

## American Nurses Association

### Comments Regarding the 2006 NCSBN Draft *Vision Paper: The Future of Regulation of Advanced Practice Nursing*

#### Overall Comments Regarding the Intent of the Vision Paper

ANA sees certain positive aspects to the vision paper in identifying concerns, particularly within regulation, that have needed to be addressed for some time by the profession. In particular, ANA would support NCSBN's efforts to seek to bring regulation of all nurses, including those in advanced practice, within the purview of the boards of nursing, rather than have them regulated under boards of medicine or other entities. As identified in Recommendation 1, ANA understands this to be the definition of "sole regulators". If the intent is something else, please provide further clarification.

ANA also agrees with the statement under Recommendation 1 that Boards of Nursing have APRN representation at the board and staff levels. However, ANA wishes to express concern that this not be nominal representation but instead, significant representation of both the numbers and roles within advanced practice nursing. It is essential for Advanced Practice Nurses to have substantial and continuing influence within the boards of nursing to provide clarity and in-depth understanding of roles, practice, education, and certification in advanced practice nursing.

ANA respects the right of NCSBN to identify its concept of the future of regulation of the nursing profession. However, NCSBN's vision is predicated upon several incorrect assumptions:

- Boards of nursing define the scope of nursing practice.

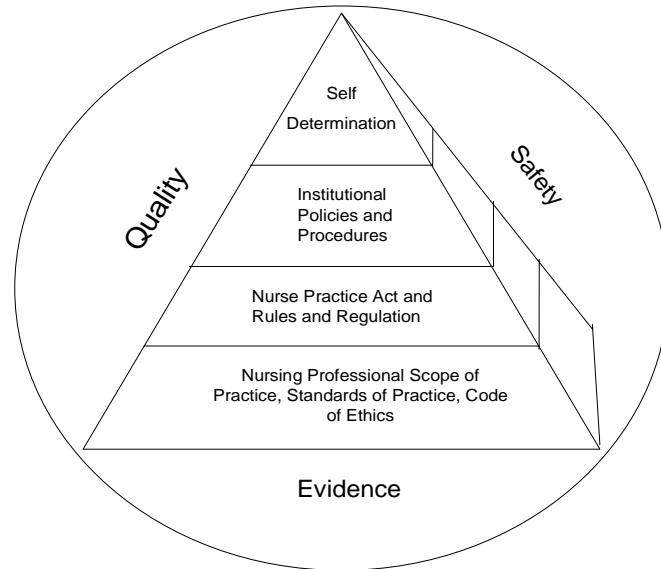
It is the long held belief of ANA and the nursing profession at large, that the responsibility for defining the Scope of Nursing Practice rests with the profession, as does self regulation of its members. Physicians and nurses have been at the forefront to define scope and standards through practice, rather than regulation. Practice is defined by those in the profession who make their life's work the fulfillment of that practice, for the benefit of those they serve.

Since at least 1973, ANA and the larger professional nursing community have fulfilled this responsibility to develop and disseminate the broader definition of nursing, the definition of the Scope and Standards of Nursing Practice, and more recently, the definition of specialty nursing scopes and standards of practice. In this draft document, many references are made to the role of NCSBN in defining the practice or the role competencies of advanced practice nurses, when, in fact, this has and will continue to be the responsibility of the profession of nursing.

Figure 1 reflects ANA's perspective of the relationship between the practice of nursing and regulation. As is depicted by the pyramid, while the profession defines

the scope and practice of nursing, the state nurse practice acts and other regulatory language codify those scopes and standards, often using similar if not identical language. Regulators attempt to ensure that codification is enforced. On this basis, ANA finds much that is referenced within the draft document is misstated with regard to the regulators' roles in defining the scope of practice of APRN roles.

**Figure 1. Building Safe, Quality, and Evidence-based Nursing Practice**



**Outcome = safe, quality, and evidence-based practice**

Description of the Graphic:

- The profession needs to be responsible to its members and to the public it serves to define the scope of practice and standards of practice.
- The scope and standards serve as the foundation for legislation and regulatory policy-making.
- Scopes of practice, standards of practice, nurse practice acts and legal regulations guide development of institutional policies and procedures.
- The registered nurse, using skills, knowledge and professional judgment, determines appropriate nursing practice based on the scope of practice, standards of practice, nurse practice act, legal regulation, and institutional policies and procedures.

On page 6 the statement declaring that APRNs are practicing medicine is most troublesome. The scope of practice of nurses may overlap with that of other disciplines, including medicine, but this does not mean that nurses are practicing medicine. The knowledge that nurses acquire and utilize in their advanced practice roles is derived from many sources. It is the synthesis and application of that knowledge that lends support to the advanced practice nurses' competencies, which is built upon the foundation of basic RN education and practice.

- The profession has agreed to and supports the need for second licensure.

This is not the case. While states vary greatly in how they proceed to recognize advanced practice nurses, the basis for licensure is the RN license and no other has been agreed upon. No other profession requires a second license for practicing at a higher skill level. In fact, other professional health disciplines do not support or concede the need for second licensure, whether physicians, physical therapists, pharmacists, etc.. Based upon the single scope of nursing practice agreed to by the profession, the lack of evidence to support the need for second licensure, and the lack of precedent by other health care disciplines, ANA does and will continue to oppose the requirement for a second license. The promotion of a second license by the NCSBN, in combination with its expected effort to dominate the testing market for that second license, create a pathway for conflict and litigation which will not serve the nursing community.

ANA continues to support the need for title protection for the registered nurse and all advanced practice registered nurses, including the clinical nurse specialist, with all nurses working under the RN license.

- All states will adopt the RN multi-state compact and will then continue to endorse the advanced practice compact.

This vision is based upon the assumption that all states agree with the mutual recognition model, when in fact only 21 states have legislated, but not necessarily successfully implemented, this model. ANA continues to be on record with its opposition to the RN compact, based on action taken by the House of Delegates (HOD), ANA's highest governing body. The rationale for the HOD's position is applicable to the Advanced Practice Nurse Compact. In addition to many of the same concerns that plague the RN/LPN nurse compact, ANA has additional concerns about an advanced practice compact which will need to reconcile the even wider variations in practice that occur from state to state, based upon state practice acts and overlap with other disciplines.

- The broadest level of education for an advanced practice role is what is required for public safety, consumer knowledge and uniformity of regulation.

Application of this concept and premise is the least acceptable. Having all APRNs, or even just all NPs and CNSs, prepared at the generalist level means that none of the

APRNs will be educated adequately to meet the needs of large consumer populations. Just as physicians have evolved to recognize that the general practitioner (family practice physician) cannot meet a significant percentage of patient care needs, likewise for APRNs. It can be readily demonstrated that a certified Pediatric Nurse Practitioner (PNP) is more knowledgeable about pediatrics than most family practice physicians.

To require that all APRNs be prepared as generalists such as family nurse practitioners, rather than as adult, pediatric, geriatric, psychiatric, neonatal, cardiovascular, women's health, or other specialists, suggests that consumers don't deserve a different level of expertise for their care. The RN is provided the broad knowledge of care across the continuum in an undergraduate program. To what end does repeating this process serve? Such a regulatory plan creates a large group of less specialized providers who then have to seek yet more education to be prepared to care for the population they most wish to serve. To waste the financial resources and graduate educational program time to prepare everyone to treat neonates to geriatrics is counter to providing the necessary clinicians to increase access to quality health care. Because the unique contributions and skills of these APRNs is undervalued, consumers will have less access to specialized advanced practice nursing.

Two negative and interrelated legal implications of the vision statement provide significant legal concerns for ANA and its related entities. First, the creation of a second licensure exam would effectively eliminate certain ANCC advanced practice certification exams as well as certification exams from other nursing certifying bodies. By essentially eliminating certifying bodies from testing advanced practice nurses, NCSBN would be undertaking a restrictive action affecting the certifying industry. In an effort to avoid liability, NCSBN cannot resort to the argument that it is essentially a state entity taking this action. The law governing public entities, and private entities working on behalf of the state, does not extend to the lengths that NCSBN would have to assert to avail itself of such a defense. Furthermore, if the NCSBN vision statement is nothing more than subterfuge to effectuate legislative change to give NCSBN a competitive advantage in promoting its own second license examination, NCSBN's efforts should fail because the law limits such actions.

Second, the vision statement purposefully creates the impression that the certifying bodies' exams are somehow too deficient to be a reliable indicator for testing minimal competence for advanced practice. By implying that certifying bodies' exams are deficient, when psychometric studies indicate otherwise, NCSBN is potentially attempting to dominate a market based upon representations unsupported by evidence. Such actions lie outside of the realm of protected actions under the law and could be challenged for commercial disparagement, product disparagement and trademark dilution/service mark infringement. Furthermore, depending on how far NCSBN takes these claims against certifying exams, NCSBN may be engaging in libel or fraud or could be liable for interfering with existing contract relations, prospective business, and business expectancy.

Much has been stated within the vision paper about attempts to create uniformity, reduce confusion, provide a broader level of preparation, and reduce risk to the public. Yet, each of these recommendations have the goal of reducing advanced practice nursing to its least common denominator, of wishing to test the minimal skills needed at a role level for the clinical nurse specialist (CNS) or nurse practitioner (NP), to minimize the significance of advanced practice certification which is what determines minimum competence to practice, and to discourage and create barriers to the evolution of advanced practice. From a practice perspective, whether as an RN or an APRN, nursing has changed from what it was 10, 20 or 30 years ago.

Both the RN and the APRN provide care, use skills and meet needs within the evolving scope of nursing practice that did not exist in 1980 or even 1990. Today's RN has far more advanced physical assessment skills, knowledge of pharmacology and experience in disease management, due to the increasing complexity of the patient seen in whatever setting the nurse works. Technology will also continue to drive this knowledge and skill set. Acute Care Nurse Practitioners (ACNPs), and the broader NP roles, utilize much greater knowledge, skills and abilities today to manage acute care needs than in the past. If nursing had been constrained to the extent being proposed in this vision statement, none of these advances would have been likely. Nursing must preserve the responsibility of the profession to evolve to meet the needs of the changing populations being served.

While many recommendations have been proposed, there has been no evidence provided in the vision paper to support the level of action required by the proposed recommendations. ANA is very concerned about the subsequent potentially negative impact these recommendations will have to over 240,000 advanced practice nurses. Where is the evidence that justifies the significant changes in practice, income, restrictive regulation, and new barriers to the continued evolution of nursing practice that will be affected?

### **Comments regarding the Premises upon which the vision is framed**

ANA shares the responsibility for providing for the health and wellbeing of the public and understands NCSBN's accountability to the public, but there were several premises identified in the vision paper that received repeated challenges from our members.

In particular, Premise 5 was not supported, for the following reasons:

- Millions of consumers do know the competencies of APRNs. They purposefully seek advanced nursing practice professionals when not available within a practice setting or care organization and rely on APRNs for their health care needs.
- The scope of RN practice includes APRN practice as part of continuum. (*Nursing: Scope and Standards of Practice*, 2004)
- APRNs, while having autonomous practice, as do many other disciplines, have no greater risk of creating harm than these other healthcare providers. In fact, evidence from the National Practitioner Data Bank and the Health Care Integrity and Protection Data Bank demonstrate substantially less risk and fewer complaints about APRNs.

- If the recommendations of the vision paper were implemented, many more APRNs would be in jeopardy of not being recognized for purposes of reimbursement.

Premise 6 also was described repeatedly by ANA members as offensive, because:

- RNs, whether performing in an advanced practice role or in a staff nurse or other role, consistently state that RN practice is knowledge-based, with critical thinking as a critical component. Nursing practice is not a functional list of tasks.
- The *ANA Principles of Nurse Staffing* repeatedly makes the point, as do the documents relating to *Principles of Delegation*, that RNs must have the knowledge and critical thinking skills to effectively delegate to others. These critical thinking skills and the related knowledge and skills, require that the RN determines the necessary skill mix and level of staffing for that patient population in that unit or setting to ensure the early identification of patients who are at risk of serious complications or death.
- Rapid response teams are built upon the concept that the nurse will first recognize that something is significantly wrong with a patient, based upon her assessment, and raise the alarms. This critical ability is derived from the complex knowledge of what constitutes a normal or abnormal response to illness or injury.

### **Other Comments regarding the proposed Recommendations**

**Recommendation 1)** Boards of Nursing will be the sole regulators of Advanced Practice Registered Nurses.

As currently interpreted, ANA is generally supportive of the effort to have all APRNs, as well as all RNs, regulated by Boards of Nursing rather than any other entity. ANA would support this as long as Boards of Nursing worked to bring APRN roles up to the equivalent status of the majority of states. For example, Pennsylvania nurse midwives currently do not have prescriptive authority and are currently under the purview of the medical board. ANA would expect that these and any other APRNs with restrictions to practice would have an improved practice status.

**Recommendation 2)** APRN licensure will be in the categories and title of nurse anesthetist, nurse midwife, and nurse practitioner.

ANA is opposed to this recommendation based upon recognition of the value of the clinical nurse specialist role during its 60 years existence. ANA is committed to facilitating a process that will assist the CNS community to identify and come to consensus regarding a common set of role competencies which can be nationally endorsed. Building upon the outcome of this consensus, ANA has also committed to facilitate a consensus process to determine a nationally endorsed set of educational standards for preparation of CNSs. This is a far more appropriate method for resolving any confusion, yet preserves the access for patients and providers to a highly valued role within nursing as advanced practice nurses. The impact of the loss of CNSs has been demonstrated, as institutions mistakenly believed the CNS role could be eliminated to

save money. Institutions soon realized they needed the skills of the CNS in their systems to provide quality patient care. Ultimately, CNSs have been rehired and continue to be in demand, as evidenced by the over 72,500 practicing CNSs (*National Sample Survey of Registered Nurses*, 2004).

ANA also believes that the role of NPs and CNSs are very different in most settings and populations served. To suggest in this recommendation that CNSs who prescribe should be grandfathered into the NP role denies the complexity of both the NP and CNS roles and the recognition that both roles serve unique and separate needs. The role competencies extend far beyond the issue of prescriptive authority. ANA does not agree with this recommendation.

**Recommendation 3)** Boards of nursing will approve APRN programs for purposes of licensure.

ANA does not support the approval of graduate programs by boards of nursing. The intent of educational standards based upon role competencies is to provide the vehicle for accreditors to implement and enforce the minimums necessary for educational curricula to appropriately provide the education of an APRN in the least restrictive manner while allowing for evolution. Today's system meets the need. ANA does not understand the appropriateness of boards of nursing to then weigh in further in this regard, unless a program has been deemed unacceptable. Furthermore, the boards of nursing do not have the expertise or infrastructure to adequately review and determine effectiveness of these programs for licensure. Currently most boards of nursing struggle to meet the demand for some sort of review for regulation of undergraduate programs.

**Recommendation 4)** All programs leading to APRN licensure, including clinical practice doctorate and post master's degree programs, will meet established educational requirements.

ANA believes that programs should be expected to meet nationally recognized education standards for minimum content, as well as clinical practice hours within the defined role and specialty. However, ANA would not support this recommendation, based upon the philosophy that this is required for second licensure. We also believe that it is not the purview of boards of nursing to determine what is specialty or subspecialty practice. A well defined process, with established criteria for recognition of a nursing specialty, is already in place and used by the profession. It is inappropriate for regulators without any expertise in the specialty or direct participation in the professional organizations to determine this for the profession.

**Recommendation 5)** Requirements for licensure as a nurse practitioner will include successful completion of a core nurse practitioner licensure examination and a residency program.

ANA has been opposed to the concept of a separate core licensure examination for advanced practice nursing for over a decade. Role competencies that are not tested within

the light of the specialty knowledge obtained at the advanced practice level serve no purpose in protecting the public. It is without precedent in other health care professions. In addition, any core role content required for the specialty is already tested within the specialty. Testing a geriatric or a pediatric nurse practitioner regarding health assessment, diagnosis, treatment, disease management prescribing, or other pharmacology, using the same questions and examples is illogical. The level at which one could legitimately test these skills has already been done via the RN licensing examination.

ANA questions the need for a residency for APRNs, given that clinical practicum requirements are well defined in terms of hours, preceptors, and other conditions for APRN educational programs. Inconsistencies in the presentation of this requirement throughout the document create significant confusion about the sequencing of licensure, examination, and full and limited licensure. Would this residency be a substitution for a clinical practicum? Would it apply equally to all APRNs, including nurse anesthetists and midwives? What would the level of recognition be for the APRN in residency, and how will this affect their ability to obtain reimbursement, obtain clinical privileges or prescriptive privileges? If there is evidence to support that APRNs are not minimally competent upon graduation, then should it not be the educational programs that increase the number of clinical hours within the program? What is this evidence that demands a residency program for APRNs?

For ANA to support such a residency requirement, in addition to satisfactory answers to the above questions, we would expect that any residency requirements would not create an additional financial burden upon the APRN graduate, extend their educational obligations, or affect their ability to be compensated.

**Recommendation 6)** Evidence of continued competency will be required for purposes of licensure renewal.

ANA does not support this recommendation because of the second licensure requirement. If specialty certification programs are deemed insufficient to provide evidence for recognition for specialty practice for APRNs, how can these initiatives demonstrate continued expertise after licensure? There are currently many options in place for APRNs to demonstrate beginning and continuing competence. While ANA is supportive of continued competence for all RNs, it believes that a variety of options already exist for many APRNs that are substantial and meaningful. ANA believes it is the role of the profession to define beginning and continuing competence for all RNs, including APRNs.

**Recommendation 7)** Fully licensed APRNs will be independent practitioners. After licensure, there will be no regulatory requirements for supervision.

ANA supports the concept of independent practice without the need for supervision. However, inclusion of the statement about supervision by a physician contradicts such a statement. ANA does not support that this independent practice needs to be based upon second licensure, as that definition is understood. ANA would view as sufficient the successful completion of an educationally appropriate program and demonstration of

certification as documentation of minimum competence to practice safely. The completion of a residency appears duplicative of existing requirements and there are many questions to answer before ANA would give its support.

**Recommendation 8)** The Advanced Practice Compact will be the regulatory model used to effect mutual recognition of advanced practice nurses.

ANA has been opposed to the multi-state compact for reasons that have been previously stated. Likewise, ANA does not support an advanced practice compact that has to respond to far greater diversity in statutes and regulatory language that codify the roles of APRNs. There is concern with regard to such a compact that APRN practice and educational preparation would be compromised and be reduced to the lowest common denominator in order to achieve common language.