GENERAL GOVERNMENT CABINET

Board of Nursing

(Amendment)

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses.

RELATES TO: KRS 218A.171, 218A.172, 218A.202, 218A.205(3)(a), (b), 314.011(7), (8), 314.042, 314.091, 314.193(2), 314.195

STATUTORY AUTHORITY: KRS 218A.205(3)(a), (b), 314.042, 314.131(1), 314.193(2).

NECESSITY, FUNCTION, AND CONFORMITY: KRS 218A.205(3)(a) and (b) require the Board of Nursing, in consultation with the Kentucky Office of Drug Control Policy, to establish by administrative regulation mandatory prescribing and dispensing standards for licensees authorized to prescribe or dispense controlled substances, and in accordance with the Centers for Disease Control and Prevention (CDC) guidelines, to establish a prohibition on a practitioner issuing a prescription for a Schedule II controlled substance for more than a three (3) day supply if intended to treat pain as an acute medical condition, unless an exception applies. KRS 314.131(1) authorizes the board to promulgate administrative regulations necessary to enable it to carry into effect the provisions of KRS Chapter 314 and authorizes the board to require by administrative regulation that licensees and applicants utilize a specific method of submission of documents or information that is required to be provided to the board, including electronic submission. KRS 314.193(2) authorizes the board to promulgate administrative regulations establishing standards for the performance of advanced practice registered nursing to

safeguard the public health and welfare. This administrative regulation establishes the scope and standards of practice for an advanced practice registered nurse.

Section 1. Definitions. (1) "Collaboration" means the relationship between the advanced practice registered nurse and a physician in the provision of prescription medication, including both autonomous and cooperative decision-making, with the advanced practice registered nurse (APRN) and the physician contributing their respective expertise.

(2) "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" or "CAPA-CS" means the written document pursuant to KRS 314.042([~~10~~]11).

(3) "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" or "CAPA-NS" means the written document pursuant to KRS 314.042(8).

(4) "Good standing" is defined by KRS 314.039.

(5) "Immediate family" means a spouse, parent, parent-in-law, stepparent, child, stepchild, son-in-law, daughter-in-law, sibling, stepsibling, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or grandchild, or other person residing in the same residence as the APRN.

(6) "KBML" means the Kentucky Board of Medical Licensure.

(7) "PDMP" [~~(5) "KASPER"~~] means the electronic prescription drug monitoring program system for monitoring scheduled controlled substances and medicinal cannabis currently in use in Kentucky pursuant to KRS 218A.202, including the Kentucky All Schedule Prescription Electronic Reporting (KASPER) System[~~, the established in KRS 218A.202~~].

Section 2. (1) The practice of the [~~advanced practice registered nurse~~] APRN shall be in accordance with the standards and functions established in scope and standards of practice statements adopted by the board in subsection (2) of this section.

(2) The following scope and standards of practice statements shall be adopted:

(a) AACN Scope and Standards for Acute Care Nurse Practitioner Practice;

(b) AACN Scope and Standards for Acute Care Clinical Nurse Specialist Practice;

(c) Neonatal Nursing: Scope and Standards of Practice;

(d) Nursing: Scope and Standards of Practice;

(e) Pediatric Nursing: Scope and Standards of Practice;

(f) Psychiatric- Mental Health Nursing: Scope and Standards of Practice;

(g) Scope of Practice for Nurse Practitioners;

(h) Standards of Practice for Nurse Practitioners;

(i) Scope of Nurse Anesthesia Practice;

(j) Standards for Nurse Anesthesia Practice;

(k) Standards for Office Based Anesthesia Practice;

(l) Standards for the Practice of Midwifery;

(m) Oncology Nursing Scope and Standards of Practice;

(n) The Women's Health Nurse Practitioner: Guidelines for Practice and Education;

(o) Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives; and

(p) Standards for Professional Nursing Practice in the Care of Women and Newborns.

Section 3. CAPA-CS Practice Requirements for APRNs. (1) In the performance of advanced practice registered nursing, the [~~advanced practice registered nurse~~] APRN shall seek consultation or referral in those situations outside the [~~advanced practice registered nurse's~~] APRN's scope of practice.

(2) An APRN wishing to have a CAPA-CS in the first year of the APRN's licensure must be employed by a health care entity or provider. If the employing provider is an APRN, the employing APRN shall have been granted an exemption under Section 7 of this administrative regulation.

(3) During term of the CAPA-CS, the APRN and the collaborating physician shall meet, either in person or via video conferencing, to review the APRN's reverse PDMP report. The review may include information from the patient's medical record that relates to the condition or conditions being treated with controlled substances by the APRN.

(a) Both the APRN and the physician shall maintain a record of:

1. The meeting date;

2. A summary of discussions; and

3. Any recommendations made shall be made in writing.

(b) The record shall be maintained by both parties for a period of one (1) year past the expiration of the APRN CAPA-CS.

5. The APRN's meeting records shall be subject to audit by the board and the physician's records shall be subject to audit by the KBML. The sole purpose of the audit shall be to document that the collaboration meetings have taken place to verify compliance with this section.

(c) In the first year of the CAPA-CS, the APRN and a physician shall meet at least quarterly; and

(d) In the ensuing three (3) years of the CAPA-CS, the APRN and the physician shall meet at least biannually.

Section 4. Advanced practice registered nursing shall include prescribing and administering medications, as well as[~~and~~] ordering treatments, devices, diagnostic tests, and performing certain procedures that shall be consistent with the scope and standards of practice of the [~~advanced practice registered nurse~~] APRN.

Section 5. Advanced practice registered nursing shall not preclude the practice by the [~~advanced practice registered nurse~~] APRN of registered nursing practice as defined by KRS 314.011(6).

Section 6. (1)(a) A CAPA-NS and a CAPA-CS shall include the:

1. Name;

2. Practice address;

3. Phone number;

4. License number of both the [~~advanced practice registered nurse~~] APRN and each physician who is a party to the agreement; and

5. Population focus and area of practice of the [~~advanced practice registered nurse~~] APRN and each physician.

(b) An [~~advanced practice registered nurse~~] APRN shall use a [~~the Common~~] CAPA-NS Agreement[~~form~~].

(c) An APRN shall use the Standardized CAPA-CS Form.

(2)(a) To notify the board of the existence of a CAPA-NS pursuant to KRS 314.042(8)(b), the APRN shall submit an online notification[~~file with the board the APRN Prescriptive Authority Notification Form~~].

(b) To notify the board that the requirements of KRS 314.042(9) have been met and that the APRN will be prescribing nonscheduled legend drugs without a CAPA-NS, the APRN shall submit an online notification[~~file the APRN Prescriptive Authority Notification Form~~].

(c) To notify the board of the existence of a CAPA-CS pursuant to KRS 314.042[~~(10)(b)~~](11)(b), the APRN shall submit an online notification[~~file with the board the APRN Prescriptive Authority Notification Form~~].

(d) To notify the board that the requirements of KRS 314.042(14) have been met and request that the APRN be exempt from prescribing scheduled legend drugs under a CAPA-CS, the APRN shall complete the request for APRN exemption from CAPA-CS prescriptive authority and pay the listed fee in administrative regulation 201 KAR 20:240, Section 3(1)(e). Each submitted request shall be subject to the fee, regardless of whether the board grants the exemption after making a determination under Section 7 of this administrative regulation.

(e) All notifications, rescissions, and exemption requests shall be submitted by the APRN to the board via the online KBN Nurse Portal at www.kbn.ky.gov, and shall include the information and documentation required by subsections (1) and (2) of this section.

(f) Upon request by the Board, the APRN shall furnish to the board a copy of the executed CAPA-NS Agreement or Standardized CAPA-CS Agreement Form.

(3) For purposes of the CAPA-NS and the CAPA-CS, in determining whether the APRN and the collaborating physician are qualified in the same or a similar specialty, the board shall consider

the facts of each particular situation and the scope of the APRN's and the physician's actual practice.

(4) An APRN with controlled substance prescriptive authority, shall:

(a) [~~An APRN with a CAPA-CS, shall obtain~~] Obtain a United States Drug Enforcement [~~Agency~~] Administration (DEA) Controlled Substance Registration Certificate and shall report [~~all~~] the APRN's Kentucky DEA number[~~s~~], [~~including a DEA-X Controlled Substance Registration Certificate~~], and any change in the status of a certificate by providing a copy of each registration certificate to the board within thirty (30) days of issuance.

(b) [~~An APRN shall register~~] Register for a master account with the [~~Kentucky All Schedule Prescription Electronic Reporting System (KASPER)~~] PDMP, within thirty (30) days of obtaining a DEA Controlled Substance Registration Certificate, and prior to prescribing controlled substances. A copy of the [~~KASPER~~] PDMP master account registration certificate shall be submitted to the board via the online KBN Nurse Portal [~~APRN Update portal~~] within thirty (30) days of receipt of confirmation of registration by [~~KASPER~~] the PDMP.

(5) An APRN shall report any changes to a CAPA-NS or a CAPA-CS to the board within thirty (30) days.

(6) If an APRN's CAPA-NS ends unexpectedly for reasons outside the APRN's control such as being ended by the physician without notice, the physician's license becoming no longer valid in Kentucky, or the death of a physician, the APRN may continue to prescribe non-scheduled legend drugs for thirty (30) days, after documenting in each patient's medical record the applicant's professional determination that the continued prescribing is justified based on the individual facts applicable to the patient's diagnosis and treatment. This thirty (30) day grace

period shall not be extended or occur successively. If an APRN's CAPA-CS ends unexpectedly, the APRN [~~with a CAPA-CS~~] shall cease prescribing controlled substances [~~if the collaborative agreement unexpectedly ends,~~] until the CAPA-CS is resumed, [~~or~~] the APRN enters into a new CAPA-CS, or the APRN is granted an exemption by the Board under Section 7 of this administrative regulation.

(7) An APRN with a CAPA-NS or a CAPA-CS shall report a practice address to the board. A change to the practice address shall be reported to the board within thirty (30) days.

(8) All documents and information required to be reported to the board by this section shall be reported by uploading the document or information through the board's [~~Web~~]website, https://kbn.ky.gov[~~, utilizing the tab APRN Update~~]. The board shall not accept documents or information sent in any other format.

Section 7. CAPA-CS Exemption Review Request. (1) An APRN who wishes to request a CAPA-CS exemption pursuant to KRS 314.042(14) shall:

(a) Complete a CAPA-CS exemption review request the board's website as required in Section 6(8) of this administrative regulation;

(b) Submit the fee required by 201 KAR 20:240, Section 3(1)(e); and

(c) Comply with the requirements established in KRS 314.042(14) and this administrative regulation.

(2) Upon receipt of the CAPA-CS exemption review request, the board shall verify the following:

(a) The APRN has had four (4) years of controlled substance prescribing authority;

(b) The APRN's license is in good standing;

(c) The APRN has maintained a DEA registration and a current registration certificate is on file with the board;

(d) The APRN has maintained a PDMP registration and a current registration is on file with the board;

(e) That a current Notification of a CAPA-CS for the APRN is on record with the board; and

(f) The APRN has an active account with the PDMP.

(3) Upon receipt of the CAPA-CS exemption review request, the board shall:

(a) Perform a criminal background check for any unreported misdemeanor or felony convictions in Kentucky; and

(b) Perform a check of the coordinated licensure information system specified in KRS 314.475 for any unreported disciplinary actions in another state.

(4) The APRN submitting the request shall cooperate with supplemental requests for documentation before the board makes a determination that the APRN's license is in good standing pursuant to KRS 314.042(14).

(5) An APRN wishing to practice in Kentucky through licensure by endorsement may request an exemption under this section.

(a) An APRN wishing to practice in Kentucky through licensure by endorsement is exempt from the CAPA-CS requirement if the APRN:

1. Has met the prescribing requirements for controlled substances in a state that grants such prescribing authority to APRNs;

2. Has had authority to prescribe controlled substances for at least four (4) years; and

3. Has a license in good standing.

(b) An APRN wishing to practice in Kentucky through licensure by endorsement who has had the authority to prescribe controlled substances for less than four (4) years and wishes to continue to prescribe controlled substances shall enter into a CAPA-CS with a physician licensed in Kentucky and comply with the provisions of KRS 314.042(11), until the requirements of this section are met.

(6) If the board determines that the APRN is eligible for the exemption after a review and determination of the exemption request under this section, the board shall notify the APRN in writing that the CAPA-CS is no longer required. The board shall not require the APRN to maintain a CAPA-CS as a condition to prescribe controlled substances unless the board imposes such a requirement as part of an action instituted under KRS 314.091(1).

(7) If the board denies the exemption request, the denial shall be in writing and shall state the reasons for the denial. The requestor may request a hearing pursuant to KRS 13B within twenty (20) days of receiving written notification of the denial. If a hearing is requested and the order of the board is adverse to the advance practice registered nurse, the board may impose costs pursuant to administrative regulation 201 KAR 20:162, Section 7.

(8) The APRN nurse shall not prescribe controlled substances without a CAPA-CS until the board has completed its review and has notified the APRN in writing that the APRN is exempt from the CAPA-CS requirement.

Section [~~7~~]8. Prescribing medications without prescriptive authority.

(1) Prescribing [~~medications~~] nonscheduled legend drugs without a CAPA-NS or prescribing controlled substances without a CAPA-CS shall constitute a violation of KRS 314.091(1), [~~except if~~] unless,

(a) In the case of nonscheduled legend drugs, the [~~a~~] CAPA-NS has been discontinued pursuant to KRS 314.042(9) or if the prescribing occurred within the grace period established in Section 6(6) of this administrative regulation[~~.~~]; or

(b) In the case of controlled substances, the APRN was granted an CAPA-CS exemption by the Board under KRS 314.042(14)(e) prior to the date the medications were prescribed.

Section [~~8~~]9. The board may make an unannounced visit to an [~~advanced practice registered nurse~~] APRN's practice to determine if the [~~advanced practice registered nurse's practice~~] it is consistent with the requirements established by KRS Chapter 314 and 201 KAR Chapter 20. [~~, and patient~~] Patient and prescribing records shall be made available for immediate inspection.

Section [~~9~~]10. Prescribing Standards for Controlled Substances. (1)(a) This section shall apply to APRNs with controlled substance prescriptive authority [~~a CAPA-CS, if prescribing a controlled substance~~]. It also applies to the utilization of [~~KASPER~~] the PDMP.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN's[~~S~~] role and population focus. This section does not alter the prescribing limits established in KRS 314.011(8).

(2) Prior to the initial prescribing of a controlled substance to a patient, the APRN shall:

(a) Obtain the patient's medical history, including history of substance use, and conduct an examination of the patient and document the information in the patient's medical record. An APRN certified in psychiatric-mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query [~~KASPER~~] the PDMP for the twelve (12) month period immediately preceding the request for available data on the patient and maintain all [~~KASPER~~] PDMP report identification numbers and the date of issuance of each [~~KASPER~~] PDMP report in the patient's record;

(c) Develop a written treatment plan stating the objectives of the treatment and further diagnostic examinations required; and

(d) Discuss with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate:

1. The risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependence;

2. That the controlled substance shall be discontinued once the condition requiring its use has resolved; and

3. Document that the discussion occurred and obtain written consent for the treatment.

(3) The treatment plan shall include an exit strategy, if appropriate, including potential discontinuation of the use of controlled substances.

(4) For subsequent or continuing long-term prescriptions of a controlled substance for the same medical complaint, the APRN shall:

(a) Update the patient's medical history and document the information in the patient's medical record;

(b) Modify and document changes to the treatment plan as clinically appropriate; and

(c) Discuss the risks and benefits of any new controlled substances prescribed, including the risk of tolerance and drug dependence with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate.

(5) During the course of treatment, the APRN shall query [~~KASPER~~] the PDMP no less than once every three (3) months for the twelve (12) month period immediately preceding the request for available data on the patient. The APRN shall maintain in the patient's record all [~~KASPER~~] PDMP report identification numbers and the date of issuance of each [~~KASPER~~] PDMP report or a copy or saved image of the [~~KASPER~~] PDMP report. If neither an identification number nor an image can be saved to the patient's record as a result of technical limitations of the APRN's electronic health record system, the APRN shall make a concurrent note in the patient's record documenting the date and time that the APRN reviewed the patient's [~~KASPER~~] PDMP report.

(6) These requirements may be satisfied by other licensed practitioners in a single group practice if:

(a) Each licensed practitioner involved has lawful access to the patient's medical record;

(b) Each licensed practitioner performing an action to meet these requirements is acting within the scope of practice of his or her profession; and

(c) There is adequate documentation in the patient's medical record reflecting the actions of each practitioner.

(7) If prescribing a controlled substance for the treatment of chronic, non-cancer pain, the APRN,[~~. In~~] in addition to the requirements of this section, shall obtain a baseline drug screen and further random drug screens if the APRN:

(a) Finds a drug screen clinically appropriate; or

(b) Believes that it is appropriate to determine whether [~~or not~~] the controlled substance is being taken by the patient.

(8) If prescribing a controlled substance for the treatment of a mental health condition, the APRN shall meet the requirements of this section and KRS 314.011(8)(a) and (b).

(9) Prior to prescribing a controlled substance for a patient in the emergency department of a hospital that is not an emergency situation, the APRN shall:

(a) Obtain the patient's medical history, conduct an examination of the patient, and document the information in the patient's medical record. An APRN certified in psychiatric - mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query [~~KASPER~~] the PDMP for the twelve (12) month period immediately preceding the request for available data on the patient and document the data in the patient's record;

(c) Develop a written treatment plan stating the objectives of the treatment and further diagnostic examinations required; and

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, the patient's legal guardian, or health care surrogate, including the risks of tolerance and drug dependence, and document that the discussion occurred and that the patient consented to that treatment.

(10) For each patient for whom an APRN prescribes a controlled substance, the APRN shall keep accurate, readily accessible, and complete medical records, which include:

(a) Medical history and physical or mental health examination;

(b) Diagnostic, therapeutic, and laboratory results;

(c) Evaluations and consultations;

(d) Treatment objectives;

(e) Discussion of risk, benefits, and limitations of treatments;

(f) Treatments;

(g) Medications, including date, type, dosage, and quantity prescribed;

(h) Instructions and agreements;

(i) Periodic reviews of the patient's file; and

(j) All [~~KASPER~~] PDMP report identification numbers and the date of issuance of each [~~KASPER~~] PDMP report.

(11) The requirement to query [~~KASPER~~] the PDMP shall not apply to:

(a) An APRN prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure of the delivery and the medication usage does not extend beyond the fourteen (14) days;

(b) An APRN prescribing or administering a controlled substance necessary to treat a patient in an emergency situation; or

(c) An APRN prescribing a controlled substance:

1. For administration in a hospital or long-term-care facility with an institutional account, or an APRN in a hospital or facility without an institutional account, if the hospital, long-term-care facility, or licensee queries [~~KASPER~~] the PDMP for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient's or resident's admission and places a copy of the query in the patient's or resident's medical records during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. To assist a patient with submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescription pursuant to subsection (1) of this section if the prescriber:

a. Substitutes a controlled substance for the initial prescribing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescription pursuant to subsection (1) of this section if the prescribing is done by another licensee in the same practice or in an existing coverage arrangement, if done for the same patient for the same condition;

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federal-wide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health;

8. During the effective period of any disaster or situation with mass casualties that have a direct impact on the APRN's practice;

9. As part of the administering or ordering of controlled substances to prisoners in a state, county, or municipal correctional facility;

10. That is a Schedule IV controlled substance for no longer than three (3) days for an established patient to assist the patient in responding to the anxiety of a nonrecurring event; or

11. That is classified as a Schedule V controlled substance.

(12) In accordance with 21 C.F.R. 1306.12(b)(1)(iv) - (v), federal regulation 21 C.F.R. 1306.12(b) concerning the issuance of multiple prescriptions for Schedule II controlled substances shall not apply to APRNs in this state.

(13) No less than once every six (6) months, an APRN who holds a DEA Controlled Substance Registration Certificate shall review a reverse [~~KASPER~~] PDMP report for the preceding six (6) months to determine if the information contained in [~~KASPER~~] the PDMP is correct. If the information is incorrect, the APRN shall comply with 902 KAR 55:110 and take the necessary steps to seek correction of the information, by:

(a) First contacting the reporting pharmacy;

(b) Contacting law enforcement if suspected fraudulent activity; or

(c) Contacting the Drug Enforcement Professional Practices Branch, Office of Inspector General, Cabinet for Health and Family Services.

(14) An APRN shall not issue a prescription for hydrocodone combination products for more than a three (3) day supply if the prescription is intended to treat pain as an acute medical condition, except if:

(a) The APRN, in his or her professional judgment, believes that more than a three (3) day supply of hydrocodone combination products is medically necessary to treat the patient's pain as an acute medical condition and the APRN adequately documents the acute medical condition and lack of alternative treatment options that justifies deviation from the three (3) day supply limit on the patient's medical records;

(b) The prescription for hydrocodone combination products is prescribed to treat chronic pain;

(c) The prescription for hydrocodone combination products is prescribed to treat pain associated with a valid cancer diagnosis;

(d) The prescription for hydrocodone combination products is prescribed to treat pain while the patient is receiving hospice or end-of-life treatment;

(e) The prescription for hydrocodone combination products is prescribed as part of a narcotic treatment program licensed by the Cabinet for Health and Family Services;

(f) The prescription for hydrocodone combination products is prescribed to treat pain following a major surgery, which is any operative or invasive procedure or a delivery, or the treatment of significant trauma; or

(g) Hydrocodone combination products are administered directly to an ultimate user in an inpatient setting.

(15) Prescriptions written for hydrocodone combination products pursuant to subsection (14)(a) through (g) of this section shall not exceed thirty (30) days without any refill.

(16) An APRN may prescribe electronically. Electronic prescription shall be as established in KRS 218A.171.

(17) For any prescription for a controlled substance, the prescribing APRN shall discuss with the patient the effect the patient's medical condition and medication may have on the patient's ability to safely operate a vehicle in any mode of transportation.

Section [~~10~~]11. Immediate Family and Self-prescribing or Administering Medications.

(1) An APRN shall not self-prescribe or administer controlled substances.

(2) An APRN shall not prescribe or administer controlled substances to his or her immediate family except as established in subsections (3) and (4) of this section.

(3) An APRN may prescribe or administer controlled substances to an immediate family member:

(a) In an emergency situation;

(b) For a single episode of an acute illness through one (1) prescribed course of medication; or

(c) In an isolated setting, if no other qualified practitioner is available.

(4)(a) An APRN who prescribes or administers controlled substances for an immediate family member pursuant to subsections (3)(a) or (b) of this section shall document all relevant information and notify the appropriate provider.

(b) An APRN who prescribes or administers controlled substances for an immediate family member pursuant to subsection (3)(c) of this section shall maintain a provider-practitioner relationship and appropriate patient records.

Section [~~11~~]12. Incorporation by Reference. (1) The following material is incorporate by reference:

(a) "AACN Scope and Standards for Acute Care Nurse Practitioner Practice", 2017 Edition, American Association of Critical-Care Nurses;

(b) "ACCN Scope and Standards for Acute Care Clinical Nurse Specialist Practice", 2014 Edition, American Association of Critical-Care Nurses;

(c) "Neonatal Nursing: Scope and Standards of Practice", 2013 Edition, American Nurses Association/ National Association of Neonatal Nurses;

(d) "Nursing: Scope and Standards of Practice", 2015 Edition, American Nurses Association;

(e) "Pediatric Nursing: Scope and Standards of Practice", 2015 Edition, American Nurses Association/ Society of Pediatric Nursing/ National Association of Pediatric Nurse Practitioners;

(f) "Psychiatric-Mental Health Nursing: Scope and Standards of Practice", 2014, American Nurses Association/ American Psychiatric Nursing Association;

(g) "Scope of Practice for Nurse Practitioners", 2019 Edition, American Association of Nurse Practitioners;

(h) "Standards of Practice for Nurse Practitioners", 2019 Edition, American Association of Nurse Practitioners;

(i) "Scope of Nurse Anesthesia Practice", 2013 Edition, American Association of Nurse Anesthetists;

(j) "Standards for Nurse Anesthesia Practice", 2019 Edition, American Association of Nurse Anesthetists;

(k) "Standards for Office Based Anesthesia Practice", 2019 Edition, American Association of Nurse Anesthetists;

(l) "Standards for the Practice of Midwifery", 2011 Edition, American College of Nurse Midwives;

(m) "Oncology Nursing Scope and Standards of Practice", 2019 Edition, Oncology Nursing Society;

(n) "The Women's Health Nurse Practitioner: Guidelines for Practice and Education", 2014 Edition, Association of Women's Health, Obstetric and Neonatal Nurses/Nurse Practitioners in Women's Health;

(o) "Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives", 2012 Edition, American College of Nurse Midwives;

(p) "Standards for Professional Nursing Practice in the Care of Women and Newborns", 2019 Edition, Association of Women's Health, Obstetric and Neonatal Nurses;

(q) ~~"APRN Prescriptive Authority Notification Form", 6/2018, Kentucky Board of Nursing; and~~]; "Standardized CAPA-CS Agreement Form", 9/2023; and

[~~(s)~~](r)"[~~Common~~] CAPA-NS Agreement Form", 9/2023[~~6/2015, Kentucky Board of Nursing~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the board's [~~Web~~]web site at [~~https://kbn.ky.gov/legalopinions/Pages/laws.aspx~~] https://kbn.ky.gov/General/Pages/Document-Library.aspx.

Amended Administrative Regulation

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses.

Adopted: August 24, 2023.

Audria Denker, DNP, RN, FAAN

Audria Denker, President
Kentucky Board of Nursing

August 24, 2023
Date

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall be held on November 21, 2023 at 10:00 AM at Kentucky Board of Nursing, 312 Whittington Parkway, Ste 300, Louisville, KY 40222. Individuals interested in being heard at this hearing shall notify this agency in writing by November 14, 2023, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing was received by that date, the hearing may be cancelled. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through November 30, 2023. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON:
Jeffrey R. Prather, General Counsel
Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Louisville, KY 40222
(502) 338-2851
Jeffrey.Prather@ky.gov

Or submit a comment at:
https://secure.kentucky.gov/formservices/Nursing/PendReg

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

201 KAR 20:057
Contact Person: Jeffrey Prather
Phone: (502) 338-2851
Email: Jeffrey.prather@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets standards for APRN practice.

(b) The necessity of this administrative regulation: This administrative regulation is necessary because of KRS 314.042.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by setting standards of practice.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by setting standards of practice.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment clears up regulatory language to use "APRN"; adds definitions for "Good standing", "Immediate family" and "PDMP" (prescription drug monitoring program). It establishes regulatory standards for APRNs engaged in a CAPA-CS, including creation of a new CAPA-CS form. The amendments further provide for the regulatory process by which an APRN may request an exemption from the CAPA-CS requirement, in accordance with Senate Bill (SB) 94 (2023RS).

(b) The necessity of the amendment to this administrative regulation: These regulation amendments were necessary due to SB 94, and the changes to KRS 314.042.

(c) How the amendment conforms to the content of the authorizing statutes: By clearly stating requirements.

(d) How the amendment will assist in the effective administration of the statutes:: By clearly stating standards, procedures, and requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Kentucky APRNs, approximately 14,000 licensees.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: APRNs who wish to be in a CAPA-CS will need to use the form incorporated by reference. If the wish to request an

exemption, they must be in good standing, provide a DEA and a PDMP registration, and meet the 4-year prescribing requirement.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No additional cost, other than the exemption request fee in 201 KAR 20:240, which is mandated by KRS 314.042(14)(b)(4),

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be in compliance with the administrative regulation and KRS 314.042, and will be authorized to prescribe controlled substances.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No additional cost.

(b) On a continuing basis: No additional cost.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fees are increased; however, a fee of $50 has been proposed in 201 KAR 20:240, which is mandated by KRS 314.042(14)(b)(4), and currently in promulgation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This regulation does not establish a fee; however, see KRS 314.042(14)(b)(4), and 201 KAR 20:240.

(9) TIERING: Is tiering applied? The changes will apply equally, there is no tiering.

FISCAL NOTE

201 KAR 20:057
Contact Person: Jeffrey Prather
Phone: (502) 338-2851
Email: Jeffrey.prather@ky.gov

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Board of Nursing.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. Kentucky Revised Statutes KRS 218A.205(3)(a), (b), 314.131(1), 314.042, and 314.193.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No additional cost.

(d) How much will it cost to administer this program for subsequent years? No additional cost.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? None.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? None.

(c) How much will it cost the regulated entities for the first year? None.

(d) How much will it cost the regulated entities for subsequent years? None.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-):

Expenditures (+/-):
Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. *"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)]* This administrative regulation will not have a major economic impact.

Summary of Material Incorporated by Reference

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses.

Summary of Material Incorporated by Reference

The following materials incorporated by reference are scope and standard statements from nationally established organizations pursuant to KRS 314.011(8) and KRS 314.193.

(a) “AACN Scope and Standards for Acute Care Nurse Practitioner Practice”, 2017 Edition, American Association of Critical-Care Nurses. This is a revised version of a previous edition and is a thirty-three (33) page booklet.

(b) “AACN Scope and Standards for Acute Care Clinical Nurse Specialist Practice”, 2014 Edition, American Association of Critical-Care Nurses. This is a forty-three (43) page booklet.

(c) “Neonatal Nursing: Scope and Standards of Practice”, 2013 Edition, American Nurses Association/ National Association of Neonatal Nurses. This is a one-hundred and twenty-one (121) page booklet.

(d) “Nursing: Scope and Standards of Practice”, 2015 Edition, American Nurses Association. This document is thirty-three (33) pages in length.

(e) “Pediatric Nursing: Scope and Standards of Practice”, 2015 Edition, American Nurses Association/ Society of Pediatric Nursing/ National Association of Pediatric Nurse Practitioners. This is a nine (9) page document.

(f) “Psychiatric-Mental Health Nursing: Scope and Standards of Practice”, 2014, American Nurses Association/ American Psychiatric Nursing Association. This is a mini booklet and is sixty (60) pages in length.

(g) “Scope of Practice for Nurse Practitioners”, 2019 Edition, American Association of Nurse Practitioners. This is a two (2) page document.

(h) “Standards of Practice for Nurse Practitioners”, 2019 Edition, American Association of Nurse Practitioners. This is a four (4) page document.

(i) “Scope of Nurse Anesthesia Practice”, 2013 Edition, American Association of Nurse Anesthetists. This is a three (3) page document.

(j) “Standards for Nurse Anesthesia Practice”, 2019 Edition, American Association of Nurse Anesthetists. This is a four (4) page document.

(k) “Office Based Anesthesia”, 2019 Edition, American Association of Nurse Anesthetists. This document is seven (7) pages in length.

(l) “Standards for the Practice of Midwifery”, 2011 Edition, American College of Nurse Midwives. This is a three (3) page document.

(m) “Oncology Nursing Scope and Standards of Practice”, 2019 Edition, Oncology Nursing Society. This is a mini booklet and is thirty-seven (37) pages in length.

(n) “The Women’s Health Nurse Practitioner: Guidelines for Practice and Education”, 2014 Edition, Association of Women’s Health, Obstetric, and Neonatal Nurses/ Nurse Practitioners in Women’s Health. This is a mini booklet and is twenty-seven (27) pages in length.

(o) “Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives”, 2012 Edition, American College of Nurse Midwives. This is a one (1) page document.

(p) “Standards for Professional Nursing Practice in the Care of Women and Newborns”, 2019 Edition, Association of Women’s Health, Obstetric, and Neonatal Nurses. This document is being added to the materials incorporated by reference and is a thirty-eight (38) page booklet.

The following materials incorporated by reference are forms that shall be executed by the Advanced Practice Registered Nurses who have entered into a collaborative agreement for prescriptive authority for controlled substances, pursuant to KRS 314.042(11), and nonscheduled legend drugs pursuant to KRS 314.042(8).

(q) “Standardized CAPA-CS Agreement Form”, 9/2023. This is a three (3) page form.

(r) "CAPA-NS Agreement Form”, 9/2023. This is a one (1) page form.

Summary of Changes to Material Incorporated by Reference

(a) APRN Prescriptive Authority Notification Form has been removed from the Material Incorporated by Reference;

(b) “Standardized CAPA-CS Agreement Form”, 9/2023 has been added to the Material Incorporated by Reference; and

(c) The "Common CAPA-NS Agreement Form", 6/2015, has been renamed “Collaborative Agreement for Advanced Practice Registered Nurse.

Prescriptive Authority for Non-Scheduled Drugs (CAPA-NS) Form", 9/2023.

STANDARDIZED COLLABORATIVE AGREEMENT FOR THE ADVANCED PRACTICE REGISTERED NURSE'S PRESCRIPTIVE AUTHORITY FOR CONTROLLED SUBSTANCES (CAPA-CS) FORM

This Collaborative Prescribing Agreement for Controlled Substances ("CAPA-CS Agreement") is entered into this _____ day of the month of _____ in the year of _____, by and between _____ herein after the "APRN", and _____ herein after the "Physician".

WITNESSETH:

WHEREAS, the APRN and the Physician desire to enter into a CAPA-CS Prescribing Agreement pursuant to KRS 314.011 and KRS 314.042.

WHEREAS, this CAPA-CS Prescribing Agreement is entered into by and between the APRN and the Physician under their respective licenses for the sole purpose of defining the scope of prescriptive authority for scheduled drugs to be exercised by the APRN in compliance with all of the applicable sections of statute and regulations.

WHEREAS, the CAPA-CS Prescribing Agreement shall state any limits on controlled substances which may be prescribed by the APRN, as agreed to by the APRN and the Physician. The limits so imposed may be more stringent than either the schedule limits on controlled substances established in KRS 314.011(8) or the limits imposed in regulations promulgated by the Kentucky Board of Nursing thereunder.

WHEREAS, with the exception of agreed-upon limitations of prescribing controlled substances, this agreement shall not be construed as limiting, in any way or to any extent, the scope of practice authority provided to the APRN pursuant to KRS Chapter 314, and the administrative regulations promulgated pursuant thereto, 201 KAR 20:056 and 20:057.

WHEREAS, this agreement is not a substitute for the independent clinical judgment of the APRN based on the specific needs of the patient. The APRN shall remain responsible and accountable pursuant to the aforementioned Kentucky statutes and regulations.

NOW, THEREFORE, the parties agree as follows:

1. All of the foregoing are a part of this agreement and are not mere recitals.

2. The APRN shall be permitted to prescribe scheduled drugs II – V, appropriate within the APRN's scope of practice, and as classified in KRS 218A.060, 218A.070, 218A.080. 218A090, 218A.100, 218A.110, 218A.120, and 218A.130, under the conditions set forth in KRS 314.011 and KRS 314.042 and all regulations promulgated by the Kentucky Board of Nursing. The relevant statutes and regulations shall be reviewed by the APRN and the Physician at the outset of the collaborative agreement.

3. Prior to prescribing controlled substances, the APRN shall obtain a Controlled Substance Registration Certificate through the U.S. Drug Enforcement Agency.

4. The CAPA-CS is not intended to serve as a substitute for the independent clinical judgment of the APRN based on the specific needs of the patient and this agreement does not place increased liability on the Physician for those decisions made by the APRN.

5. This agreement shall remain in effect unless terminated by either party with 30 days'-written notice to the other party.

6. The APRN shall notify the Kentucky Board of Nursing of the existence of the CAPA-CS and the name of the Physician and shall, upon request, furnish to the board or its staff a copy of the completed CAPA-CS and a record of collaboration meeting dates and any recommendations made.

7. A copy of the completed CAPA-CS shall be available at each site where the APRN is providing patient care.

8. Collaboration and communication between the APRN and the Physician regarding the prescribing of controlled substances by the APRN shall take place, preferably in person or via video conferencing, or by phone when in-person or videoconferencing is not available.

9. In the first year of the CAPA-CS, the Physician and the APRN shall meet at least quarterly preferably in person or via video conferencing, or by phone, when in-person or videoconferencing is not available, to review the APRN's reverse Prescription Drug Monitoring Program ("PDMP") system report. Any consultation related to specific prescriptions identified in the reverse PDMP report may include pertinent information from the patient's medical record to facilitate meaningful discussion regarding prescriptions identified in the reverse PDMP report and any subsequent prescribing recommendations. A record of the meeting date and any recommendations made shall be noted in writing and a copy retained by both parties to the agreement. The meeting records shall be subject to audit by the KY Board of Nursing for the APRN and by the KY Board of Medical Licensure for the Physician.

10. In the ensuing three (3) years of the CAPA-CS, the Physician and the APRN shall meet at least biannually preferably in person or via video conferencing, or by phone when in-person or videoconferencing is not available, to review the APRN's reverse PDMP report. Any consultation related to specific prescriptions identified in the reverse PDMP report may include pertinent information from the patient's medical record to facilitate meaningful discussion regarding prescriptions identified in the reverse PDMP report and any subsequent prescribing recommendations. A record of the meeting date, and any recommendations made, shall be noted in writing and a copy retained by both parties to the agreement. The meeting records shall be subject to audit by the

KY Board of Nursing for the APRN and by the KY Board of Medical Licensure for the Physician.

Date Agreement Signed: _____	Date Agreement Signed: _____
_____	_____
APRN name	Physician name
_____	_____
APRN signature	Physician signature
_____	_____
APRN license #	Physician license #
_____	_____
APRN DEA Certificate #	Physician DEA Certificate #
_____	_____
APRN specialty	Physician specialty
_____	_____
APRN practice street address	Physician practice street address
_____	_____
City, state, zip	City, state, zip
_____	_____
Phone	Phone
_____	_____
Email	Email

[~~Common~~] Collaborative Agreement for Advanced Practice Registered Nurse Prescriptive Authority for Non-Scheduled Drugs (CAPA-NS) Form

THIS COLLABORATIVE PRESCRIBING AGREEMENT (the "Agreement") is entered into this _____day of the month of _____in the year_____, by and between_____ APRN, herein after the "APRN", and_____ M.D./D.O., herein after the “Physician".

WHEREAS, the APRN and the physician desire to enter into a Collaborative Prescribing Agreement pursuant to KRS 314.042(8); and

WHEREAS, this Collaborative Prescribing Agreement is entered by and between the APRN and the Physician for the sole purpose of defining the scope of prescriptive authority to be exercised by the APRN, all in compliance with the applicable sections of KRS Chapter 314; and

WHEREAS, this agreement is not a substitute for the independent clinical judgment of the APRN based on the specific needs of the patient. The APRN shall remain responsible and accountable pursuant to KRS 314.021(2).

NOW, THEREFORE, the parties agree as follows:

1. All of the foregoing are a part of this agreement and are not mere recitals.

2. The APRN shall be permitted to prescribe all nonscheduled legend drugs appropriate for conditions which the APRN may treat pursuant to the APRNs scope of practice as defined in 201 KAR 20:057 in the specialty of _____.

3. The APRN shall only be permitted to prescribe nonscheduled legend drugs as defined in KRS 217.905, and under the conditions set forth in KRS 314.042 and KRS 314.011.

4. This agreement shall not be construed as limiting, in any way or to any extent, the scope of practice authority provided to the APRN pursuant to KRS Chapter 314, and the administrative regulations promulgated pursuant thereto, 201 KAR 20:056 and 20:057; nor shall it be construed as governing the authority of the nurse anesthetist to deliver anesthesia care.

5. This agreement is not intended to serve as a substitute for the independent clinical judgment of the APRN based on specific needs of the patient and this agreement does not place increased liability on the Physician for those decisions made by the APRN.

6. This agreement shall remain in effect unless terminated by either party with thirty (30) days notice.

_____	_____
APRN name	Physician name
_____	_____
APRN Signature	Physician Signature
_____	_____
APRN license no.	Physician license no.
_____	_____
Practice address	Practice address
_____	_____
City, state, zip	City, state, zip
_____	_____
Phone	Phone