,		

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			pharmacists, and registered nurses, and for which a pharmacist has received appropriate training required by these policies, procedures, or protocols: (F) As authorized by *a licensed physician's written instructions*, initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's *licensed physician* and related to the condition for which the patient has been seen by the *licensed physician*; provided that the pharmacist shall issue written notification to the patient's *licensed physician* or enter the appropriate information in an electronic patient record system shared by the licensed physician, within twenty-four hours; "Licensed physician" means a physician licensed by the board of medical examiners pursuant to chapter 453 or 460		
HRS 321-23.6			**Compassionate Care Only Bracelet application** (a) The department shall adopt rules for emergency medical services which shall include: (1) Uniform methods of rapidly identifying an adult person who: (A) Has been certified in a written "comfort care only" document by the *person's physician* to be a terminally ill patient of that physician; and (B) Has certified in the same written "comfort care only" document that the person directs emergency medical services personnel, first responder personnel, and health care providers not to administer chest compressions, rescue breathing, electric shocks, or medication, or all of these, given to restart the heart if the person's breathing or heart stops, and directs that the person is to receive care for comfort only,		

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			including oxygen, airway suctioning, splinting of fractures, pain medicine, and other measures required for comfort; and (C) Has been prescribed by *a physician* a "comfort care only" identifying bracelet or necklace; (2) The written document containing both certifications must be signed by the patient with the terminal condition, by the *patient's physician*, and by any one other adult person who personally knows the patient;		
DHS 17-892.1 DHS 17-1625 DHS 17-1627 DHS 17-895 DHS 17-896 DHS 17-1417 DHS 17-1440 DHS 17-1454 DHS 17-1439			**Licensing of Group Child Care Centers and Group Child Care Homes** **Licensing of Foster Family Homes for Children** **Licensing of Child Caring Institutions** **Licensing of Infant Toddler Child Care Centers** **Licensing of Before and After School Child Care Facilities** **Adult Day Care Centers** **Home and Community Based Services for Elderly Foster Family Community Care Homes** **Regulations of Home and Community based Case Management Agencies and Community Care Foster Family Homes** **Home and Community Based Services for the Developmentally Disabled/Mentally Retarded**	**Need for DHS to review all of their regulations relating to children and adults to address authority of APRN commensurate with current applicable regulations**	

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DCAB HRS 291-51 & HAR 11-219-4-5			**Handicap Parking Passes** **"Certificate of disability"** means a medical statement issued by a *licensed practicing physician*, which verifies that a person is disabled, limited, or impaired in the ability to walk. **HAR §11-219-4 Definitions.** As used in this chapter, unless the context clearly indicates otherwise: "Certificate of disability" means a form designed by the state disability and communication access board, and signed by *a licensed practicing physician* who certifies that the person is a person with a disability as defined in this section. … "*Licensed practicing physician*" means a doctor of medicine, naturopathy, osteopathy, or podiatry duly licensed and authorized to practice in the State of Hawaii in accordance with chapters 453, 455, 460, and 463E, HRS. … "Special license plates" means license plates issued to a person whose disability is expected to last for at least four years as certified *by a licensed practicing physician*. The license plates shall display the International Symbol of Access in a color that contrasts to the background, and in the same size as the letters and numbers on the plates. **§11-219-5** Processing of the parking permit application. The following provisions shall govern the application process for removable windshield placards, temporary removable windshield placards, special license plates, and identification cards to "persons with disabilities": (1) In order to be considered for issuance of a parking permit (removable windshield placard, temporary removable windshield placard, or		

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			special license plates) and identification card, the applicant shall submit a completed application to the issuing agency. The application form shall be approved by the disability and communication access board and provided to the applicant by the issuing agency. The certificate of disability section of the form shall be completed by a *licensed practicing physician*. The certification of *the licensed practicing physician* shall be valid for no more than sixty days prior to submitting the application.		
HRS 621			Related to potential juror exclusion due to disability certification		
HRS 346-352			Related to prior authorizations	SB 1453 Task force to study Prior authorization establishing statewide standardization of prescription drug prior authorization process. Testimony in favor of mandating waiver rather than task force . Passed out of HLTH with amendments; then passed out of CPC unamended 3/23/11 Next House Finance No change (as of 3/29/11)	
HRS 347-13			Related to life jackets		
HRS 302A-1156			Exemption from childhood immunizations		
HRS 327E-5			**POLST** (physician orders for life sustaining treatment)		

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DHS Medicaid/QUEST			The PT and/or OT provider has written documentation that the therapy is ordered or prescribed by a licensed physician.		

Out of 50 facilities 11 responded for a 22% response rate. Of the 11 facilities 5 are located on the neighbor islands.

Question #1a: Use of APRNs have benefitted our residents in the following ways:

1) Early detection & treatment of health issues, as they are in our homes at least 3-4 times per week. They provide on-the-spot education & in-service training for LNs which increases quality of care for our residents. They attend family meetings when appropriate which helps to facilitate smooth transitions into LTC.
2) Thorough assessments, more available than physicians, answers pages right away and come to facility when there's a condition change on a resident.
3) They are available when MDs are not. Double the availability of medical attention to our residents.
4) More accessible & answers calls or pages promptly, unlike some MDs, Easier to contact & returns calls when you leave them messages
5) • Patient care - primary care, episodic care
   • Patient Transitions - Hospital transfers/admissions
   • Patient H&P - Timely completion of required H&P visits
   • Patient orders - Timely orders for medically necessary medications or treatments
   •Physician Communication/Liaison - Case summaries and troubleshooting
   •Patient Triage/Assessment
   •Resident/Patient functional assessments
   •Staff Training/Clinical Resource
   •Infection Control/Monitoring
   •Quality Assurance
   •Policy & Procedure Review - The APRN enhances the work environment and has improved quality of care. There are a number of things that the APRN has assisted. Decreasing pressure ulcers and decreasing number of medications residents receive and just a couple things that the APRN has assisted in.
   a) More timely assessment of the residents, increased collaboration with the physician groups, education to the staff.
6) Our APRN is an Independent Contractor & has an office in our building. She treats staff & residents when they call upon her. She also oversees resident care when necessary. She is readily available & convenient for residents. Utilizing her speeds up "paperwork process".

Question #1b: Some challenges in working with APRNs are:

1) Have not encountered any yet
2) Their scope is limited. MDs sometimes defer work to them that is mandatory to be done by MD. They are not always comfortable initiating psychotropic.
3) Cannot utilize them for new admissions, Cannot utilize them for Medicare patients first 100 days for recertification, All their orders need to be countersigned by MD.
4) Cost - higher education level/ certification requires higher rate, Availability - part time use only at present, Regulatory limitations - APRNs who work for the facility have limitations on completing required visits for LTC/SNF residents.
5) We have been delighted to work with our APRN. We are a team.
6) Unable to write or call in narcotic prescriptions

Question #2: We do not currently utilize APRNs in our facility due to the following:

1) We have been utilizing APRNs through a contract with Kaiser. This contract is ending however, we are unclear if we can contract directly with, or directly employ an APRN. Do we have to contract with a physician who contracts with the APRN?
2) Do not have an organized structure for APRN now, as we are small facility
3) Limitations in State Law
4) We do not have physicians available to oversee or participate in a program/service for APRNs
5) We utilize them to get our problems/concerns to the physicians faster & also get our answers fast.
6) Plans are to have a GNP. She has not come on board at yet. She's waiting to be approved by the Board.

Question #3: We would utilize APRNs but understand they are limited in the following areas:

1) By regulation, every other 60 day visit must be done b y the physician vs. a physician extender.
2) I do not think an APRN would be limited in our practice setting. Would need training and could support physician practice.
3) Cannot do admissions, annual H&P, only every other visit & problem oriented.
4) We do utilize even with limitations
5) They cannot sign telephone orders nor give telephone orders, They can only relay problems called to MD & give answers after talking to MD, They cannot sign recertification, although they come & asses & document progress.

Question #4: Ideally in a nursing home setting, we would like to see APRNs do the following:

1) Everything the attending can do. Also, there should not be a distinction between a nursing home-hired APRN vs. one hired by a separate entity. The duties they perform should be consistent- for example, certification/recertification for post hospital care. See attached.
2) In our setting the APRN could support care completely, with physician support. Need to have peds/complex care skills.
3) Complete and Authorize 1147s/1144, Complete certification/recertification assessments including physical assessments & required documentation, Consultation
4) We have a good working relationship with the APRN that is assigned to our facility
5) Adjunct to treating MD, including a psychiatrist
6) Able to give simple orders, such as: Transfer orders to acute care setting during emergencies, when the physician cannot be reached, Able to prescribe medications during emergencies, such as when the resident is extremely combative and the MD is not available.
7) Patient care - Including primary care, initial H&Ps, required certifications visits, and medically necessary or episodic visits, Infection Control, Quality Assurance, Staff education/Teaching/Clinical Resource/Education, Policy & Procedure Review, Physician Liaison
8) Physical assessments, case management, order diagnostic studies, medications, treatments, refer

Developed by: Sister Alicia Damien Lau and Dianne Okumura