



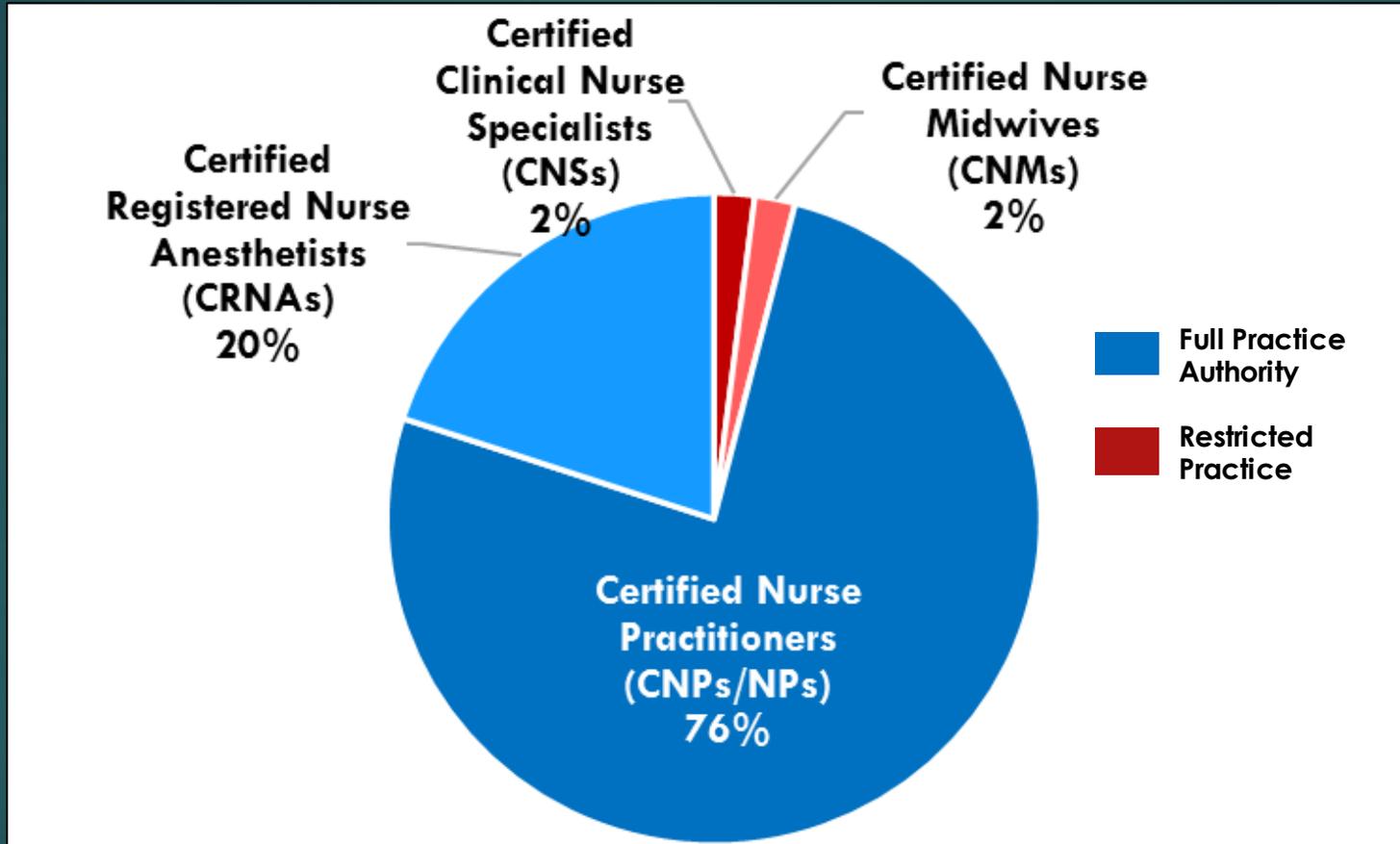
APRN Credentialing Review

OCTOBER 8, 2020

The Proposal

- 
- ▶ **Create a single statute for uniform regulation of all APRNs**
 - ▶ APRN Consensus Model
 - ▶ Nebraska Gubernatorial EO# 17-04
 - ▶ **Full Practice Authority for CNSs and CNMs**
 - ▶ Remove regulatory barriers to practice
 - ▶ Increase access to care

96% of Nebraska APRNs currently have Full Practice Authority



Full Practice Authority for APRNs

1. *Practice to the top of education and certification*
2. *Accountability for practice under the authority of APRN licensure*

Current state: Inconsistent regulation, based on past history and incremental legislation

	CNM	CRNA	CNS	NP
▶ National certification	Yes	Yes	Yes	Yes
▶ Accredited APRN Ed	Yes	Yes	Yes	Yes
▶ Full practice authority	No	Yes	^No	Yes
▶ Practice agreement	Yes	No	No	No
▶ Prescriptive authority	*Yes	Yes	^No	Yes
▶ Transition to Practice (TTP)	No	No	No	Yes

* Limited by practice agreement

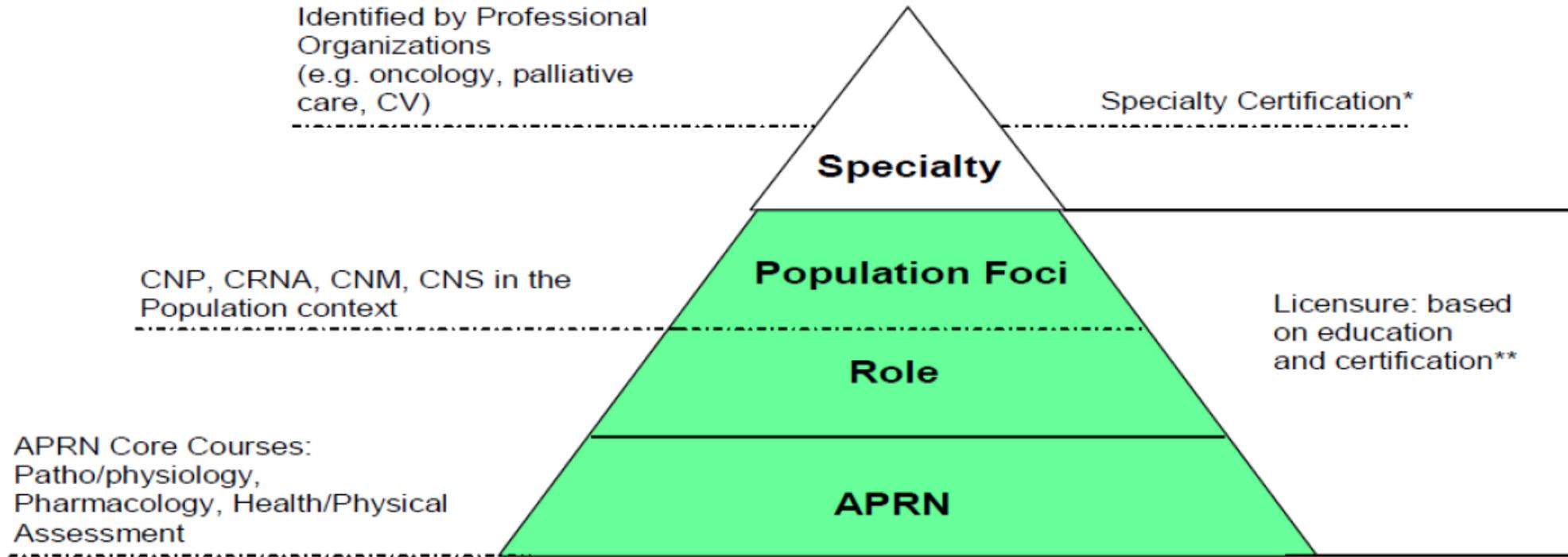
^ Statute currently silent



***The APRN Consensus Model
is the model for
state implementation of
full practice authority***

Competencies

Measures of competencies



* Certification for specialty may include exam, portfolio, peer review, etc.

** Certification for licensure will be psychometrically sound and legally defensible examination be an accredited certifying program,



Education

4-008.04 CRITERION FOUR: THE CURRENT EDUCATION AND TRAINING FOR THE HEALTH PROFESSION ADEQUATELY PREPARES PRACTITIONERS TO PERFORM THE NEW SKILL OR SERVICE.

APRN Education

- ▶ American Association of Colleges of Nursing
 - ▶ Establish educational benchmarks and expected outcomes
 - ▶ Delineates expected competencies and essential curricular elements
 - ▶ *Nursing science, evidence-based standards*
- ▶ Competencies are aligned insuring that they are appropriately leveled and advance nursing practice across the healthcare system and continuum of care
- ▶ See handouts that reflect curricula for each of the four roles
- ▶ Post-graduate education and certification can be obtained for additional role/population (e.g., Psych/Mental health)

Competency

4-008.05 CRITERION FIVE: THERE ARE APPROPRIATE POST-PROFESSIONAL PROGRAMS AND COMPETENCE ASSESSMENT MEASURES AVAILABLE TO ENSURE THAT THE PRACTITIONER IS COMPETENT TO PERFORM THE NEW SKILL OR SERVICE IN A SAFE MANNER.

4-008.06 CRITERION SIX: THERE ARE ADEQUATE MEASURES TO ASSESS WHETHER PRACTITIONERS ARE COMPETENTLY PERFORMING THE NEW SKILL OR SERVICE AND TO TAKE APPROPRIATE ACTION IF THEY ARE NOT PERFORMING COMPETENTLY.

<u>Accreditation, Education, Certification and Licensure</u>	Certified Clinical Nurse Specialist	Certified Nurse Midwife	Certified Registered Nurse Anesthetist	Certified Nurse Practitioner
Completion of an <u>Accredited</u> Education Program	✓	✓	✓	✓
Minimum Master's Degree				
<u>Education</u> Core Content Graduate-Level <ul style="list-style-type: none"> • Advanced Pathophysiology • Advanced Pharmacology • Advanced Physical Assessment 	✓	✓	✓	✓
National <u>Certification</u> from an <u>Accredited</u> Certifying Body Certification is the formal recognition of the knowledge, skills and experience demonstrated by the achievement of standards identified by the profession	✓	✓	✓	✓
<u>Licensure</u> Occurs at the Level of Role and Population Foci	✓	✓	✓	✓



What is the evidence?

4-008.03 CRITERION THREE: THE PROPOSED CHANGE IN SCOPE OF PRACTICE DOES NOT CREATE A SIGNIFICANT NEW DANGER TO THE HEALTH, SAFETY, OR WELFARE OF THE PUBLIC

APRN-CNS Outcomes

Clinical Nurse Specialist (CNS)

▶ **Primary role is chronic disease management**

- ▶ Discharge planning and follow-up created a significant reduction in readmissions in cardiac patients Naylor et al, 1999, 2004
- ▶ Significant increase in patient satisfaction with CNS management of breast cancer patients Libert et al, 2003
- ▶ Significant reduction of catheter-related infections in acute care hematology patients Moller et al, 2005
- ▶ Overall positive impact on the quality of life, satisfaction, hospitalization, and cost of patients living with chronic disease/illness Moore & McQuestion, 2012
- ▶ Develop evidence based, best practices to improve patient outcomes across care settings Gordon, Lorilla, Lehman, 2012

APRN-CNM Outcomes

Certified Nurse Midwife (CNM)

- ▶ Lower preterm births, fewer c-sections, cost savings (\$2000 per mother-baby) and improved outcomes over women with similar risk factors delivering in traditional hospital-based care

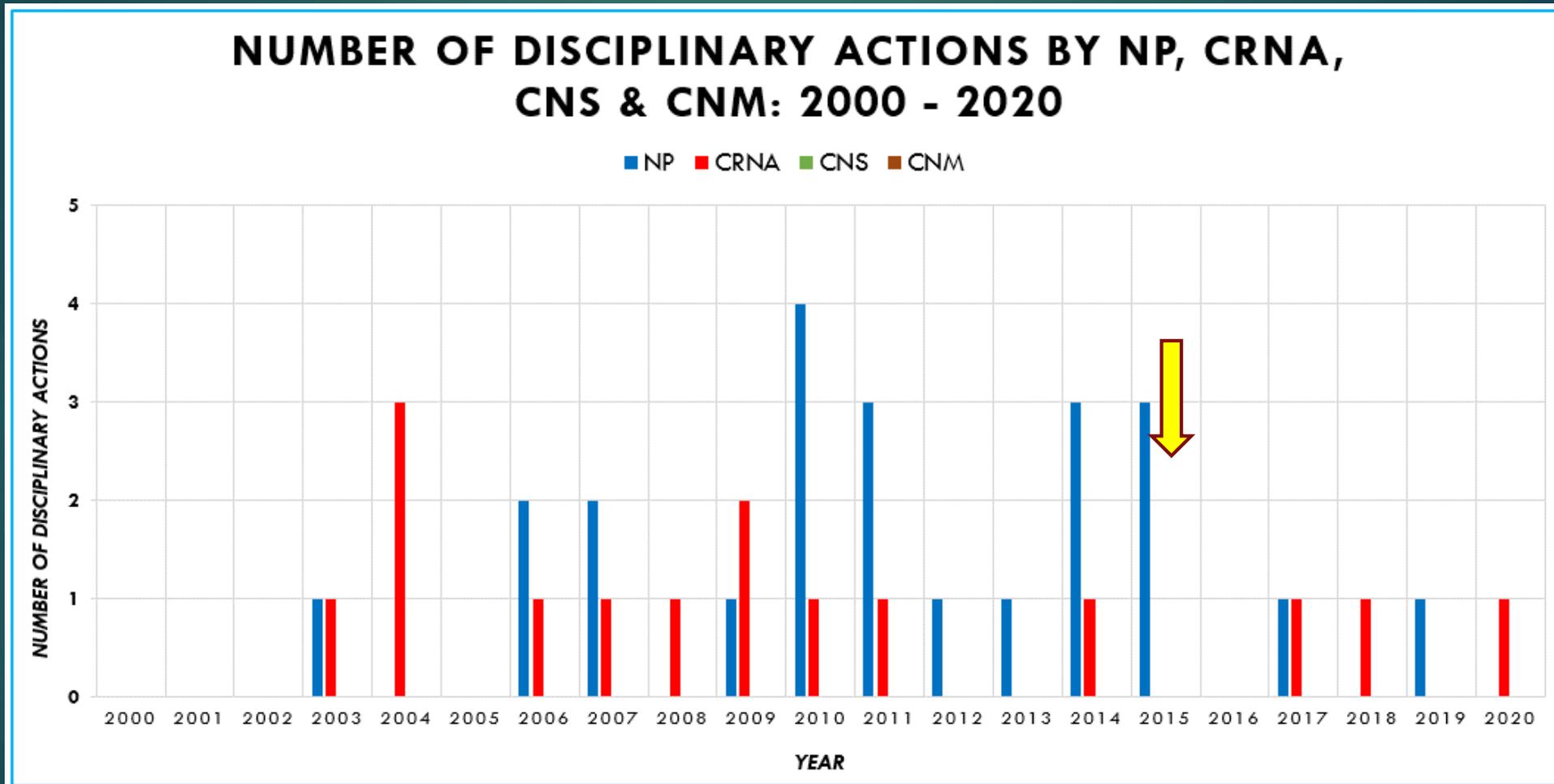
CMS “Strong Start” Initiative, 2018; Cochrane 2016

- ▶ 85% of women delivering in hospitals are low-risk and appropriate for CNM care American Association of Birth Centers, 2016

- ▶ Women with risk factors benefit from CNM-led care or collaborative care with a maternal-fetal medicine specialist Cochrane, 2016

- ▶ 10% of time spent on deliveries—90% of practice is prenatal, postnatal, gynecological and newborn care Personal Communication, 2020

How safe are Nebraska APRNs?





Why does this matter for Nebraska?

4-008.01 CRITERION ONE: THE HEALTH SAFETY, AND WELFARE OF THE PUBLIC ARE INADEQUATELY ADDRESSED BY THE PRESENT SCOPE OF PRACTICE OR LIMITATIONS ON THE SCOPE OF PRACTICE.

4-008.02 CRITERION TWO: ENACTMENT OF THE PROPOSED CHANGE IN SCOPE OF PRACTICE WOULD BENEFIT THE HEALTH, SAFETY, OR WELFARE OF THE PUBLIC

Nebraska APRNs with Full Practice Authority (FPA)

Certified Registered Nurse Anesthetists (CRNAs)

- ▶ 99% ORs Nebraska HHS testimony, 2015
- ▶ Only anesthesia providers > 95% Critical Access Hospitals (CAHs)
T. Rauner, UNMC Health Professions Tracking Service, December 2018

Nurse Practitioners (NPs)

- ▶ 47.8% growth in rural Nebraska 2008 – 2018 mirrors trend (43.2%) in other FPA states Barnes, et. al., 2018
- ▶ NPs provide 75-100% Emergency Department (ED) coverage in some Critical Access Hospitals (CAHs) Nebraska Nurse Practitioners, 2020
- ▶ Following implementation of FPA in 2015, dramatic increase in NPs providing psychiatric-mental health services Nebraska Center for Nursing, 2018



Number of APRNs Working in a Rural Health Clinic (RHC) or Critical Access Hospital (CAH)

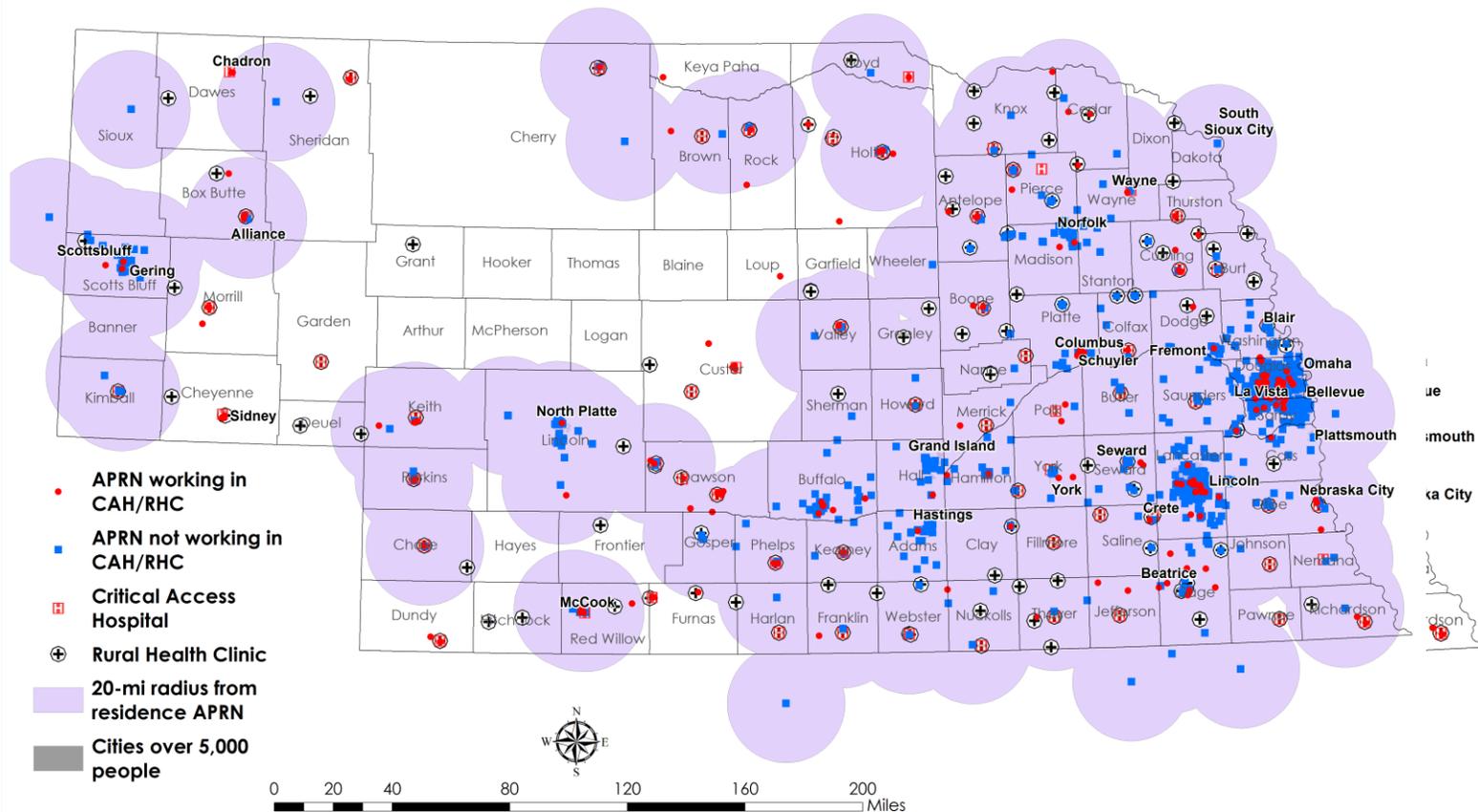
Type of Health Care Facility	Total Number of APRNs
Rural Health Clinic	23
Critical Access Hospital	150
Work in both type of settings	23
Total	196

In 2018, 196 APRNs (10.5% of the APRN workforce) were employed in a RHC and/or CAH

Nebraska Center for Nursing, 2018

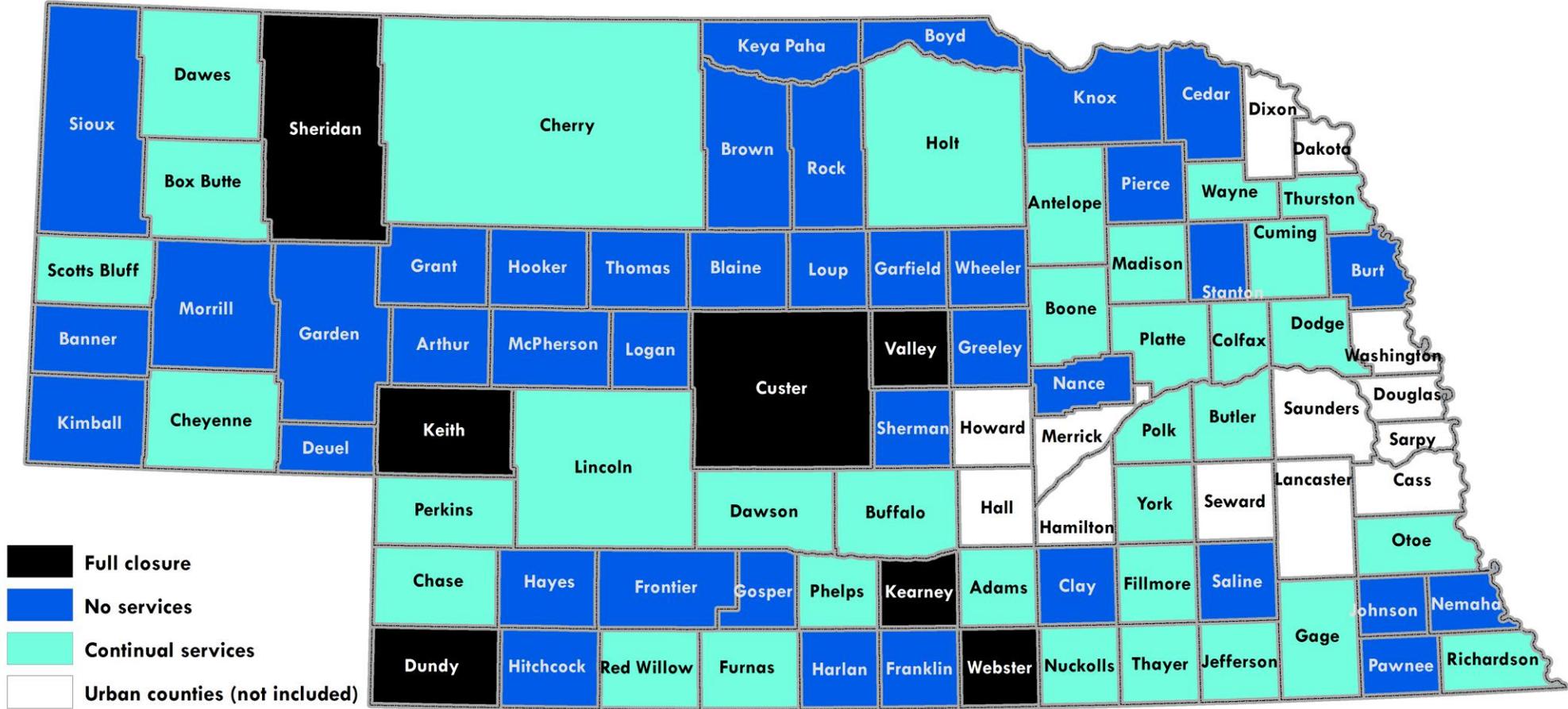
Proximity of the APRN Workforce

20-mile buffer from APRNs overlapping location of RHCs & CAHs



- 91% of Rural Health Clinics (RHCs) ($n = 130$) and 87% of Critical Access Hospitals (CAHs) ($n = 56$) are located within a 20-mile radius of an APRN not working there
- APRNs have the capacity to improve access to services provided in these practice settings

Hospital obstetric services in Nebraska counties, 2004–14



DEFINITIONS:

Full closure: all in-county hospital obstetric services closed during the study period.

No services: no in-county hospital obstetric services in the study period.

Continual services: at least one in-county hospital that provided obstetric services in the study period.

SOURCE:

Hung, P., Henning-Smith, C. E., Casey, M. M., & Kozhimannil, K. B. (2017).

Access to obstetric services in rural counties still declining,

with 9 percent losing services, 2004–14.

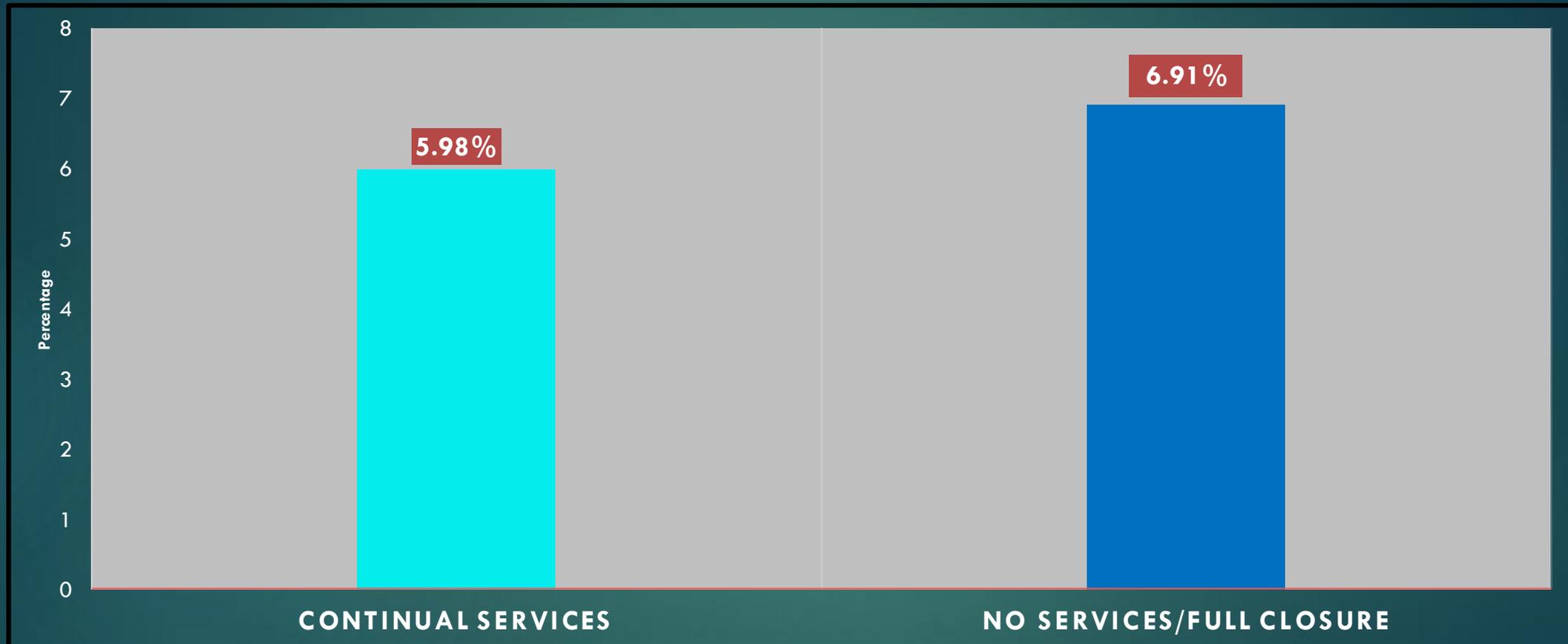
Health Affairs, 36(9), 1663-1671.



**NEBRASKA
CENTER FOR
NURSING**

March 2020

Average percentage of low birthweights by hospital obstetric services in Nebraska

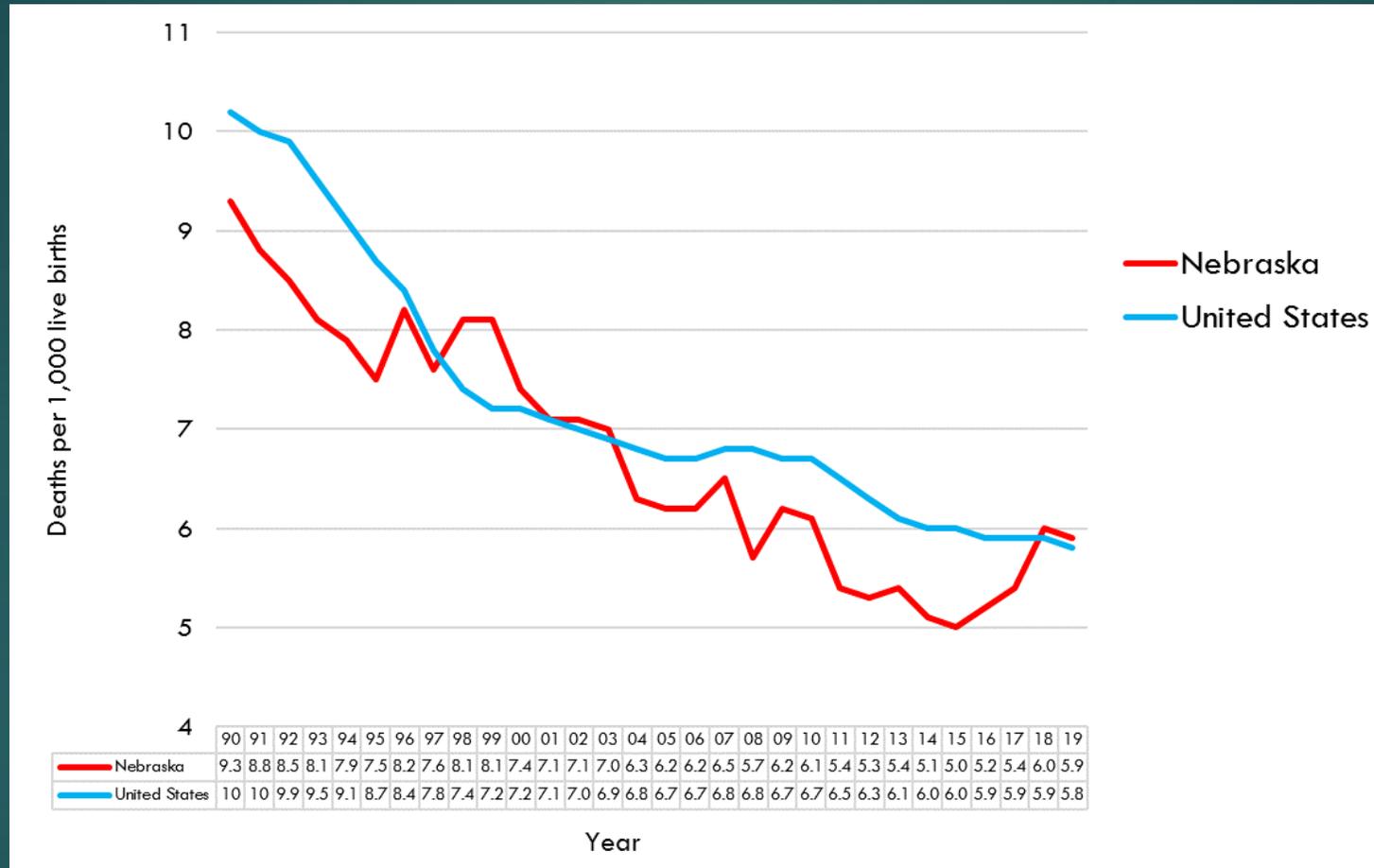


Sources:

Hung, P., Henning-Smith, C. E., Casey, M. M., & Kozhimannil, K. B. (2017). Access to obstetric services in rural counties still declining, with 9 percent losing services, 2004–14. *Health Affairs*, 36(9), 1663-1671.

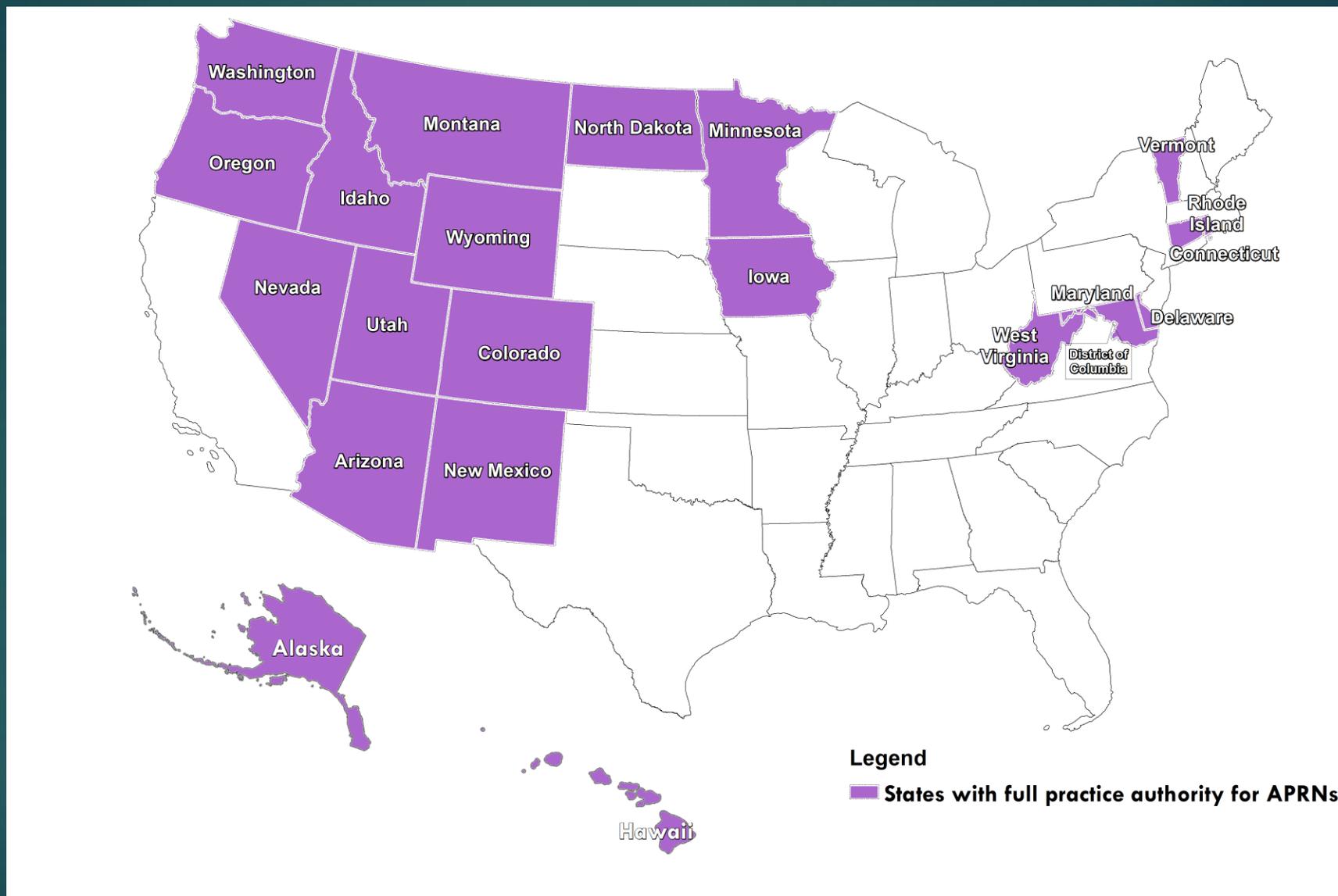
Infant Mortality Trend

1990-2019



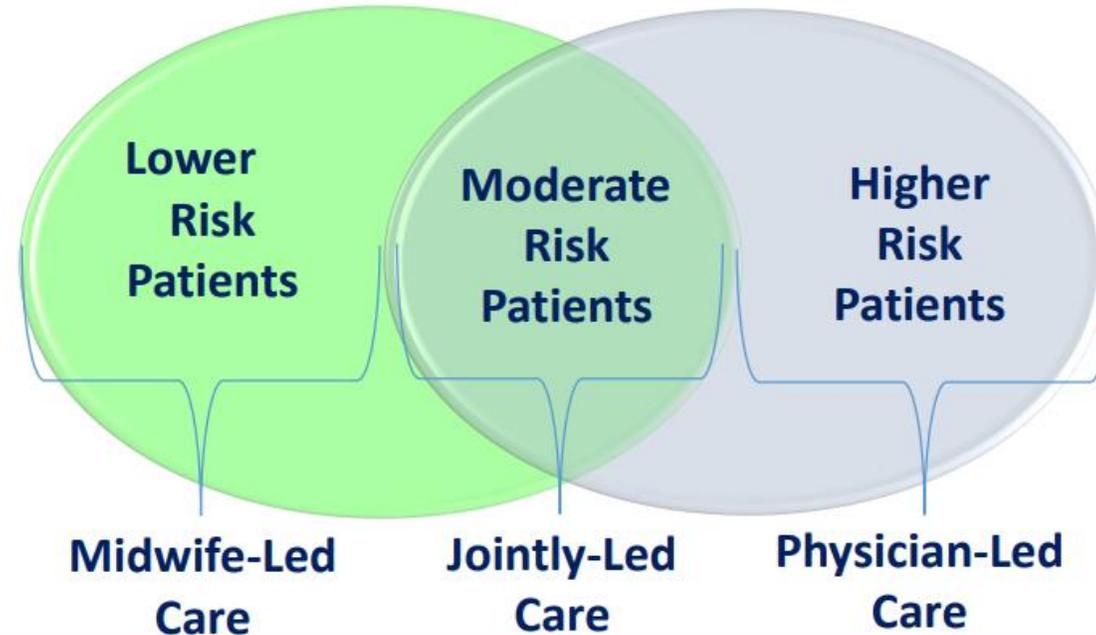
Number of infant deaths (before age 1) per 1,000 live births (2-year estimate)

APRN Friendly States in the U.S.



Source: <https://nursingamerica.org/>

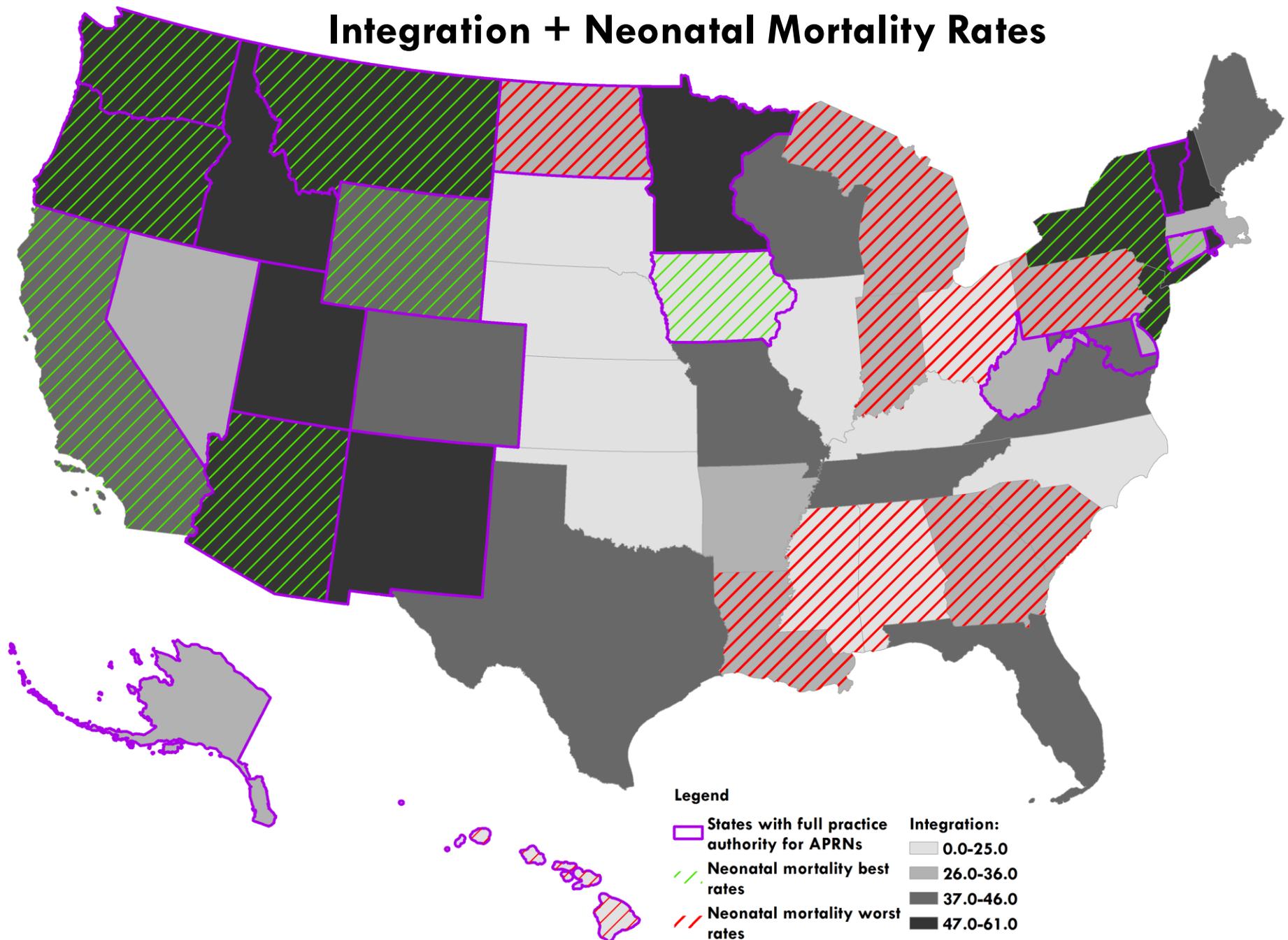
Integration of Midwifery Services



“Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.”

Joint Statement of Practice Relations Between Obstetrician/Gynecologists and Certified Nurse-Midwives/Certified Midwives

Integration + Neonatal Mortality Rates



Source: <https://www.birthplacelab.org/maps/>

Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, Cheyney M, et al. (2018) PLoS ONE 13(2): e0192523. <https://doi.org/10.1371/journal.pone.0192523>

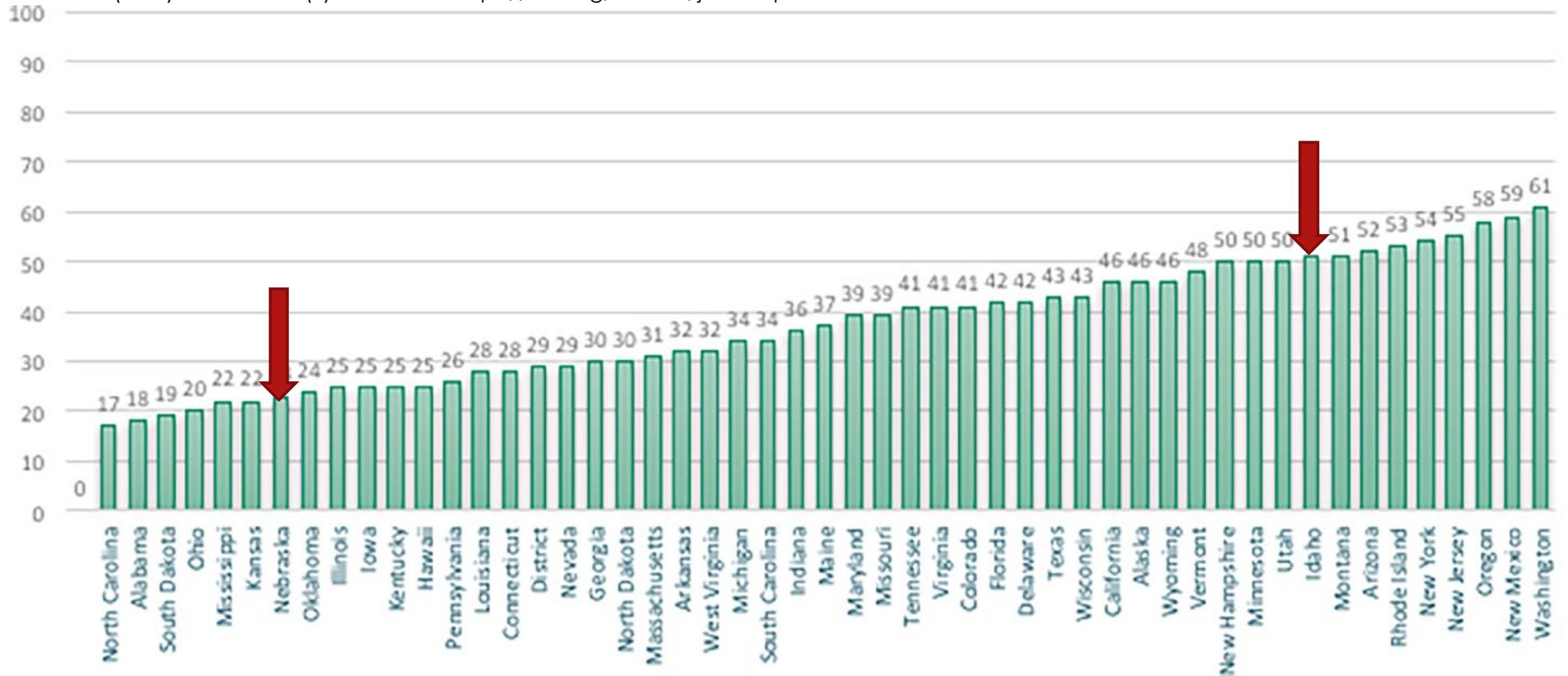
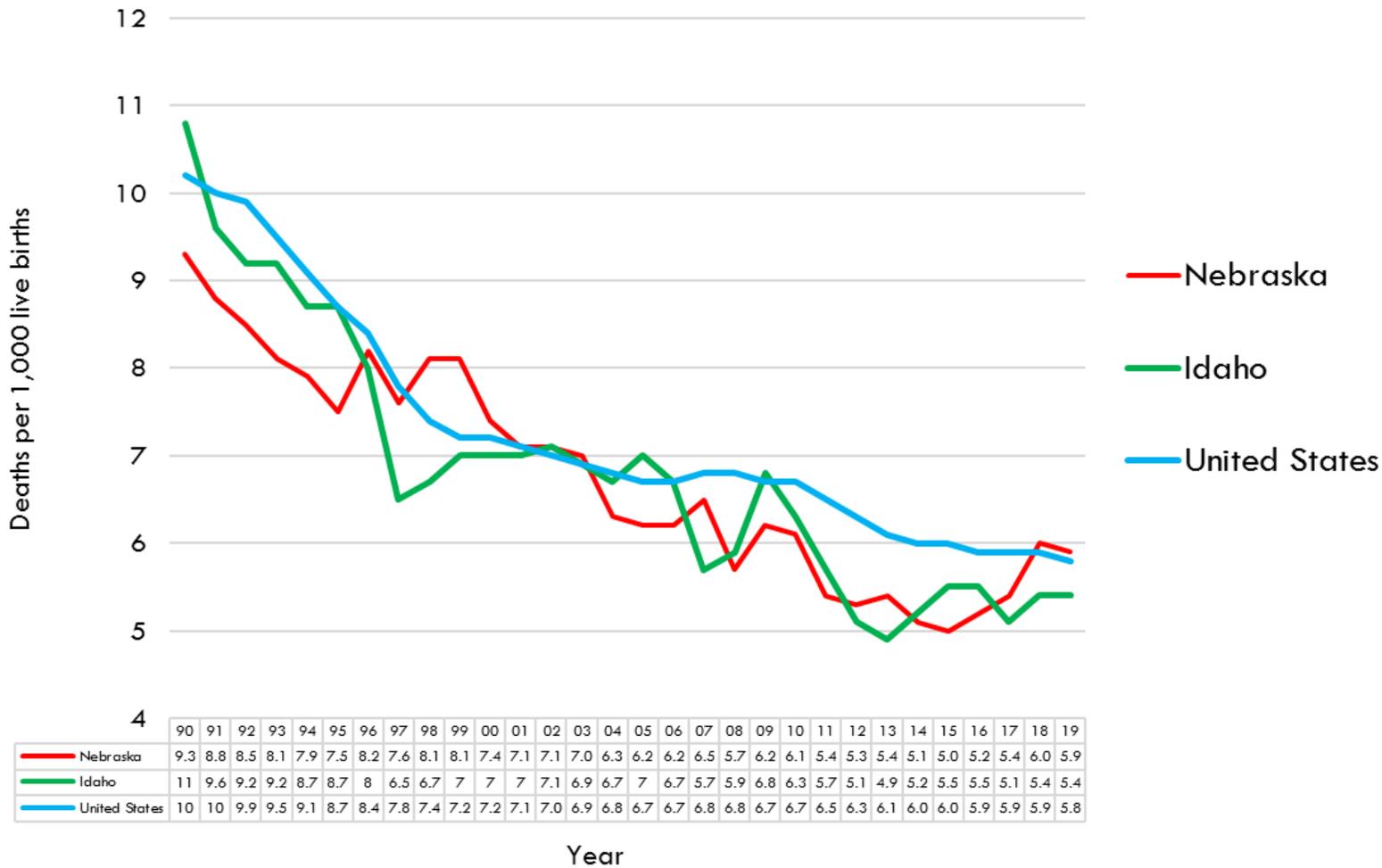


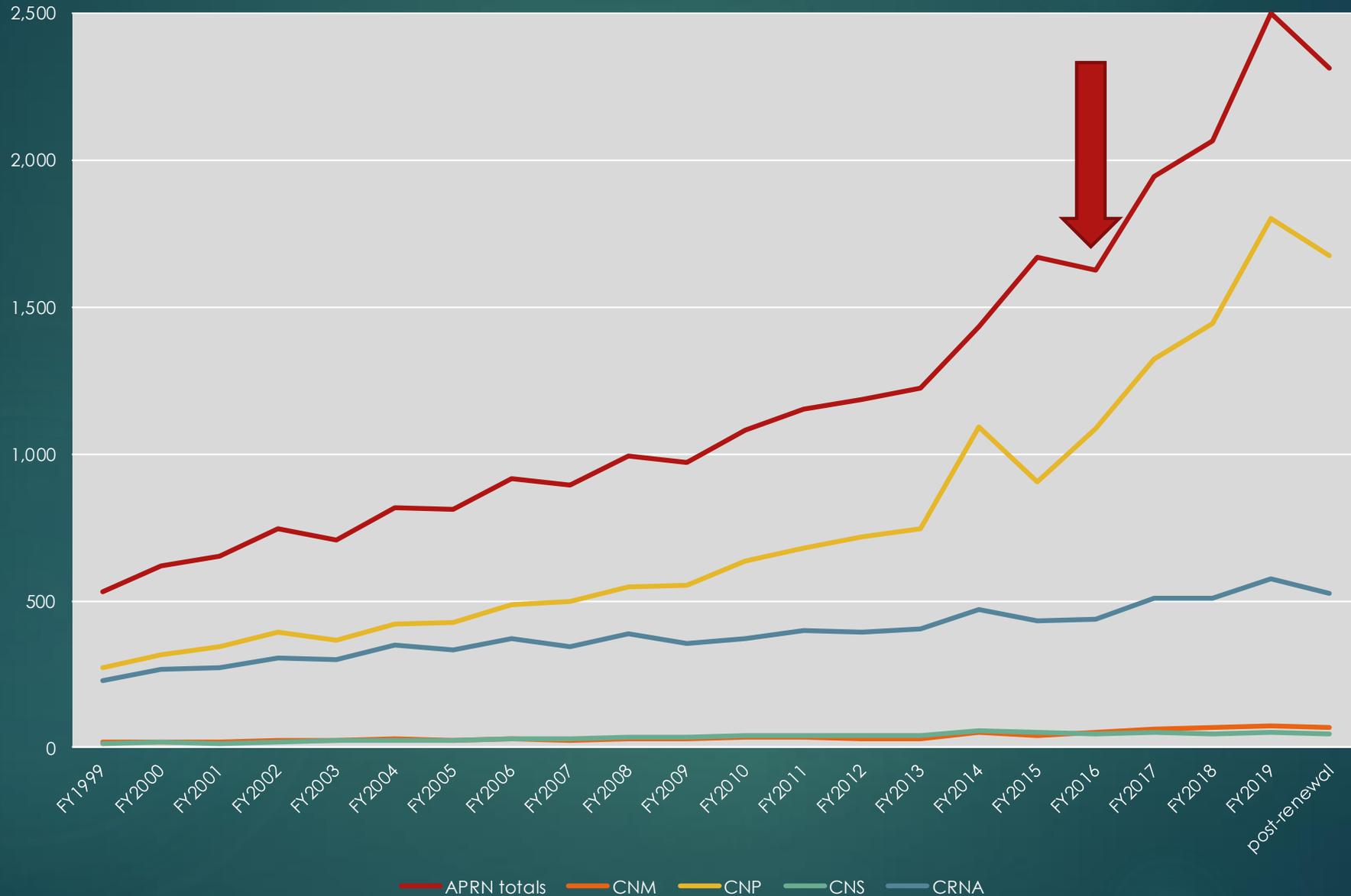
Fig 1. Rank-ordered integration scores for 50 states and Washington, DC (2014–2015).

Infant Mortality Trend in Nebraska, Idaho, and the U.S. 1990-2019



Number of infant deaths (before age 1) per 1,000 live births (2-year estimate)

Idaho APRN Active License Counts



CNP 104%

CRNA 51%

CNM 107%

CNS 27%

Not a New Problem

1991 BOARD OF HEALTH STUDY

Solutions To the Rural Health Crisis in Nebraska

Mid-Level Practitioners: Alternatives to a Declining Physician Population

Report of Findings by the Mid-Level Practitioners Task
Force of the Board of Health

and

Staff Report of Findings by the Nebraska Board of Health

June 1991

Introduction

In response to the deepening rural health crisis, the State of Nebraska sponsored a Conference and subsequent regional forums between 1989 and 1990 to identify possible solutions.

The result was publication of the Rural Health Agenda for Nebraska in October, 1990, calling for action in several areas. This task force is an initiative of the Nebraska Board of Health to focus on "mid-level practitioners": Physicians Assistants, Nurse Midwives, and Nurse Practitioners.

The Task Force builds on the findings of an internal report on the subject by the Department of Health, adding input from representatives of key educational, governmental and professional associations as well as drawing extensively from numerous professional and general publications.

The Agenda found that the physician was the cornerstone of the rural health system, but many were retiring or relocating to urban areas.

Nationally in 1988 there were 13,000 rural regions needing 4,100 physicians. In Nebraska there are 43 states designated family practice shortage areas and 24 federally designated primary care health manpower shortage areas.

90 Nebraska communities are actively recruiting a doctor, but others say have given up or feel overwhelmed. It is difficult for an economically depressed rural community to understand why they have to put together a committee to go out and recruit a doctor to come into the area to make more money than most of the residents, who are already quite happy to live and work there without special considerations. Some U.S. towns have gone as far as offering \$1,000 cash bounties for a doctor.

Despite the need, doctors are not going to the rural communities. 251 of U.S. doctors in counties of less than 10,000 people plan to retire or relocate within five years. The number of medical students who prefer to practice in rural areas has decreased by 50% since 1985. Between 1973 to 1985, the number of U.S. doctors increased 32% overall, but rural physicians increased only by 14%. Current trends suggest that only 5-8 new doctors will start rural practice in Nebraska per year.

One problem is maldistribution. While 15% of the U.S. population is rural (33% in Nebraska), only 13% of doctors practice there.

Federal policy changes extended to state practice

▶ **Veterans Affairs (VA) System**

- ▶ Largest integrated health system in the US for primary care
- ▶ Largest employer of nurses
- ▶ 2016 Ruling granted full practice authority to APRNs

▶ **President Trump**

- ▶ Proclamation #9994, March, 2020
- ▶ Creates waivers from practice agreements that impede public safety

▶ **Governor Ricketts**

- ▶ EO #20-27, June, 2020 – deferred need for any practice agreement, including Certified Nurse Midwives (CNMs)

What have we learned from other states?

- ▶ Based on state sovereignty, all states have individual licensure laws which evolved incrementally over time
- ▶ The APRN Consensus Model is the 'model' for regulatory consistency and implementation full practice authority
- ▶ The APRN Consensus Model brings all 4 roles together for education and certification based on role and population foci
- ▶ The number of APRNs increases in states with full practice authority, with migration to rural areas and underserved populations
- ▶ No state has ever reversed full practice authority for APRNs

Summary

All APRN roles are prepared for full practice authority (FPA)

- ▶ Incremental legislative changes have spawned regulatory inconsistencies and resulted in barriers to APRN practice/access to services
- ▶ APRN education has a common core (3 P's) with subsequent requirements specific to role and population foci – nursing science and evidence-based processes in nationally accredited programs
- ▶ APRNs are licensed for practice following education and certification for a specific role and patient population

APRNs are SAFE Practitioners

- ▶ There are competency requirements for maintaining active certification for license renewal
- ▶ Very few APRN discipline cases in NE w/wo FPA
- ▶ There is ample evidence for quality, safety and cost-effective outcomes for APRN practice
- ▶ Experience in other states demonstrates steady legislative progress towards full practice authority

Current state: Inconsistent regulation, based on past history and incremental legislation

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Future state: *One Statute* *Consistent Regulation*

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