

Shedding Light on Nurse Practitioner Prescribing

Elissa Ladd, PhD, FNP-BC, and Alex Hoyt, PhD, RN

ABSTRACT

Transparency initiatives in society are growing. In the realm of prescribing, recent federal, state, and private initiatives are shedding light on health care provider practice and payments. These transparency initiatives commonly include information on nurse practitioners. Recently implemented federal and state Sunshine laws are discussed. Also, the newly released Medicare Part D data, which include nurse practitioner identified information, are described in the context of the federal data release as well as the news outlets that are utilizing this watershed of information to inform the public on health care provider practice.

Keywords: Medicare Part D, nurse practitioner, pharmaceutical industry, prescribing, Sunshine laws, transparency

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We live in a transparent world, whether we like it or not. In recent years, society, both explicitly and implicitly, has moved toward increasing transparency in multiple realms, such as science, business, government, and politics. This growing cultural shift toward transparency over the past 50 years has been seen in such noteworthy initiatives such as WikiLeaks or the Obama Administration's Open Government Program. This trend is also noted in health care, from the movement toward acknowledging fault in medical errors, to multiple public data sources on health care provider practices. This paper addresses some of the recent trends in federal, state, and private initiatives that seek to shed light on health care provider practice in general, and includes information on nurse practitioners (NPs) more specifically. Policy and practice implications of current transparency initiatives are highlighted.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: SUNSHINE PROVISIONS

In 2010, Congress passed the landmark Patient Protection and Affordable Care Act. One less well-known provision of the law, the Sunshine Act (Section 6002) was included in order to increase the transparency of financial relationships between health care providers and the pharmaceutical and

medical device industries.¹ The Sunshine Act grew out of an increasing concern regarding the financial relationships that physicians have with industry. Although some of these relationships are thought to be beneficial and contribute to the development of new drugs and devices, other relationships can generate conflicts of interest in both research and practice. Numerous studies over the past 20 years have reported high levels of financial interaction between physicians and the pharmaceutical industry.²⁻⁵ Broadly, these studies demonstrate that payments in the form of speakers fees, meals, consulting, and sponsored continuing education programs impact clinical decision-making and that such interactions between clinicians and industry can lead to biased prescribing practices and conflicts of interest.^{6,7}

The Sunshine Act requires that all pharmaceutical and medical device manufacturers providing products via Medicare, Medicaid, and the Children's Health Insurance Program disclose payments made to hospitals and all licensed physicians (doctors of medicine, osteopathy, dentists, podiatrists, optometrists, and chiropractors). These payments are reported to the Center for Medicare and Medicaid Services (CMS) and are available on the public website Open Payments (www.cms.gov/OpenPayments/). The

types of payments that are reportable include general payments, such as speakers' fees, honoraria, travel and entertainment expenses, food, and education. Payments of < \$10, unless over the course of a year exceeding \$100, are exempt. Investment interests and research payments are also included.

It is important to note that other health care professionals who have prescriptive authority, such as NPs, physician assistants (PAs), psychologists, and pharmacists (in designated states), are not included in the statute. The exclusion of these professionals has generated broad concern for several reasons. NPs and other prescribers have been described as being vulnerable or "soft targets" to industry's promotional activities, and flying "under the radar" of educational initiatives that seek to mitigate conflicts of interests between industry and prescribers.^{8,9} Also, the omission of data on other prescribing clinicians may incentivize manufacturers to shift financial relationships to these other prescribers.¹⁰ Moreover, as transparency expands around the financial transactions between physicians and industry, other prescribers who are not included in the law may become more vulnerable to the conflicts of interest that have heretofore plagued physician/industry relationships.¹¹

Federal Data Surprises

Despite the fact that NPs, PAs, and other prescribers were not included in the federal Sunshine statute, many manufacturers, nonetheless, are reporting payments made to these prescribers. This information is publically available on the CMS Open Payments website. NPs and PAs are listed together in 1 category: Physician Assistants & Advance Practice Nursing Providers/Nurse Practitioners. Additional designations are listed by specialty, namely Adult, Family, Acute, Pediatric, Psych/Mental Health, Women's Health, and Neonatal. The initial data (August to December 2013) were released in 2014, and the full data for 2014 were released on June 30, 2015.

Importantly, the data disclose specific identifying information, such as name, workplace address, and specialty. The data also include the total dollar amount that the individual has received; what the payment covered, such as food and beverage, travel, speaking fees, consulting, etc; and the drug or

medical devices being promoted, along with the name of the manufacturer. It is important to note that, although this broad category does not differentiate NPs from PAs, the information is readily available on the internet with a simple Google search of the clinician's name.

Although the information provided in the Open Payment website is very specific and detailed, it is not comprehensive and does not include information from all manufacturers. Notably, a number of larger companies, such as Pfizer, Eli Lilly, and Boehringer Ingelheim, are not included on the list of manufacturers that provided payments to NPs and PAs. It is likely that they chose not to report NP and PA data as it was not their legal responsibility to do so. For the companies that did choose to submit payment information for NPs and PAs, the reasons for doing so can only be postulated. It may be due in part to a companies' interest in total transparency of payments made to prescribers, or may simply be a result of the difficulties in teasing out provider designations. It is important to note, however, that CMS designated this provider type in their data because provider designations were based on the federal government taxonomy codes for health care professionals (CMS, personal communication, July 9, 2015).

Embedded in these data were 1,711 reports of payments made to NPs and PAs in 2013 and 1,618 reports of payments made in 2014. The total amounts reported in the data were \$82,843 for 2013 (5 months) and \$75,567.59 for 2014. However, the average amount paid to these providers was \$47.14, with the vast majority of payments categorized under Food and Beverage. Also, there were errors noted in the data because some of the covered recipients, while being identified as NPs or PAs, were actually physicians.

On Oct. 7, 2015 Senators Grassley (R-Iowa) and Blumenthal (D-Connecticut) introduced Senate Bill S. 2153, an amendment that would require industry to include information regarding payments made to physician assistants, nurse practitioners, and other advance practice nurses in transparency reports submitted to the Center for Medicare and Medicaid, Open Payments website.

STATE-LEVEL TRANSPARENCY INITIATIVES

Currently, there are 9 states that have enacted legislation that mandates the transparency of interactions between health care providers (institution or individual) and the pharmaceutical and medical device industries. The laws, which vary by state, typically include behavioral prohibitions (bans or limits on gifts, meals, or entertainment) or disclosure requirements (the nature, value, and purpose of industry-sponsored payments or activities).¹² Minnesota was the first state to enact “Sunshine” legislation in 1993 with other states following suit over the ensuing 2 decades.

Massachusetts enacted the Pharmaceutical and Medical Device Manufacturer Code of Conduct Law in 2010,¹³ which is widely considered to be one of the most comprehensive laws of its kind in the US.¹⁴ This law requires that health care practitioners not only disclose payments from industry but also banned certain gifts and meals that are provided in non-health care settings.¹⁵ Although the Law was amended in 2012 to allow for meals in some non-health care settings (ie, restaurants), it still maintains comprehensive disclosure requirements for practitioners who fall outside the federally mandated Sunshine Act.¹⁶

Six of these states or jurisdictions (Vermont, Minnesota, Massachusetts, West Virginia, Connecticut, and the District of Columbia) include NPs in their definition of “covered recipients.” This includes full bans for food (Vermont), a prohibition on practitioner gifts (Minnesota) to other reportable activities, such as the receipt of samples (Vermont), attendance at industry-funded educational events, and other payments for speaking and consultation.¹⁷ Moreover, 2 states recently expanded their disclosure laws to include other advanced practice clinicians, in part because these prescribers were not included in the federal Sunshine Act reporting obligations. Minnesota expanded their law in 2014 to include NPs, PAs, and dental therapists (HF 2402).¹⁸ Connecticut recently passed legislation in 2014 aimed to create reporting mechanisms of industry payments that are made specifically to advanced practice registered nurses. Also, this is the first such law in the US that was directly tied to a state’s independent scope of practice law for advanced practice registered nurses (see [Table](#)).¹⁹

MEDICARE REIMBURSEMENT AND PRESCRIBING DATA

Since the inception of Medicare 50 years ago, CMS has concealed the claims records of providers participating in Medicare. This secrecy was upheld as a result of a permanent injunction in 1979 that was won by the American Medical Association against Medicare to prevent the release of physician payment data. In 2013, this injunction was lifted by the US District Court in Florida. As a result, in 2014, CMS released the first public use files that identified provider payment claims.²⁰

Moreover, as a part of the Obama Administration’s goals of “better care, smarter spending, and healthier people,” CMS released Medicare Part D data, identifying the providers and the drugs prescribed. The purpose of the release of these data was to provide transparency to consumers, researchers, health systems, and other stakeholders to identify how many prescription drugs are prescribed by individual prescribers and how much these drugs cost the health system.²¹ Although public, the data are not easily manipulated and there are no data tools, such as in Open Payments, available at this time.

OTHER PUBLICALLY SEARCHABLE DATABASES

News outlets are taking notice and are starting to utilize data that have previously been difficult to access or was unavailable. Propublica, an independent, not-for-profit organization that produces in-depth investigative journalism in the public interest, provides several data sources that contain NP data and are searchable by the public. Based on their data tools, they have published numerous articles that pertain to health care, which have earned a number of prominent journalism awards, including 2 Pulitzer Prizes (2010 and 2011) and a Peabody Award (2013).

Two of their recent investigations, *Dollars for Docs: How Industry Money Reaches Physicians* and *Prescriber Checkup: Inside the Government’s Drug Data*, are particularly applicable to prescribing practices of health care providers. These investigations include numerous stories in series format and are accompanied by user-friendly data tools that allow the public to search for health care providers by name if included in the federal data.

Table. State-based Transparency Laws

Covered Recipient			Disclosure/ Reporting Law	Reportable Activities	Gift/Food Ban
Federal (PPACA: Sunshine Act)	• MDs, DOs, DPMs • DDSs, DMDs • Teaching hospitals		Yes	• Consulting fees • Honoraria • Speaking fees • Food • Travel	• Entertainment • Role in CME • Research • Royalties • Investment
VT	• All from the federal Sunshine Act • NPs, PAs, • Pharmacists • Employees of prescribers • Nonteaching hospitals/clinics • Health plans	• Pharmacies • Universities • Nonprofit foundations • Patient advocacy associations • Professional associations	Yes	• All from the federal Sunshine Act • Samples • OTC drugs and devices • Demo units • Coupons • Vouchers	• Co-pay cards • Patient starter kits • Accredited CME • Patient education and disease management materials Total ban on food and other gifts
MA	• All from the federal Sunshine Act • NPs, PAs • Residents	• Pharmacists • Employees of prescribers • Nonteaching hospitals/clinics • Nursing homes	Yes	• All from the federal Sunshine Act • Accredited CME • Anatomic models, charts	Yes (allows modest out of office meals)
MN	• All from the federal Sunshine Act • NPs, PAs	• Dental therapists • Residents • Not pharmacists	Yes (\$50 limit on meals)	• All from the federal Sunshine Act	Yes
WV	• All from the federal Sunshine Act • NPs, PAs	• Residents • Not pharmacists	Yes	• All from the federal Sunshine Act • All national and print drug advertising	No
DC	All licensed health care providers (eg, RNs, CDEs, nutritionists, radiology techs, etc.)	• Teaching and nonteaching hospitals/clinics • Universities • Patient advocacy organizations	Yes (\$25 limit on meals)	• All from the federal Sunshine Act • Print and media drug advertising within DC	Yes
CT	APRNs only (APRNs who work independently according to newly expanded scope of practice statute)		Yes (no minimum reporting amount)	• All from the federal Sunshine Act	No

APRN = advanced practice registered nurse; CDE = certified diabetes educator; CME = continuing medical education; DDS = doctor of dental surgery; DO = doctor of ophthalmology; DPM = doctor of podiatric medicine; MD = medical doctor; NP = nurse practitioner; OTC = over the counter; PA = physician's assistant; PPACA = Patient Protection and Affordable Care Act; RN = registered nurse.

Adapted from: (1) Gorchak I, Pham-Kanter G. Physician Payment Sunshine Act: review of individual state reporting requirements. 2013. <http://www.policymed.com/2014/04/physician-payments-sunshine-act-review-of-individual-state-reporting-requirements.html/>; and (2) Finan A. Shining a light on Connecticut's version of the Sunshine Act. 2015. Available at: <http://www.law360.com/articles/659984/shining-a-light-on-conn-s-version-of-the-sunshine-act/>.

The *Dollars for Docs* series is based on 2 sources of data. Beginning in 2010, Propublica compiled data based on payment reports that resulted from legal

settlements with the federal government. These settlements often were based on whistleblower lawsuits that alleged improper marketing or kickbacks. As a

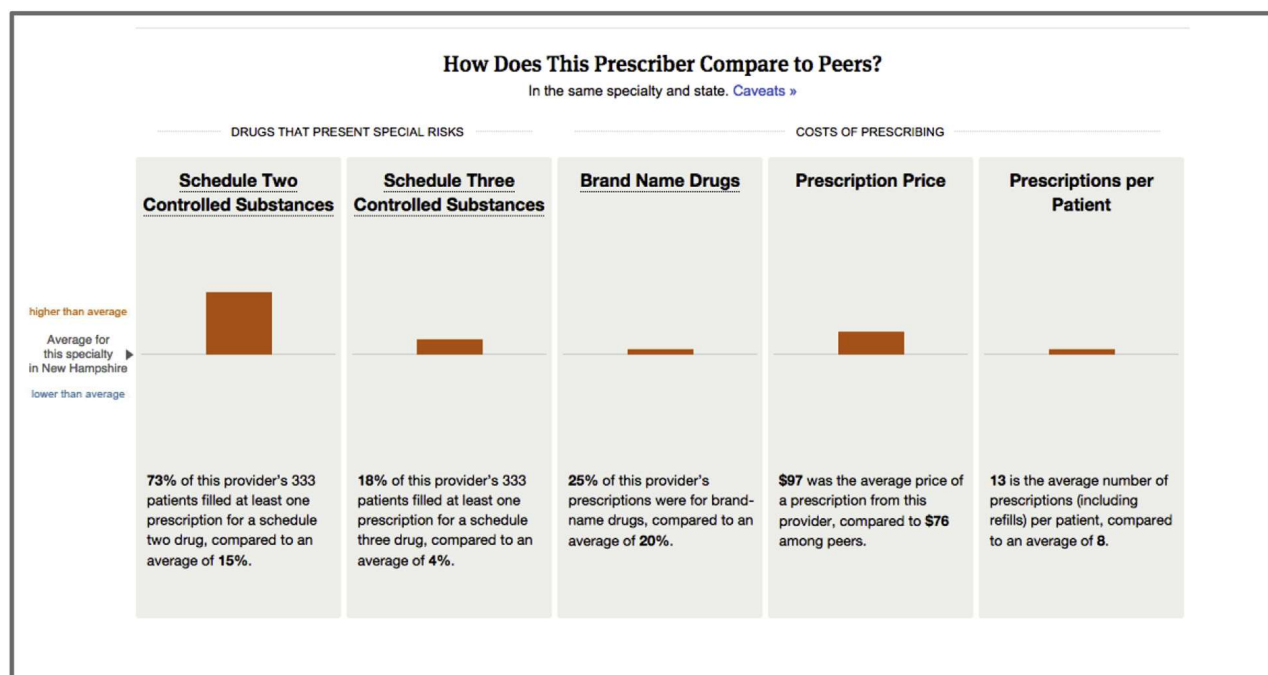
part of these settlements, pharmaceutical companies entered into corporate integrity agreements with the Department of Health and Human Services, Office of the Inspector General. A number of companies had corporate integrity agreements that mandated the reporting of payments made to health care providers. It was these payment data that populated Propublica's first data tool and provided the basis for the first series of articles in the *Dollars for Docs* series.²² This first data tool, which covers payments made between 2009 and 2013, contains numerous references to NPs that are searchable by profession, name, and state, and is quite robust in terms of identifying clinicians who received payments from industry (<http://projects.propublica.org/d4d-archive/>).

The second source of data used in the *Dollars for Docs* series is based on information compiled from the CMS Open Payments program. Like the data from the Open Payments program, the *Dollars for Docs* searchable tool contains information on payments made to physicians and hospitals, and includes information on NPs and PAs. However, unlike the

federal website, *Dollars for Docs* does not allow a search based on specialty, and therefore NP or PA data can only be searched based on name. Although the majority of payments made to NPs and PAs in these data are for small amounts, usually for food, there are numerous references to payments made to NPs for consulting and speaking, which amount to thousands of dollars.

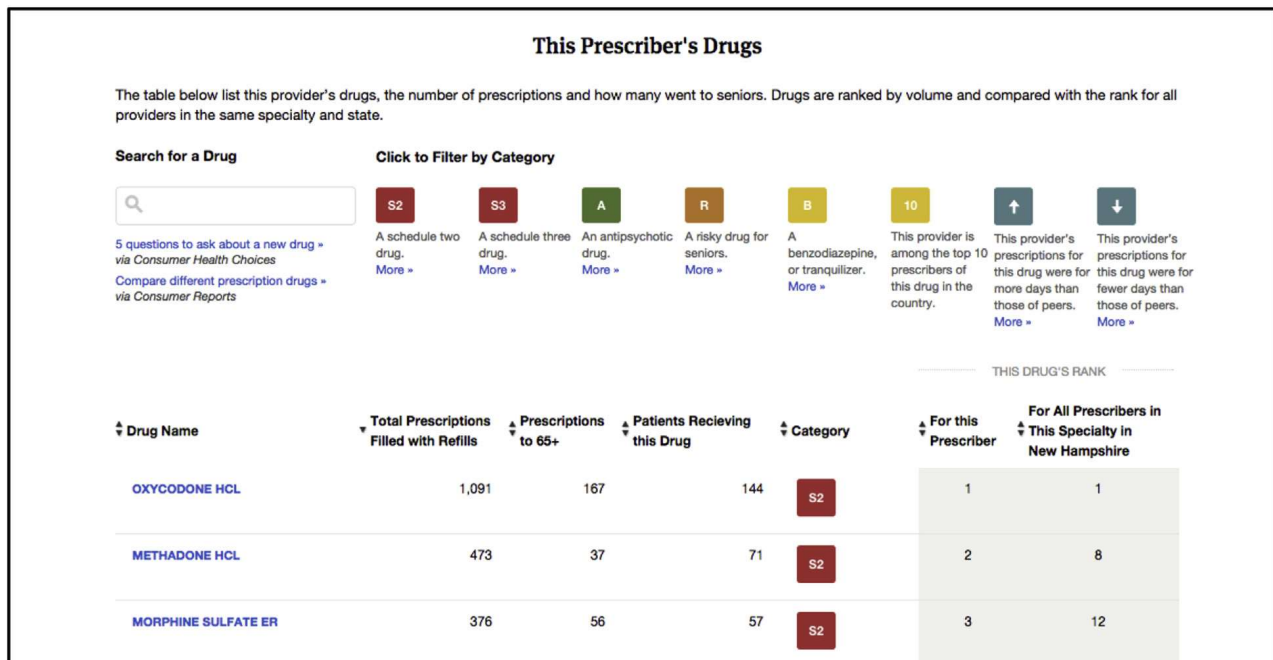
Prescriber Checkup (<http://projects.propublica.org/checkup/>) represents a more robust, readily accessible data source on NP prescribing. This data tool utilizes Medicare Part D data for 2013 (which was released in September of 2014). As noted earlier, Medicare data had heretofore not been available publicly and were only accessible for researchers at a significant cost. Propublica petitioned CMS via the Freedom of Information Act for the Medicare Part D data for 2012 and CMS later independently released the 2013 data as public use files. These data clearly designate all prescribers, such as physicians, NPs, PAs, dentists, etc, which are generated from National Provider Identifier numbers. Personal information, including

Figure 1. Propublica's *Prescriber Checkup*: Example NP Peer Comparison. (Figures for this Article have been De-identified.) From: *Prescriber Checkup*. Available at: <http://projects.propublica.org/checkup/providers/1144295544/>.



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Figure 2. Propublica's *Prescriber Checkup*: Example Data by Schedule II Drugs. (Figures for this Article have been De-identified.) From: *Prescriber Checkup*. Available at: <http://projects.propublica.org/checkup/providers/1144295544/>.



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provider name, state of licensure, and workplace address, is displayed.

Propublica also highlights the drugs that each provider prescribes based on the following domains: Drugs That Present Special Risks, such as Schedule II or Schedule III drugs; and Cost of Prescribing, which includes data on brand name drugs, prescription price, and prescriptions per patient. It compares each individual prescriber to other prescribers in the state, based on state averages for controlled substances, brand name drugs, prescription price, and prescriptions per patient (see Figure 1). Also, Propublica provides the ability to filter the provider's prescriptions based on the following categories: antipsychotic drugs; risky drugs for seniors (based on the Beers List); benzodiazepines; prescribing rank in the country for specific drugs; and the prescriber rank according to their peers in the state and by individual drug (see Figure 2). Propublica limits the data to represent information on 410,022 providers who wrote > 50 prescriptions for at least 1 drug to a Medicare Part D recipient; 34,530 prescribers were categorized as NPs.

NPs in the News

Propublica's *Prescriber Checkup* has spawned several stories in the national media that have particular pertinence to NPs. One story, published in *The Hartford Courant*, "Connecticut Nurse One of the Highest Prescribers in the US," highlighted Propublica data that shed light on an NP from that state who was identified as one of the nation's highest prescribers of opioids and other Schedule II drugs.²³ She ultimately pled guilty to receiving kickbacks from the drug company, Insys Therapeutics (Chandler, Arizona), in exchange for prescribing large amounts of their drug, Subsys (fentanyl sublingual spray).²⁴ Another story, "Transparency Program Obscures Pharma Payments to Nurses, Physician Assistants," by National Public Radio and Propublica, highlighted the financial ties that this same Connecticut NP had with Insys Therapeutics. She was a paid speaker for the drug company and gave more than 70 dinner lectures for about \$1,000 per event. It was noted that the payments for these talks were not reported to the federal Open Payments

database because NPs and PAs are not included in the statute of the Affordable Care Act.²⁵

IMPLICATIONS FOR POLICY AND PRACTICE

Recent transparency initiatives that were originally directed toward physicians are now touching NPs. NPs, who are playing an increasingly strategic role in our nation's health care system, should embrace these changes as they can only lead to increased quality and improved efficiency. The Sunshine laws (both federal and state) are intended to shed light on the amount of money spent on marketing drugs and devices and to mitigate the conflicts of interest that can arise when financial relationships exist between health care providers and industry. The pharmaceutical industry spent \$27 billion on drug promotion in 2012; \$24 billion of that amount was spent on marketing directly to clinicians. Moreover, in 2013, 9 of the 10 largest pharmaceutical companies spent more on marketing than the research and development of new drugs.²⁶ These expenditures are principally designed to influence prescribing practices and promote products.^{4,27}

A recent systematic review published in *PLoS Medicine* reported that “non-physician” clinicians perceived disparities between themselves and their physician colleagues in the areas of access to practice resources and the affordability of attendance at conferences. The authors noted that this perceived disparity caused the non-physician clinicians to be more amenable to interactions with industry as a way to advance their status in the health care system or to attain similar privileges that have heretofore been afforded to physicians.²⁸

Importantly, many authors have noted that the exclusion of advanced practice clinicians (NPs and PAs) from federal Sunshine statutes may serve to incentivize industry to increase promotional activities directed to this important provider group, due in part to decreased public scrutiny.^{11,28} Indeed, pharmaceutical industry marketing to advanced practice clinicians is poised to grow exponentially. This shift of payments to nonreportable clinicians may eventually be empirically detected by quantifying payment decreases to physicians, especially in states where NPs have broader scopes of practice.²⁹ However, it may be that the inclusion of advanced practice

clinicians into federal Sunshine statutes would more effectively mitigate the growing shift of marketing to this group of providers as well as address the disparities that exist in federal policy. Also, because of the federal omission of advanced practice clinicians, states may step in to create or expand Sunshine laws to include this provider group.³⁰ Connecticut's recent statutory addition that links transparency laws to expanded scope of practice for NPs may become a model for state legislatures that are considering expanded scope legislation.

The public release of Medicare Part D claims data may have broader implications for NP practice. Medicare data have been described as the “eighth wonder of the world,” due to the scope and breadth of information they contain. These data represent remarkable potential for researchers to be able to quantify both quality and cost metrics of NP prescribing practices. However, as has been noted in the *Propublica* series, it also creates a facile source for journalists and other researchers, who are becoming increasingly interested in NP practice, to closely scrutinize our prescribing activity. This scrutiny may become progressively compelling and provocative, especially because recent transparency initiatives, such as the federal Sunshine provisions, do not include advanced practice clinicians.

It will behoove NPs to be apprised of the information that is available publically concerning their interactions with industry as well as their prescribing patterns, based on Medicare Part D data. This information provides a comparative context; NPs should know if their practice patterns differ significantly from other providers in their community. If erroneous information is disclosed, especially in the case of the Open Payments data, any clinician has the recourse to submit corrections. However, in general, we should know our numbers, because everyone else does.

CONCLUSION

The prescribing behaviors of NPs have largely remained “under the radar” in terms of policy initiatives directed at increasing transparency with industry. Except in a handful of states, industry is not required to report their interactions with NPs. One implication of this is clear. Promotional activities by

industry will certainly shift focus to this growing group of non-reportable clinicians. This may or may not matter as Medicare Part D data are now publicly searchable with metrics related to expensive brand-name drugs—precisely the drugs that are marketed extensively. The time may be approaching that we will have to consider who influences our prescribing decisions, and ask ourselves the question: Who is *really* paying for that “free lunch”... or dinner? **JNP**

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Both authors are affiliated with the MGH Institute of Health Professions in Boston, MA. Elissa Ladd, PhD, RN, FNP-BC, is an associate professor. She can be reached at eladd@mghihp.edu. Alex Hoyt, PhD, RN, is an assistant professor. In compliance with national ethical guidelines, the authors report no relationships with business or industry that would pose a conflict of interest.

1555-4155/15/\$ see front matter
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<http://dx.doi.org/10.1016/j.nurpra.2015.09.017>

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